AMA
AMERICAN MEDICAL ASSOCIATION

# AMA House of Delegates Handbook

## 2025 AMA Interim Meeting
## Gaylord National Resort & Convention Center
## Nov. 14–18

Access the handbook online at ama-assn.org/hod-business.

#AMAmtg
@AmerMedicalAssn

INTERIM 25

© 2025 American Medical Association. All rights reserved. AI22:25-1406250:10/25

# MEMORANDUM FROM THE SPEAKER OF THE HOUSE OF DELEGATES

- **All Delegates, Alternate Delegates and others receiving this material are reminded that it refers only to items to be considered by the House.**

- **No action has been taken on anything herein contained, and it is informational only.**

- **Only those items that have been acted on finally by the House can be considered official.**

- **The Interim Meeting is focused on advocacy issues. A resolution committee (see AMA Bylaw 2.13.3) considers each resolution and recommends that the item be considered or not considered at the Interim Meeting. Items that meet the following definition of advocacy or that are considered urgent are recommended for acceptance:**

  *Active use of communication and influence with public and private sector entities responsible for making decisions that directly affect physician practice, payment for physician services, funding and regulation of education and research, and access to and delivery of medical care.*

  **Resolutions pertaining to ethics should also be included in the agenda. Remaining items are recommended against consideration, but any delegate may request consideration when resolutions are presented for consideration (during Saturday's "Second Opening" Session). A simple majority of those present and voting is required for consideration.**

- **REMINDER***: Only the Resolve portions of the resolutions are considered by the House of Delegates. The Whereas portions are informational and explanatory only.*

AMA
AMERICAN MEDICAL ASSOCIATION

# UNDERSTANDING THE RECORDING OF AMERICAN MEDICAL ASSOCIATION POLICY

Current American Medical Association (AMA) policy is catalogued in PolicyFinder, an electronic database that is updated after each AMA House of Delegates (HOD) meeting and available online. Each policy is assigned to a topical or subject category. Those category headings are alphabetical, starting with "abortion" and running to "women"; the former topic was assigned the number 5, and "women" was assigned 525. Within a category, policies are assigned a 3 digit number, descending from 999, meaning that older policies will *generally* have higher numbers within a category (eg, 35.999 was initially adopted before 35.984). A policy number is not affected when it is modified, however, so a higher number may have been altered more recently than a lower number. Numbers are deleted and not reused when policies are rescinded.

AMA policy is further categorized into one of four types, indicated by a prefix:

- "H" – for statements that one would consider positional or philosophical on an issue
- "D" – for statements that direct some specific activity or action. There can be considerable overlap between H and D statements, with the assignment made on the basis of the core nature of the statement.
- "G" – for statements related to AMA governance
- "E" – for ethical opinions, which are the recommendations put forward in reports prepared by the Council on Ethical and Judicial Affairs and adopted by the AMA-HOD

AMA policy can be accessed at https://policysearch.ama-assn.org/policyfinder.

The actions of the AMA-HOD in developing policy are recorded in the *Proceedings*, which are available online as well. Annotations at the end of each policy statement trace its development, from initial adoption through any changes. If based on a report, the annotation includes the following abbreviations:

BOT – Board of Trustees
CCB – Council on Constitution and Bylaws
CEJA – Council on Ethical and Judicial Affairs
CLRPD – Council on Long Range Planning and Development
CME – Council on Medical Education
CMS – Council on Medical Service
CSAPH – Council on Science and Public Health

If a resolution was involved, "Res" is indicated. The number of the report or resolution and meeting (A for Annual; I for Interim) and year (two digits) are also included (eg, BOT Rep. 1, A-14 or Res. 319, I-12).

AMA policy is recorded in the following categories, and any particular policy is recorded in only a single category.

| | |
|---|---|
| 5.000 Abortion | 10.000 Accident Prevention/Unintentional Injuries |
| 15.000 Accident Prevention: Motor Vehicles | 20.000 Acquired Immunodeficiency Syndrome |
| 25.000 Aging | 30.000 Alcohol and Alcoholism |
| 35.000 Allied Health Professions | 40.000 Armed Forces |
| 45.000 Aviation Medicine | 50.000 Blood |
| 55.000 Cancer | 60.000 Children and Youth |
| 65.000 Civil and Human Rights | 70.000 Coding and Nomenclature |
| 75.000 Contraception | 80.000 Crime |
| 85.000 Death and Vital Records | 90.000 Disabled |
| 95.000 Drug Abuse | 100.000 Drugs |
| 105.000 Drugs: Advertising | 110.000 Drugs: Cost |
| 115.000 Drugs: Labeling and Packaging | 120.000 Drugs: Prescribing and Dispensing |
| 125.000 Drugs: Substitution | 130.000 Emergency Medical Services |
| 135.000 Environmental Health | 140.000 Ethics |
| 145.000 Firearms: Safety and Regulation | 150.000 Foods and Nutrition |

| | |
|---|---|
| 155.000 Health Care Costs | 160.000 Health Care Delivery |
| 165.000 Health Care/System Reform | 170.000 Health Education |
| 175.000 Health Fraud | 180.000 Health Insurance |
| 185.000 Health Insurance: Benefits and Coverage | 190.000 Health Insurance: Claim Forms and Claims Processing |
| 195.000 Health Maintenance Organizations | 200.000 Health Workforce |
| 205.000 Health Planning | 210.000 Home Health Services |
| 215.000 Hospitals | 220.000 Hospitals: Accreditation Standards |
| 225.000 Hospitals: Medical Staff | 230.000 Hospitals: Medical Staff - Credentialing and Privileges |
| 235.000 Hospitals: Medical Staff - Organization | 240.000 Hospitals: Reimbursement |
| 245.000 Infant Health | 250.000 International Health |
| 255.000 International Medical Graduates | 260.000 Laboratories |
| 265.000 Legal Medicine | 270.000 Legislation and Regulation |
| 275.000 Licensure and Discipline | 280.000 Long-Term Care |
| 285.000 Managed Care | 290.000 Medicaid and State Children's Health Insurance Programs |
| 295.000 Medical Education | 300.000 Medical Education: Continuing |
| 305.000 Medical Education: Financing and Support | 310.000 Medical Education: Graduate |
| 315.000 Medical Records and Patient Privacy | 320.000 Medical Review |
| 330.000 Medicare | 335.000 Medicare: Carrier Review |
| 340.000 Medicare: PRO | 345.000 Mental Health |
| 350.000 Minorities | 355.000 National Practitioner Data Bank |
| 360.000 Nurses and Nursing | 365.000 Occupational Health |
| 370.000 Organ Donation and Transplantation | 373.000 Patients |
| 375.000 Peer Review | 380.000 Physician Fees |
| 383.000 Physician Negotiation | 385.000 Physician Payment |
| 390.000 Physician Payment: Medicare | 400.000 Physician Payment: Medicare - RBRVS |
| 405.000 Physicians | 406.000 Physician-Specific Health Care Data |
| 410.000 Practice Parameters | 415.000 Preferred Provider Arrangements |
| 420.000 Pregnancy and Childbirth | 425.000 Preventive Medicine |
| 430.000 Prisons | 435.000 Professional Liability |
| 440.000 Public Health | 445.000 Public Relations |
| 450.000 Quality of Care | 455.000 Radiation and Radiology |
| 460.000 Research | 465.000 Rural Health |
| 470.000 Sports and Physical Fitness | 475.000 Surgery |
| 478.000 Technology - Computer | 480.000 Technology - Medical |
| 485.000 Television | 490.000 Tobacco Use, Prevention and Cessation |
| 495.000 Tobacco Products | 500.000 Tobacco: AMA Corporate Policies and Activities |
| 505.000 Tobacco: Federal and International Policies | 510.000 Veterans Medical Care |
| 515.000 Violence and Abuse | 520.000 War |
| 525.000 Women | 600.000 Governance: AMA House of Delegates |
| 605.000 Governance: AMA Board of Trustees and Officers | 610.000 Governance: Nominations, Elections, and Appointments |
| 615.000 Governance: AMA Councils, Sections, and Committees | 620.000 Governance: Federation of Medicine |
| 625.000 Governance: Strategic Planning | 630.000 Governance: AMA Administration and Programs |
| 635.000 Governance: Membership | 640.000 Governance: Advocacy and Political Action |

## LIST OF MATERIALS INCLUDED IN THIS HANDBOOK (I-25)

Resolutions and reports have been collated by referral according to reference committee assignment. In the listing below, referral is indicated by letter following the title of the report. Resolutions have been numbered according to referrals (i.e., those referred to the Reference Committee on Ethics and Bylaws begin with 001, Reference Committee B begins with 201, etc.).

The informational reports contain no recommendations and will be filed on Saturday, November 15, unless a request is received for referral and consideration by a Reference Committee (similar to the use of a consent calendar).

1. **Memorandum from the Speaker**

2. **Understanding the Recording of American Medical Association Policy**

3. **Declaration of Professional Responsibility - Medicine's Social Contract with Humanity**

4. **Delegate / Alternate Delegate Job Description, Roles, and Responsibilities**

5. **Seating Allocation and Seating Chart for the House of Delegates**

6. **Hotel Maps**

7. **Official Call to the Officers and Members of the AMA**
   - **Officials of the Association and AMA Councils**
   - **Ex Officio Members of the HOD**
   - **SSS Representatives**
   - **Listing of Delegates and Alternate Delegates**

8. **Reference Committee Schedule and Room Assignments**

9. **Note on Order of Business**

10. **Summary of Fiscal Notes**

11. **List of Resolutions by Sponsor**

### FOLLOWING COLLATED BY REFERRAL

12. **Report(s) of the Board of Trustees - David H. Aizuss, MD, Chair**

| | | |
|---|---|---|
| 01 | Calling for a Multifaceted Approach to the Illicit Fentanyl Crisis | B |
| 02 | Laser Surgery | B |
| 03 | Stark Law Self-Referral Ban | B |
| 04 | Addressing and Reducing Patient Boarding in Emergency Departments (EDs) | B |
| 05 | Addressing the Unregulated Body Brokerage Industry | E&B |
| 06 | Information Blocking Rule | B |
| 07 | Codification of the Chevron Deference Doctrine | B |
| 08 | On the Ethics of Human Lifespan Prolongation | E&B |

| | | |
|---|---|---|
| 09 | 2025 AMA Advocacy Efforts | Info. Report |
| 10 | Improving Usability of Electronic Health Records (EHRs) for Transgender and Gender Diverse Patients | E&B |
| 11 | Supporting Diversity in Research | E&B |
| 12 | Support For Doula Care Programs | B |
| 13 | Antidiscrimination Protections for LGBTQ+ Youth in Foster Care | B |
| 14 | AMA Efforts on Medicare Payment Reform and Increasing Transparency of AMA Medicare Payment Reform Strategy | Info. Report |
| 15 | Protecting Evidence-Based Medicine, Public Health Infrastructure and Biomedical Research Report | B |
| 16 | Preservation of Medicaid | B |
| 17 | Establishing an Advisory Committee on AI/AN Affairs | Info. Report |
| 18 | Published Metrics for Hospitals and Hospital Systems | J |
| 19 | Addressing the Historical Injustices of Anatomical Specimen Use | E&B |
| 20 | AMA Reimbursement of Necessary HOD Business Meeting Expenses for Delegates and Alternates | Info. Report |

**13. Report(s) of the Council on Constitution and Bylaws - Jerry P. Abraham, MD, MPH, Chair**

| | | |
|---|---|---|
| 01 | Bylaws Review Report | E&B |
| 02 | Bylaws Clarifications Subsequent to A-25 House of Delegates Meeting | E&B |
| 03 | Credentialing of Temporary Delegates and Alternate Delegates | E&B |

**14. Report(s) of the Council on Ethical and Judicial Affairs - Rebecca Brendel, MD, Chair**

| | | |
|---|---|---|
| 01 | Amendment to Opinion 1.1.1 “Patient-Physician Relationships” | E&B |
| 02 | Supporting Efforts to Strengthen Medical Staffs Through Collective Actions and/or Unionization | E&B |
| 03 | Ethical Impetus for Research in Pregnant and Lactating Individuals | E&B |

**15. Opinion(s) of the Council on Ethical and Judicial Affairs - Rebecca Brendel, MD, Chair**

| | | |
|---|---|---|
| 01 | Contracts to Deliver Health Care Services | Info. Report |
| 02 | Organ Transplantation Allocation Decisions | Info. Report |

**16. Report(s) of the Council on Long Range Planning and Development - Jan Kief, MD, Chair**

| | | |
|---|---|---|
| 01 | Private Practice Physicians Section Five-Year Review | F |
| 02 | Evaluation of the Structure of the AMA House of Delegates | F |

**17. Report(s) of the Council on Medical Education - Kelly J. Caverzagie, MD, FACP, FHM, Chair**

| | | |
|---|---|---|
| 01 | Additional Pathways for International Medical Graduates | C |

**18. Report(s) of the Council on Medical Service - Betty Chu, MD, MBA, Chair**

| | | |
|---|---|---|
| 01 | Health Savings Account Reform | J |
| 02 | Telehealth Licensure | J |
| 03 | Payment Models to Sustain Rural Hospitals | J |
| 04 | Payment for Biosimilars | J |

**19. Report(s) of the Council on Science and Public Health - Padmini Ranasinghe, MD, MPH, Chair**

| | | |
|---|---|---|
| 01 | Drug Shortages: 2025 Update | Info. Report |
| 02 | Regulation of Ionizing Radiation Exposure for Health Care Professionals | K |
| 03 | Plastic Pollution Reduction | K |

**20. Report(s) of the HOD Committee on Compensation of the Officers - Jessica Krant, MD, Chair**

| | | |
|---|---|---|
| 01 | Report of the House of Delegates Committee on the Compensation of the Officers | F |

**21. Report(s) of the Speakers - Lisa Bohman Egbert, MD, Speaker; John H. Armstrong, MD, Vice Speaker**

| | | |
|---|---|---|
| 01 | Online Reference Committees | F |
| 02 | Election Committee Review of Election Rules for Clarification | F |
| 03 | Speaker Recorded Interviews for AMA Elections | Info. Report |

**22. Resolutions**

| | | |
|---|---|---|
| 001 | Clarifying Conscientious Objection | E&B |
| 002 | Ensuring Ethical Use of Wearable Recording Devices in Clinical Encounters | E&B |
| 003 | Report on Gender-Based Pay Equity in Medicine | E&B |
| 004 | Patient Options to Restrict Secondary Use of Their Healthcare Data | E&B |
| 005 | Preserving Autonomy in the Patient-Physician Relationship | E&B |
| 006 | Amendment to AMA Bylaws to Enable Continuity of Leadership | E&B |
| 007 | Improving Protection for Reproductive Health Information | E&B |
| 008 | Health Plan In-Network Steering of Pathology/Laboratory Services | E&B |
| 009 | Gender Equity in Disability Insurance for Physicians | E&B |
| 201 | Model State Legislation incorporating Medical Malpractice Tort Reform Based on Utah H.B. 503 (2025) | B |
| 202 | Deepfake Technology and Harm to Physicians and Patients | B |
| 203 | Restore and Enhance Federal Loan Programs for Medical Education | B |
| 204 | Addressing Anti-Physician Contractual Provisions | B |
| 205 | Restoring Balance Billing and Allowing Copay Forgiveness to Preserve Independent Practice and Improve Access to Care | B |
| 206 | Restore Funding to USAID | B |
| 207 | Support for a Federal Tax Incentive for Volunteer Community Preceptors | B |
| 208 | Centralization of Medicare Provider Data Sources | B |
| 209 | Support for Legislative Changes Allowing Partial Medicare Opt-Out for Physicians | B |
| 210 | PBM Divestiture and Transparency | B |
| 211 | Access to, and Retention of, Electronic Medical Records | B |
| 212 | Acknowledging Flexibility on Buprenorphine Mono-product Use for Opioid Use Disorder Opioid Use Disorder | B |
| 213 | Pathways to U. S. Permanent Residency for H-1B Physicians | B |
| 214 | Physician Visa Protection and Pathway to Serve Underserved Communities | B |
| 215 | Extending the Medicaid Work Requirement Exemption up to 12 Months Postpartum | B |
| 216 | Ensuring Timely J-1 Visa Processing to Protect IMG Participation in Residency Programs | B |

| | | |
|---|---|---|
| 217 | Protecting Access to Public Service Loan Forgiveness (PSLF), Income-Driven Repayment (IDR), and Direct Plus Loans for Graduate or Professional Students (Grad PLUS Loans) | B |
| 218 | Amend AMA Policy D-160.921 on Sensitive Locations to Protected Areas | B |
| 219 | Addressing the Harms and Misleading Nature of Medicare Advantage Plans | B |
| 220 | Medicare Should not Unfairly Penalize Physicians | B |
| 221 | Not-for-Profit Status | B |
| 222 | Tackling Administrative Waste—Let Us Be Part of the Solution to Putting Our Health System on a Sustainable Path | B |
| 223 | Halt the Rollout of New Payment Models by the Center for Medicare & Medicaid Innovation (CMMI)—A New Administration Offers an Opportunity | B |
| 224 | Recoupment by CMS Recovery and Audit Contractors (RAC)—Due Process | B |
| 225 | Federal Legislation to Prohibit the Corporate Practice of Medicine | B |
| 226 | Transparency with the Term "Emergency Department" | B |
| 227 | Call for Immediate and Aggressive Action by the AMA to Reverse Medicaid Cuts Impacting Seniors | B |
| 228 | Support Permanent Funding and Expansion of Native Hawaiian Healthcare | B |
| 229 | Protection of Medicaid Beneficiaries' Private Health Information from Immigration Enforcement | B |
| 230 | Banning Non-compete Agreements in States | B |
| 231 | Ensuring Equitable and Timely Medical Licensure for Physicians Providing Abortion and Gender-Affirming Care | B |
| 232 | Safeguarding Access to IVF Amid Restorative Reproductive Medicine Legislation | B |
| 233 | Renewing Mental Health Infrastructure in the School System | B |
| 234 | Study on Impact of Inflation Reduction Act on Oncology, Other Physician Practices | B |
| 236 | Deceptive Advertising in Accredited Allied Health Professional, Non-Physician Graduate Programs | B |
| 237 | Protecting and Improving Rural Health | B |
| 301 | Preventing Sleep Deprivation and Supporting Medical Student Wellness | C |
| 304 | Systemic Exclusion of IMGs from Residency Programs | C |
| 305 | Paid Sick Leave and Flexible Work Arrangements for Caregivers of Individuals with Special Needs, Chronic Illness, or Elderly Parents | C |
| 306 | Support for Paid Prenatal Leave | C |
| 307 | Integrating Artificial Intelligence (AI) Literacy Into UME, GME, and CME | C |
| 308 | Enhancing the Pathway for Black Male Medical Students | C |
| 311 | Gender and URiM Disparities in Surgical Training Volumes | C |
| 601 | Reimagining and Modernizing the U.S. Healthcare Delivery System | F |
| 602 | Standardizing the Appointment Process for AMA Councils | F |
| 802 | Patient Choice of Physician | J |
| 804 | Medicare Advantage Filing Limit | J |
| 805 | Shared Medical Appointments | J |
| 806 | Insurance Coverage for Colonoscopy Preparation Cost | J |
| 807 | Protecting Hospitals and Patients from Inappropriate Denials of Inpatient Admissions | J |
| 808 | No Prior Authorization for Inexpensive Medications | J |

| | | |
|---|---|---|
| 809 | Ensuring Patient Safety and Physician Oversight in the Integration of Hospital Inpatient Virtual Nursing | J |
| 811 | Non-Medical Switching | J |
| 812 | Discontinue Review Choice Demonstration Project for Inpatient Rehabilitation Hospital Admissions | J |
| 813 | Increased Regulation of For-Profit Healthcare Insurance | J |
| 814 | Mandate for Insurance Companies to Assist in the Transition of Patients to Alternative Participating Physicians Upon Contract Termination | J |
| 815 | Mandating Health Insurers to Provide a Real-Time Online Tool for Coverage and Payment Policies, Integrated into Electronic Health Records (EHRs) | J |
| 816 | Prohibit Arbitrary Time Limits on Preauthorizations | J |
| 817 | Prohibiting Insurers from Denying Payment for Procedures Based on Site of Service | J |
| 818 | Universal Out-of-Network Benefits | J |
| 819 | Update the status of Virtual Credit card policy, EFT fees, and lack of Enforcement of Administrative Simplification Requirements by CMS | J |
| 821 | Improving Access to Emergency Ophthalmologic Surgical Care | J |
| 822 | Improving Home or Community-Based Services Waiver Waiting List Management | J |
| 823 | Accountability in the Use of Augmented Intelligence for Prior Authorization | J |
| 824 | Equitable Payment and Increased Access for In-Office Pediatric Lead Screening and Testing | J |
| 825 | Ensuring Coverage for In-Office Point-of-Care (POC) Testing in Outpatient Medical Practices | J |
| 826 | Increase National Immunization Rates by Advocating for Equitable Vaccine Payments | J |
| 827 | Opposition to Prior Authorization in Medicare Fee-for-Service, Burdensome Administrative Requirements | J |
| 828 | Creating a Public Scorecard on Insurer Delays in Care and Payment Caused by Prior Authorization | J |
| 829 | Publicize Insurer Financial Gains from Delayed Care and Payment Caused by Prior Authorization | J |
| 901 | Distinction Between Healthful and Unhealthful “Ultraprocessed” Foods | K |
| 903 | Nitrous Oxide Inhalant Abuse | K |
| 904 | Supporting Certification of the Public Health Workforce | K |
| 905 | Standardizing Brain Death Policies | K |
| 906 | Rethink the Medicare Annual Wellness Visit | K |
| 907 | In-Office Dispensing of Generic Medications | K |
| 908 | Support of Access to Insulin-Detemir | K |
| 909 | Clinical Significance of Sleepiness | K |
| 911 | Safeguarding NIH-Funded and Other Women’s Health Research in Peer-Reviewed Publishing | K |
| 912 | Increasing Access through Federated Healthcare Data Architecture | K |
| 917 | Urging Comprehensive Research and Safety Testing of Industry-Engineered Food Additives (IEFAs), Including High Fructose Corn Syrup | K |
| 918 | Remove Outdated Barriers to Genetic Testing | K |

| | | |
|---|---|---|
| 919 | Strengthening Trust through AMA-Based Leadership for Evidence-Based Vaccines (STABLE Vaccines) | K |
| 920 | Alcohol and Aging: Educating Physicians and Advocating for Safer Warnings | K |
| 921 | Prioritizing Deprescribing in Seniors | K |
| 922 | Addressing Health Impacts of Indian Boarding Schools | K |
| 923 | Enhancing Disaster Preparedness Mechanisms for People with Disabilities | K |
| 924 | Preserving Access to Gamete Donation and Gestational Carriers and Protecting Parental Rights | K |
| 925 | Evidence-Based Vaccine and Preventive Services Recommendations | K |
| 926 | Establishment of Federal and State Offices of Men's Health | K |
| 927 | Battlefield Acupuncture – An Educational Call to Arms | K |
| 929 | Protecting Access to Evidence-based Psychotropic Medication for the Treatment of Pediatric Mental Illness | K |
| 930 | Establishing Fire Risk Standards for Civilian and Non-Industrial Clothing | K |
| 931 | Preserving Evidence-Based, Equitable Grooming Standards in Military Service | K |
| 932 | Shared Decision-Making and Low Dose CT Lung Cancer Screening in Clinical Practice | K |
| 933 | Addressing Gaps in National Healthcare Safety Network (NHSN) Data Quality | K |

**23. Not for Consideration**

| | | |
|---|---|---|
| 235 | Ensuring Medical Liability Insurance Transparency and Continuity | B |
| 302 | Increasing the Use of Retired Physicians in Teaching Students and Residents | C |
| 303 | Expanding Graduate Medical Education to Address Rural Primary Care Shortage | C |
| 309 | Reasonable Workplace Accommodations for Residents and Fellows During Pregnancy | C |
| 310 | Remedying the Harms of AMA's Role in the Flexner Report | C |
| 801 | Excessive Cost of Multi-State DEA Licensure | J |
| 803 | Ensuring Physician Input in the Development of Alternative Payment Models (APMs) | J |
| 810 | Opposing Unilateral Downcoding of Physician Services by Insurance Companies | J |
| 820 | Establishing an AMA "First Responder Team" for Real-Time Physician Advocacy Against Adverse Insurance Company Actions | J |
| 902 | Advocating for Improvements in Systems of Care for Autism | K |
| 910 | Increasing Funding for Gynecological Cancer Research | K |
| 913 | Establish AMA Policy and Project to Compile and Distribute JAMA Patient Pages to Enhance Public Medical Literacy | K |
| 914 | Develop Climate-Conscious Resources for Physicians | K |
| 915 | Reduce Environmental Impact of Medical Journals | K |
| 916 | Studying the Environmental Impact of Ambient Clinical Intelligence Use | K |
| 928 | AMA's Continued Support for COVID-19 Vaccination in Pregnant Individuals and Children | K |

# DECLARATION OF PROFESSIONAL RESPONSIBILITY: MEDICINE'S SOCIAL CONTRACT WITH HUMANITY

## Preamble

**Never in the history of human civilization** has the well-being of each individual been so inextricably linked to that of every other. Plagues and pandemics respect no national borders in a world of global commerce and travel. Wars and acts of terrorism enlist innocents as combatants and mark civilians as targets. Advances in medical science and genetics, while promising great good, may also be harnessed as agents of evil. The unprecedented scope and immediacy of these universal challenges demand concerted action and response by all.

As physicians, we are bound in our response by a common heritage of caring for the sick and the suffering. Through the centuries, individual physicians have fulfilled this obligation by applying their skills and knowledge competently, selflessly and at times heroically. Today, our profession must reaffirm its historical commitment to combat natural and man-made assaults on the health and well-being of humankind. Only by acting together across geographic and ideological divides can we overcome such powerful threats. Humanity is our patient.

## Declaration

**We, the members of the world community of physicians,** solemnly commit ourselves to:

1. Respect human life and the dignity of every individual.

2. Refrain from supporting or committing crimes against humanity and condemn all such acts.

3. Treat the sick and injured with competence and compassion and without prejudice.

4. Apply our knowledge and skills when needed, though doing so may put us at risk.

5. Protect the privacy and confidentiality of those for whom we care and breach that confidence only when keeping it would seriously threaten their health and safety or that of others.

6. Work freely with colleagues to discover, develop, and promote advances in medicine and public health that ameliorate suffering and contribute to human well-being.

7. Educate the public and polity about present and future threats to the health of humanity.

8. Advocate for social, economic, educational, and political changes that ameliorate suffering and contribute to human well-being.

9. Teach and mentor those who follow us for they are the future of our caring profession.

We make these promises solemnly, freely, and upon our personal and professional honor.

Adopted by the House of Delegates of the American Medical Association
in San Francisco, California on December 4, 2001

**Delegate/Alternate Delegate Job Description, Roles and Responsibilities**

*At the 1999 Interim Meeting, the House of Delegates adopted as amended Recommendation 16 of the final report of the Special Advisory Committee to the Speaker of the House of Delegates. This recommendation included a job description and roles and responsibilities for delegates and alternate delegates. The description and roles and responsibilities were modified at the 2002 Annual Meeting by Recommendation 3 of the Joint Report of the Board of Trustees and Council on Long Range Planning and Development. The modified job description, qualifications, and responsibilities are listed below.*

Delegates and Alternate Delegates should meet the following job description and roles and responsibilities:

Job Description and Roles and Responsibilities of AMA Delegates/Alternate Delegates

Members of the AMA House of Delegates serve as an important communications, policy, and membership link between the AMA and grassroots physicians. The delegate/alternate delegate is a key source of information on activities, programs, and policies of the AMA. The delegate/alternate delegate is also a direct contact for the individual member to communicate with and contribute to the formulation of AMA policy positions, the identification of situations that might be addressed through policy implementation efforts, and the implementation of AMA policies. Delegates and alternate delegates to the AMA are expected to foster a positive and useful two-way relationship between grassroots physicians and the AMA leadership. To fulfill these roles, AMA delegates and alternate delegates are expected to make themselves readily accessible to individual members by providing the AMA with their addresses, telephone numbers, and e-mail addresses so that the AMA can make the information accessible to individual members through the AMA web site and through other communication mechanisms. The qualifications and responsibilities of this role are as follows:

A. Qualifications
- AMA member.
- Elected or selected by the principal governing body or the membership of the sponsoring organization.
- The AMA encourages that at least one member of each delegation be involved in the governance of their sponsoring organization.

B. Responsibilities
- Regularly communicate AMA policy, information, activities, and programs to constituents so he/she will be recognized as the representative of the AMA.
- Relate constituent views and suggestions, particularly those related to implementation of AMA policy positions, to the appropriate AMA leadership, governing body, or executive staff.
- Advocate constituent views within the House of Delegates or other governance unit, including the executive staff.
- Attend and report highlights of House of Delegates meetings to constituents, for example, at hospital medical staff, county, state, and specialty society meetings.
- Serve as an advocate for patients to improve the health of the public and the health care system.
- Cultivate promising leaders for all levels of organized medicine and help them gain leadership positions.
- Actively recruit new AMA members and help retain current members.
- Participate in the AMA Membership Outreach Program.

# SEATING ALLOCATION – 2025 INTERIM MEETING

**ADDICTION MEDICINE - 3**
American Society of Addiction Medicine (ASAM) – 3
Trustee (Levin) – 1
Delegates - 2

**AMGA - 1**
American Medical Group Association (AMGA) - 1

**ANESTHESIOLOGY - 11**
American Society of Anesthesiologists (ASA) - 9
Delegates - 8
Resident and Fellow Section Delegate - 1
American Society of Regional Anesthesia and Pain Medicine (ASRAPM) - 2

**ARS – 1**
American Rhinologic Society (ARS) - 1

**CARDIOLOGY - 18**
American College of Cardiology (ACC) - 9
American Society of Echocardiography (ASE) - 2
American Society of Nuclear Cardiology (ASNC) - 2
Heart Rhythm Society (HRS) - 1
Society for Cardiovascular Angiography and Interventions (SCAI) - 2
Society for Cardiovascular Magnetic Resonance (SCMR) - 1
Society of Cardiovascular Computed Tomography (SCCT) - 1

**CHEST PHYSICIANS - 2**
American College of Chest Physicians (CHEST) (ACCP) - 2

**CRITICAL CARE MEDICINE- 2**
Society of Critical Care Medicine (SCCM) - 2

**DERMATOLOGY - 16**
American Academy of Dermatology Association (AAD) – 7
Trustee (Van Beek) - 1
Former President (Resneck) - 1
Delegates - 5
American College of Mohs Surgery (ACMS) - 1
American Contact Dermatitis Society (ACDS) - 1
American Society for Dermatologic Surgery Association (ASDSA) - 3
American Society for Laser Medicine and Surgery, Inc.(ASLMS) - 1
American Society of Dermatopathology (ASD) - 1
Society for Investigative Dermatology (SID) - 1
Society for Pediatric Dermatology (SPD) - 1

**EMERGENCY MEDICINE - 14**
American Academy of Emergency Medicine (AAEM) - 3
American College of Emergency Physicians (ACEP) - 11
Delegates - 9
Resident and Fellow Section Delegates - 2

**ENDOCRINOLOGY - 3**
American Assn of Clinical Endocrinology (AACE) - 1
The Endocrine Society (ES) - 2

**FAMILY PHYSICIANS - 27**
American Academy of Family Physicians (AAFP) - 27
Former Board Chair (Langston) - 1
Delegates - 26

**GASTROENTEROLOGY - 7**
American College of Gastroenterology (ACG) - 3
American Gastroenterological Association (AGA) - 2
American Society for Gastrointestinal Endoscopy (ASGE) - 2

**GERIATRIC MEDICINE - 2**
American Geriatrics Society (AGS) – 2

**GREAT LAKES - 61**
Illinois - 15
Delegates - 12
Medical Student Regional Delegate - 1
Resident and Fellow Section Delegate - 1
Society of Nuclear Medicine and Molecular Imaging (SNMMI) - 1
Indiana - 7
Trustee (Welsh) - 1
Delegates – 5
Medical Student Regional Delegate - 1
Michigan - 16
Delegates - 14
Resident and Fellow Section Delegate - 1
American Osteopathic Association (AOA) – 1
Ohio - 15
Delegates (minus Speaker @ dais) - 11
Medical Student Regional Delegate - 1
Resident and Fellow Section Delegates - 3
Wisconsin - 8
Delegates - 5
Medical Student Regional Delegate - 1
Resident and Fellow Section Delegate - 1
Undersea & Hyperbaric Medical Society (UHMS) - 1

**HEART OF AMERICA - 10**
Kansas - 4
Delegates - 3
Medical Student Regional Delegate - 1
Missouri – 6

**HEMATOLOGY - 2**
American Society of Hematology (ASH) - 2

**HOSPITAL MEDICINE - 3**
Society of Hospital Medicine (SHM) - 3

**INFECTIOUS DISEASE - 2**
Infectious Diseases Society of America (IDSA) - 2

**INTERNAL MEDICINE - 38**
American College of Lifestyle Medicine (ACLsM) - 2
American College of Physicians (ACP) – 35
Trustee (Fryhofer) - 1
Delegates - 34
Renal Physicians Association (RPA) - 1

**MOBILITY CAUCUS - 13**
American Acad of Orthopaedic Surgeons (AAOS) – 5
Trustee (Suk) - 1
Delegates - 4
Former President (Gurman)
American Association for Hand Surgery (AAHS) - 1
American Orthopaedic Association (AOrA) - 1
American Orthopaedic Foot and Ankle Society (AOFAS) - 1
American Society for Surgery of the Hand (ASSH) - 1
American Society of Interventional Pain Physicians (ASIPP) - 1
International Soc for the Advancement of Spine Surgery (ISASS) -1
North American Spine Society (NASS) - 2

**NEUROSCIENCES - 36**
Academy of Consultation-Liaison Psychiatry (ACLP) - 1
American Academy of Addiction Psychiatry (AAAP) - 1
American Academy of Child and Adolescent Psychiatry (AACAP) - 2
American Academy of Hospice and Palliative Medicine (AAHPM) - 2
American Academy of Neurology (AAN) - 7
Delegates - 3
Resident and Fellow Section Delegates - 4
American Academy of Pain Medicine (AAPM) - 1
American Acad of Psychiatry and the Law (AAPL) - 1
American Assoc for Geriatric Psychiatry (AAGP) - 1
American Association of Neurological Surgeons (AANS) - 3
Former President (Carmel) - 1
Delegates – 2
Amer Assn of Neuromuscular & Electrodiagnostic Med (AANEM)- 1
American Psychiatric Association (APA) - 11
Former President (Harris) - 1
Delegates - 8
Resident and Fellow Section Delegates – 2
Congress of Neurological Surgeons (CNS) - 2
GLMA: Health Professionals Advancing LGBTQ+ Equality – 1
North American Neuromodulation Society (NANS) - 1
International Pain and Spine Intervention Society (IPSIS) - 1

**NEW ENGLAND - 32**
Connecticut - 8
Trustee (Breig) - 1
Delegates - 4
Medical Student Regional Delegate- 1
Resident and Fellow Section Delegates - 2
Maine - 2
Massachusetts - 17
Delegates - 13
Medical Student Regional Delegate- 1
Resident and Fellow Section Delegate – 2
American Academy of Allergy, Asthma & Immunology (AAAAI) – 1
New Hampshire - 1
Rhode Island - 3
Delegates - 2
Resident and Fellow Section Delegates – 1
Vermont – 1

**NEW YORK - 30**
Former President (Nielsen) - 1
Delegates - 23
Medical Student Regional Delegates - 2
Resident and Fellow Section Delegate – 1
American College of Nuclear Medicine (ACNM) - 1
American Society of Neuroradiology (ASN) - 2

**NORTH CENTRAL - 19**
Iowa - 6
Delegates - 4
Medical Student Regional Delegate - 1
Outpatient Endovascular and Interventional Society (OEIS)- 1
Minnesota – 6
Delegates - 5
Resident and Fellow Section Delegate – 1
Nebraska – 2
North Dakota - 3
Delegates - 2
Medical Student Regional Delegate - 1
South Dakota - 2

**OBSTETRICIANS AND GYNECOLOGISTS - 19**
American Association of Gynecologic Laparoscopists (AAGL) - 2
American College of Medical Genetics and Genomics (ACMGG) -1
American College of Obstetricians and Gynecologists (ACOG) - 15
Delegates - 14
Former President (Wah)
Resident and Fellow Section Delegate - 1
American Society for Reproductive Medicine (ASRM) - 1

**ONCOLOGY - 6**
Association for Clinical Oncology (ASCO) – 6
Delegates - 5
Former President (McAneny)
Resident and Fellow Section Delegate - 1

**PACWEST CONFERENCE - 91**
Alaska - 1
Arizona - 8
Delegates - 5
Medical Student Regional Delegate - 1
Resident and Fellow Section Delegates – 1
American College of Radiation Oncology (ACRO) - 1
American Institute of Ultrasound in Medicine (AIUM) - 2
California - 47
Trustee (Huynh) - 1
Delegates - 37
Medical Student Regional Delegates - 2
Resident and Fellow Section Delegates - 3
American Clinical Neurophysiology Soc (ACNS) – 1
American Soc for Radiation Oncology (ASRO) – 2
North American Neuro-Ophthalmology Society (NANOS) - 1
Colorado -11
Former Presidents (Lazarus) - 1
Delegates - 6
Medical Student Regional Delegate - 1
Resident and Fellow Section Delegates - 2
Obesity Medicine Association (OMA) - 1
Hawaii - 2
Idaho - 1
Montana - 1
Nevada – 3
Delegates - 2
American College of Legal Medicine (ACLM) - 1
New Mexico - 2
Oregon - 4
Utah - 3
Washington - 7
Trustee (Rege) - 1
Delegates - 6
Wyoming – 1

**PALTmed –1**
Post-Acute and Long-Term Care Medical Association (PALTmed) – 1

**PATHOLOGY - 9**
American Society for Clinical Pathology (ASCP) – 3
American Society of Cytopathology (ASC) - 1
College of American Pathologists (CAP) – 4
National Association of Medical Examiners (NAME) - 1

**PEDIATRICS - 7**
American Academy of Pediatrics (AAP) - 7
Trustee (Garretson) - 1
Delegates - 5
Resident and Fellow Section Delegates - 1

**PENNSYLVANIA - 19**
Trustee (Heine) – 1
Delegates - 15
Medical Student Regional Delegate- 1
Resident and Fellow Section Delegate - 1
American Hernia Society (AHS) - 1

**PHYSICAL MEDICINE AND REHABILITATION - 5**
American Acad of Physical Med & Rehabilitation (AAPMR) - 4
Delegates - 3
Resident and Fellow Section Delegate - 1
Association of Academic Physiatrists (AACP) - 1

**PREVENTIVE MEDICINE - 7**
Aerospace Medical Association (AsMA) - 1
American Academy of Insurance Medicine (AAIM) - 1
American Association of Public Health Physicians (AAPHP) – 2
Delegate - 1
Resident and Fellow Section Delegate - 1
American College of Medical Quality (ACMQ) - 1
American College of Occup & Environmental Med (ACOEM) -1
American College of Preventive Medicine (ACPM) - 1

**RADIOLOGY - 16**
American College of Radiology (ACR) – 8
Delegates – 8
Former President (Johnson)
American Roentgen Ray Society (ARRS) – 3
Association of Academic Radiology (AAR) - 1
Radiological Society of North America (RSNA) – 3
Society of Interventional Radiology (SIR) - 1

**RHEUMATOLOGY - 2**
American College of Rheumatology (ACRh) - 2

**SECTIONS - 12**
Academic Physicians Section (APS) - 1
Integrated Physician Practice Section (IPPS) - 1
International Medical Graduates Section (IMG) - 1
LGBTQ+ Section - 1
Medical Student Section (MSS) - 1
Underrepresented in Medicine Advocacy Section (UMAS) - 1
Organized Medical Staff Section (OMSS) - 1
Private Practice Physicians Section (PPPS) - 1
Resident and Fellow Section (RFS) – 1
Senior Physicians Section (SPS) - 1
Women Physicians Section (WPS) -1
Young Physicians Section (YPS) - 1

**SERVICES - 6**
Air Force - 1
Army - 1
AMSUS - Society of Federal Health Professionals - 1
Navy - 1
Public Health Service - 1
Veterans Affairs - 1

**SLEEP MEDICINE – 2**
American Academy of Sleep Medicine (AASM) - 2

**SOUTHEASTERN - 117**
Alabama - 4
Arkansas -3
Trustee (Ferguson) - 1
Delegates - 2
Delaware - 2
Former Board Chair (Permut) – 1
Delegate - 1
District of Columbia - 2
Florida - 20
Delegates - 17
Medical Student Regional Delegate- 1
National Medical Association (NMA) - 1
The Triological Society (TS) - 1
Georgia - 9
Delegates - 7
Medical Student Regional Delegate- 1
Resident and Fellow Section Delegate - 1
Kentucky - 5
Louisiana - 8
Trustee (Magrath) - 1
Delegates - 7
Maryland - 8
Delegates - 6
Acad of Physicians in Clinical Research (APCR) - 1
American Medical Women's Association (AMWA) - 1
Mississippi - 4
Delegates - 3
Medical Student Regional Delegate- 1
New Jersey - 11
Delegates - 9
Medical Student Regional Delegate- 1
American Assn of Physicians of Indian Origin (AAPIO) - 1
North Carolina - 6
Oklahoma - 8
Delegates - 4
Medical Student Regional Delegate - 1
Resident and Fellow Section Delegates - 3
Puerto Rico - 2
South Carolina – 6
Former Presidents (Harmon) - 1
Delegates - 4
Medical Student Regional Delegate - 1
Tennessee - 8
Delegates - 6
Medical Student Regional Delegate - 1
American Vein and Lymphatic Society (AVLS) - 1
Virginia - 8
Delegates - 7
Medical Student Regional Delegate- 1
West Virginia – 3
Delegates - 2
Medical Student Regional Delegate- 1

**SURGEONS - 45**
American Academy of Cosmetic Surgery (AACS) - 1
American Acad of Facial Plastic and Reconstructive Surg (AAFPRS) -1
American Academy of Ophthalmology (AAO) – 4
American Acad of Otolaryngic Allergy (AAOA) - 1
Amer Acad of Oto-Head & Neck Surgery (AAOHNS) -3
American Association for Thoracic Surgery (AATS) - 1
American Association of Plastic Surgeons (AAPS) - 1
American College of Surgeons (ACS) - 9
Delegates (minus Vice Speaker @ dais) - 7
Resident and Fellow Section Delegates – 2
American Society for Aesthetic Plastic Surgery (ASAPS) - 1
American Soc for Metabolic and Bariatric Surgery (ASMBS) - 1
American Soc for Reconstructive Microsurgery (ASRMS) - 1
American Soc of Cataract and Refractive Surgery (ASCTRS) - 2
American Soc of Colon and Rectal Surgeons (ASCRS) - 2
American Soc of Maxillofacial Surgeons (ASMS) - 1
Amer Soc of Ophthalmic Plastic & Reconstructive Surg (ASOPRS) -1
American Soc of Plastic Surgeons (ASPS) - 4
Trustee (Jeffers) - 1
Delegates - 3
American Soc of Retina Specialists (ASRS) - 1
American Soc of Transplant Surgeons (ASTS) - 1
American Venous Forum (AVF) - 1
International Coll of Surgeons-US Section (ICS-US) - 1
Society for Vascular Surgery (SVS) - 1
Soc of Amer Gastrointestinal Endo Surgeons (SAGES) -2
The American Soc of Breast Surgeons (ASBS) - 1
The Soc of Laparoscopic and Robotic Surgeons (SLRS) - 1
Society of Thoracic Surgeons (STS) - 2

**TERRITORIES - 2**
Guam - 1
Virgin Islands - 1

**TEXAS - 27**
Delegates - 22
Medical Student Regional Delegate - 1
Resident and Fellow Section Delegates - 2
American College of Allergy, Ashtma & Immunology (ACAAI) - 1
International Society of Hair Restoration Surgery (ISHRS) – 1

**THORACIC MEDICINE - 2**
American Thoracic Society (ATS) - 2

**UROLOGY - 4**
American Assoc of Clinical Urologists (AACU) - 2
American Urological Association (AUA) – 2

**OFFICIAL OBSERVERS - 30**
Accreditation Association for Ambulatory Health Care
Alliance for Continuing Education in the Health Professions
Alliance for Regenerative Medicine
Ambulatory Surgery Center Association
American Academy of Physician Associates
American Association of Medical Assistants
American Board of Medical Specialties
American Dental Association
American Health Quality Association
American Hospital Association
American Nurses Association
American Podiatric Medical Association
American Public Health Association
Association of periOperative Registered Nurses
Association of State and Territorial Health Officials
Commission on Graduates of Foreign Nursing Schools
Council of Medical Specialty Societies
Federation of State Medical Boards
Federation of State Physician Health Programs
Intealth (ECFMG)
Medical Group Management Association
Medical Professional Liability Association
National Association of County and City Health Officials
National Commission on Correctional Health Care
National Council of State Boards of Nursing
National Indian Health Board
Society for Academic Continuing Medical Education
US Pharmacopeia
United States Professional Association for Transgender Health
World Medical Association

**TELLERS - 4**

# HOUSE OF DELEGATES · GAYLORD NATIONAL RESORT & CONVENTION CENTER, NATIONAL HARBOR, MARYLAND (I-25)

**Audience Left** — STAGE — **Audience Right**

SPEAKER — VICE SPEAKER

| | 17 | 16 | 15 | 14 | 13 | 12 | 11 | 10 | 9 | 8 | 7 | 6 | 5 | 4 | 3 | 2 | 1 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | MINNESOTA - 6 | | | | | | NEBRASKA - 2 | | RHEUM - 2 | | UROLOGY - 4 | | | | MISSOURI - 6 | | |
| 1 | | | | | | MN RESIDENT | | | | | AACU | AACU | AUA | AUA | | | |
| | SD - 2 | | IOWA - 6 | | | | | | ONCOLOGY - 6 | | | | | | MISSOURI | | |
| 2 | | | | | | | IA STUDENT | OEIS | ASCO RESIDENT | ASCO MCANENY | ASCO | ASCO | ASCO | ASCO | | | |
| | NEUROSCIENCES - 36 | | | | | NORTH DAKOTA - 3 | | | OBSTETRICIANS & GYNECOLOGISTS - 19 | | | | | KANSAS - 4 | | | |
| 3 | ACLP | AAAP | AACAP | AACAP | AAPL | | | ND STUDENT | ACOG WAH | ACOG | ACOG | ACOG | ACOG | KS STUDENT | | | |
| | NEUROSCIENCES | | | | | | | | OBSTETRICIANS & GYNECOLOGISTS | | | | | | | | |
| 4 | AAGP | APA | APA | APA | APA | APA | APA RESIDENT | AAPM | AAHPM | AAHPM | ACOG | ACOG | ACOG | ACOG | ACOG | ACOG | ACOG |
| | NEUROSCIENCES | | | | | | | | | | OBSTETRICIANS & GYNECOLOGISTS | | | | | | |
| 5 | GLMA | APA | APA | APA | APA RESIDENT | HARRIS | AAN | AAN | AAN | AAN RESIDENT | ACOG RESIDENT | ACOG | ACOG | ASRM | ACMGG | AAGL | AAGL |
| | NEUROSCIENCES | | | | | | | | | | | | SERVICES - 6 | | | | |
| 6 | CARMEL | AANS | AANS | CNS | CNS | AANEM | IPSIS | NANS | AAN RESIDENT | AAN RESIDENT | AAN RESIDENT | AMSUS | NAVY | AF | USPHS | ARMY | VA |
| | CALIFORNIA - 47 | | | | | | | | | | SECTIONS - 12 | | | | | | |
| 7 | | | | | | | | | CA STUDENT | CA STUDENT | UMAS | OMSS | PPPS | RFS | SPS | WPS | YPS |
| | CALIFORNIA | | | | | | | | | | THORACIC - 2 | | SECTIONS | | | | |
| 8 | | | | | | | | CA RESIDENT | CA RESIDENT | CA RESIDENT | | | APS | IPPS | IMG | LGBTQ+ | MSS |
| | CALIFORNIA | | | | | | | | | | DERMATOLOGY - 16 | | | | | | |
| 9 | | | | | | | | | ASRO | ASRO | RESNECK | VAN BEEK | AAD | AAD | AAD | AAD | AAD |
| | CALIFORNIA | | | | | | | | | | DERMATOLOGY | | | | | | |
| 10 | | | | | | | | | ACNS | NANOS | ASDSA | ASDSA | ASDSA | ASLMS | SID | ASD | SPD |
| | NEVADA - 3 | | CALIFORNIA | | | | | | | | DERMATOLOGY | | ANESTHESIOLOGY - 11 | | | | |
| 11 | ACLM | | | | | | | | | HUYNH | ACMS | ACDS | ASA RESIDENT | ASA | ASA | ASA | ASA |
| | ARIZONA - 8 | | | | | | | | HAWAII - 2 | | PALT - 1 | | ANESTHESIOLOGY | | | | |
| 12 | | | | | | ACRO | AIUM | AIUM | | | PALT | ASRAPM | ASRAPM | ASA | ASA | ASA | ASA |
| | ID - 1 | MT - 1 | NEW MEXICO - 2 | | UTAH - 3 | | WASHINGTON - 7 | | | | GASTROENTEROLOGY - 7 | | | | | | |
| 13 | | | | | | | | | | | ACG | ACG | ACG | AGA | AGA | ASGE | ASGE |
| | OREGON - 4 | | | | AK - 1 | WY - 1 | WASHINGTON | | | | TERRITORIES - 2 | | PHYSICAL MEDICINE & REHABILITATION - 5 | | | | |
| 14 | | | | | | | | | | REGE | GU | VI | AACP | AAPMR RESIDENT | AAPMR | AAPMR | AAPMR |
| | COLORADO - 11 | | | | | | | | | | | EMERGENCY MEDICINE - 14 | | | | | |
| 15 | | | | | | | CO RESIDENT | CO RESIDENT | CO STUDENT | LAZARUS | OMA | ACEP RESIDENT | ACEP | ACEP | ACEP | ACEP | ACEP |
| | PREVENTIVE MEDICINE - 7 | | | | | | AAPHP RESIDENT | CRITICAL CARE - 2 | | EMERGENCY MEDICINE | | | | | | | |
| 16 | AsMA | AAIM | ACMQ | ACOEM | ACPM | AAPHP | | | | AAEM | AAEM | AAEM | ACEP RESIDENT | ACEP | ACEP | ACEP | ACEP |
| | ADDICTION MED - 3 | | INFECTIOUS DIS - 2 | | CHEST PHYS - 2 | | GERIATRIC MED - 2 | | ENDOCRINOLOGY - 3 | | | SLEEP MED - 2 | | | HOSPITAL MED - 3 | | |
| 17 | | | LEVIN | | | | | | ES | ES | AACE | | | | | | |
| | SURGEONS - 45 | | | | | | | | | | CARDIOLOGY - 18 | | | | | | |
| 18 | ACS | ACS | ACS | ACS | ACS | ACS | ACS | ACS RESIDENT | ACS RESIDENT | ASMBS | ASMS | SCCT | SCMR | SCAI | SCAI | ASNC | ASNC |
| | SURGEONS | | | | | | | | | | ARS - 1 | CARDIOLOGY | | | | | |
| 19 | ASCRS | ASCRS | AVF | ICSUS | SVS | SAGES | SAGES | ASBS | ASTS | AATS | | ACC | ACC | ACC | HRS | ASE | ASE |
| | SURGEONS | | | | | | | | PENNSYLVANIA - 19 | | | CARDIOLOGY | | | | | |
| 20 | AACS | AAFPRS | AAPS | ASAPS | ASRMS | SLRS | STS | STS | | | | ACC | ACC | ACC | ACC | ACC | ACC |
| | SURGEONS | | | | | | | | | PENNSYLVANIA | | | | | | | |
| 21 | ASPS | ASPS | ASPS | JEFFERS | ASRS | AAO | AAO | AAO | AAO | PA STUDENT | | | | | | | |
| | SURGEONS | | | | | | | HEMATOLOGY-2 | | PENNSYLVANIA | | | | | | | |
| 22 | AAOHNS | AAOHNS | AAOHNS | AAOA | ASOPRS | ASCTRS | ASCTRS | | | AHS | HEINE | PA RESIDENT | | | | | |

| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | PATHOLOGY - 9 | | | | | RADIOLOGY - 16 | | | | | | | |
| 1 | T | T | T | T | ASCP | ASCP | ASCP | ASC | NAME | ACRO JOHNSO | ACR | ACR | ACR | ACR | ACR | ACR | ACR |
| | MICHIGAN - 16 | | | | PATHOLOGY | | | | | RADIOLOGY | | | | | | | |
| 2 | | | | | | CAP | CAP | CAP | CAP | AAR | ARRS | ARRS | ARRS | RSNA | RSNA | RSNA | SIR |
| | MICHIGAN | | | | | | | | | TEXAS - 27 | | | | | | | |
| 3 | | | | | | | MI RESIDENT | AOA | TX STUDENT | | | | | | | | |
| | MICHIGAN | | | INDIANA - 7 | | | | | | TEXAS | | | | | | | |
| 4 | | | | | | | | IN STUDENT | TX RESIDENT | | | | | | | | |
| | OHIO - 15 | | | | | | INDIANA | | | TEXAS | | | | | | | |
| 5 | | | | | | OH RESIDENT | | WELSH | TX RESIDENT | | | | | | | ACAAI | ISHRS |
| | OHIO | | | | | | ILLINOIS - 15 | | | MASSACHUSETTS - 17 | | | | | | | |
| 6 | | | | | OH RESIDENT | OH RESIDENT | | | MA STUDENT | MA RESIDENT | | | | | | | |
| | OHIO | | | ILLINOIS | | | | | | MASSACHUSETTS | | | | | | | NH - 1 |
| 7 | | | OH STUDENT | | | | | IL RESIDENT | AAAAI | MA RESIDENT | | | | | | | |
| | ILLINOIS | | | | | | | | | CONNECTICUT - 8 | | | | | | | VT - 1 |
| 8 | | | | | | | IL STUDENT | SNMMI | BREIG | CT RESIDENT | CT RESIDENT | CT STUDENT | | | | | |
| | WISCONSIN- 8 | | | | | | | | MAINE - 2 | | RHODE ISLAND - 3 | | | PEDIATRICS - 7 | | | |
| 9 | | | | | WI STUDENT | WI RESIDENT | UHMS | | | | RI RESIDENT | | | AAP RESIDENT | | | |
| | ALABAMA - 4 | | | | DC - 2 | | DELAWARE - 2 | | FAMILY PHYSICIANS - 27 | | | | | | PEDIATRICS | | |
| 10 | | | | | | | | PERMUT | | | | | | | GARRETSON | | |
| | MARYLAND - 8 | | | | | | | | FAMILY PHYSICIANS | | | | | | | | |
| 11 | | | | | APCR | AMWA | | | | | | | | | | | |
| | TENNESSEE - 8 | | | | | | | | FAMILY PHYSICIANS | | | | | | | | |
| 12 | | | | TN STUDENT | | AVLS | | | LANGSTON | | | | | | | | |
| | NORTH CAROLINA - 6 | | | | | | WEST VIRGINIA - 3 | | FAMILY PHYSICIANS | | INTERNAL MEDICINE - 38 | | | | | | |
| 13 | | | | | | | | WV STUDENT | | | | | | | | | |
| | FLORIDA - 20 | | | | | | | | INTERNAL MEDICINE | | | | | | | | |
| 14 | | | | FL STUDENT | | | | | | | | | | | | | |
| | FLORIDA | | | | | | | | INTERNAL MEDICINE | | | | | | | | |
| 15 | | | | NMA | | | TS | | | | | | | | | | |
| | SOUTH CAROLINA - 6 | | | | | | FLORIDA | | INTERNAL MEDICINE | | | | | | | | |
| 16 | | | HARMON | SC STUDENT | | | | | | | | | | | | | |
| | VIRGINIA - 8 | | | | | | | AMGA - 1 | INTERNAL MEDICINE | | | | | | | | |
| 17 | | | | VA STUDENT | | | | | | FRYHOFER | | | | | | ACLsM | ACLsM | RPA |
| | OKLAHOMA - 8 | | | | | | | | MOBILITY - 13 | | | | | | | | |
| 18 | | | OK STUDENT | OK RESIDENT | | OK RESIDENT | OK RESIDENT | | AOFAS | AOrA | ASSH | AAHS | SUK | AAOS GURMAN | AAOS | AAOS | AAOS |
| | GEORGIA - 9 | | | | | | | | PR - 2 | | MOBILITY | | | | NEW YORK | | |
| 19 | | | | GA STUDENT | GA RESIDENT | | | | | | ASIPP | ISASS | NASS | NASS | ASN | ASN | |
| | NEW JERSEY - 11 | | | | | | | | NEW YORK - 30 | | | | | | | | |
| 20 | | | | NJ STUDENT | | AAPIO | | | NY STUDENT | NY STUDENT | | | | | | | |
| | MISSISSIPPI - 4 | | | | NEW JERSEY | | | | NEW YORK | | | | | | | | |
| 21 | | | | MS STUDENT | | | | NIELSEN | NY RESIDENT | | | | | | | | |
| | LOUISIANA - 8 | | | | | | | | NEW YORK | | | | | | | | |
| 22 | | | MAGRATH | | | | | | ACNM | | | | | | | | |
| | ARKANSAS - 3 | | | KENTUCKY - 5 | | | | | | | | | | | | | |
| 23 | | | FERGUSON | | | | | | | | | | | | | | |

# Meeting Space Map

## National Harbor Conference Rooms

- A National Harbor Conference Rooms

## Ballroom Level

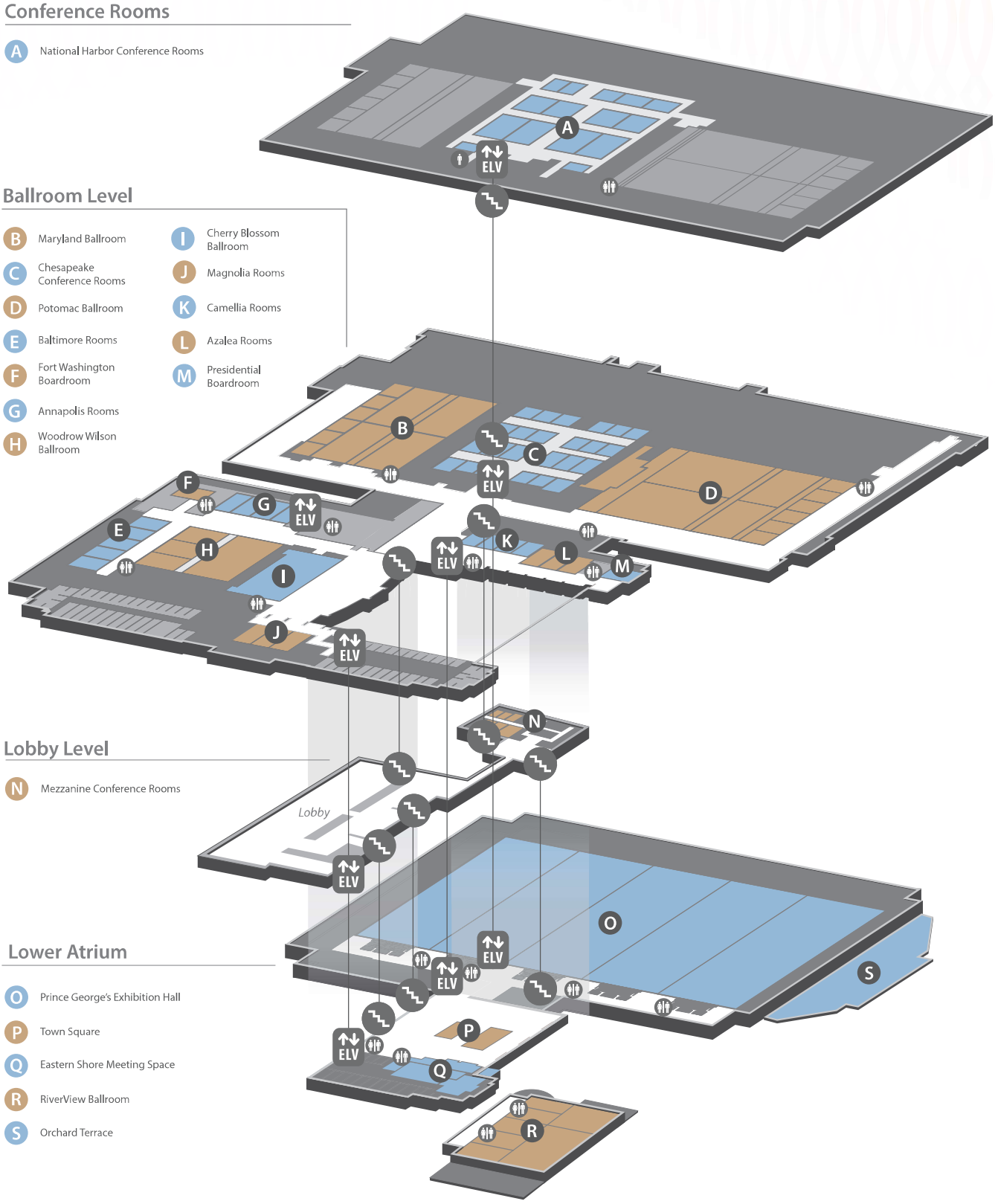
- B Maryland Ballroom
- C Chesapeake Conference Rooms
- D Potomac Ballroom
- E Baltimore Rooms
- F Fort Washington Boardroom
- G Annapolis Rooms
- H Woodrow Wilson Ballroom
- I Cherry Blossom Ballroom
- J Magnolia Rooms
- K Camellia Rooms
- L Azalea Rooms
- M Presidential Boardroom

## Lobby Level

- N Mezzanine Conference Rooms

## Lower Atrium

- O Prince George's Exhibition Hall
- P Town Square
- Q Eastern Shore Meeting Space
- R RiverView Ballroom
- S Orchard Terrace



**2025 INTERIM MEETING OF THE AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES**

Official Call to the Officers and Members of the American Medical Association to attend the November 2025 Interim Meeting of the House of Delegates in National Harbor, Maryland, November 14 -18, 2025.

The House of Delegates will convene at 6:00 p.m., on November 14 at the Gaylord National Resort & Convention Center.

## STATE ASSOCIATION REPRESENTATION IN THE HOUSE OF DELEGATES

| | | | | |
|---|---|---|---|---|
| Alabama 4 | Guam 1 | Massachusetts 13 | New York 23 | Tennessee 6 |
| Alaska 1 | Hawaii 2 | Michigan 14 | North Carolina 6 | Texas 22 |
| Arizona 5 | Idaho 1 | Minnesota 5 | North Dakota 2 | Utah 3 |
| Arkansas 2 | Illinois 12 | Mississippi 3 | Ohio 12 | Vermont 1 |
| California 37 | Indiana 5 | Missouri 6 | Oklahoma 4 | Virgin Islands 1 |
| Colorado 6 | Iowa 4 | Montana 1 | Oregon 4 | Virginia 7 |
| Connecticut 4 | Kansas 3 | Nebraska 2 | Pennsylvania 15 | Washington 6 |
| Delaware 1 | Kentucky 5 | Nevada 2 | Puerto Rico 2 | West Virginia 2 |
| District of Columbia 2 | Louisiana 7 | New Hampshire 1 | Rhode Island 2 | Wisconsin 5 |
| Florida 17 | Maine 2 | New Jersey 9 | South Carolina 4 | Wyoming 1 |
| Georgia 7 | Maryland 6 | New Mexico 2 | South Dakota 2 | |

## SPECIALTY SOCIETY REPRESENTATION IN THE HOUSE OF DELEGATES

American Academy of Child and Adolescent Psychiatry 2
American Academy of Dermatology 5
American Academy of Emergency Medicine 3
American Academy of Family Physicians 26
American Academy of Hospice and Palliative Medicine 2
American Academy of Neurology 3
American Academy of Ophthalmology 4
American Academy of Orthopaedic Surgeons 4
American Academy of Otolaryngology-Head and Neck Surgery 3
American Academy of Pediatrics 5
American Academy of Physical Medicine and Rehabilitation 3
American Academy of Sleep Medicine 2
American Association of Clinical Urology, Inc. 2
American Association of Gynecologic Laparoscopists 2
American Association of Neurological Surgeons 2
American College of Cardiology 9
American College of Chest Physicians (CHEST) 2
American College of Emergency Physicians 9
American College of Gastroenterology 3
American College of Lifestyle Medicine – 2
American College of Obstetricians and Gynecologists 14
American College of Physicians 34
American College of Radiology 8
American College of Rheumatology 2
American College of Surgeons 8
American Gastroenterological Association 2
American Geriatrics Society 2
American Institute of Ultrasound in Medicine 2
American Psychiatric Association 8
American Roentgen Ray Society 3
American Society for Clinical Pathology 3
American Society for Dermatologic Surgery 3
American Society for Gastrointestinal Endoscopy 2
American Society for Radiation Oncology 2
American Society of Addiction Medicine 2
American Society of Anesthesiologists 8
American Society of Cataract and Refractive Surgery 2
American Society of Colon and Rectal Surgeons 2
American Society of Echocardiography 2
American Society of Hematology 2
American Society of Neuroradiology 2
American Society of Nuclear Cardiology – 2
American Society of Plastic Surgeons 3
American Society of Regional Anesthesia and Pain Medicine 2
American Thoracic Society 2
American Urological Association 2
Association for Clinical Oncology 5
College of American Pathologists 4
Congress of Neurological Surgeons 2
Infectious Diseases Society of America 2
North American Spine Society 2
Radiological Society of North America 3
Society for Cardiovascular Angiography and Interventions 2
Society of American Gastrointestinal Endoscopic Surgeons 2
Society of Critical Care Medicine 2
Society of Hospital Medicine 3
Society of Thoracic Surgeons 2
The Endocrine Society 2

*Remaining eligible national medical specialty societies (74) are entitled to one delegate each.*

The Academic Physicians Section, Integrated Physician Practice Section, International Medical Graduates Section, LGBTQ+ Section, Medical Student Section, Underrepresented in Medicine Advocacy Section, Organized Medical Staff Section, Private Practice Physicians Section, Resident and Fellow Section, Senior Physicians Section, Women Physicians Section, Young Physicians Section, Army, Navy, Air Force, Public Health Service, Department of Veterans Affairs, Professional Interest Medical Associations, AMWA, AOA and NMA are entitled to one delegate each.

| | |
|---|---|
| State Medical Associations | 322 |
| National Medical Specialty Societies | 322 |
| Professional Interest Medical Associations | 3 |
| Other National Societies (AMWA, AOA, NMA) | 3 |
| Medical Student Regional Delegates | 25 |
| Resident and Fellow Delegate Representatives | 41 |
| Sections | 12 |
| Services | 5 |
| **Total Delegates** | **733** |

**Registration facilities will be maintained at the Gaylord National Resort & Convention Center Foyer.**

| | | |
|---|---|---|
| Bobby Mukkamala, MD | Lisa Bohman Egbert, MD | Alex Ding, MD, MS, MBA |
| President | Speaker, House of Delegates | Secretary |

**2025 - 2026**

**OFFICIALS OF THE ASSOCIATION**

**BOARD OF TRUSTEES (OFFICERS)**

President – Bobby Mukkamala..... Flint, Michigan
President-Elect - Willie Underwood, III..... Buffalo, New York
Immediate Past President – Bruce A. Scott..... Louisville, Kentucky
Secretary – Alexander Ding..... Louisville, Kentucky
Speaker, House of Delegates - Lisa Bohman Egbert..... Dayton, Ohio
Vice Speaker, House of Delegates - John H. Armstrong..... Ocala, Florida

David H. Aizuss (2028), *Chair*..... Encino, California
Toluwalase A. Ajayi (2026), *Chair-Elect*..... San Diego, California
Geralyn R. Breig (2028)..... West Port, Connecticut
Scott Ferguson (2026)..... West Memphis, Arkansas
Sandra Adamson Fryhofer (2026)..... Atlanta, Georgia
Melissa Garretson (2028)..... Fort Worth, Texas
Marilyn J. Heine (2026)..... Dresher, Pennsylvania
Pauline P. Huynh (2026)..... Oakland, California
Lynne Jeffers (2028)..... Oxnard, California
Ilse R. Levin (2028)..... Silver Spring, Maryland
Justin W. Magrath (2026)..... New Orleans, Louisiana
Sheila D. Rege (2029)..... TriCities, Washington
Michael Suk (2027)..... Danville, Pennsylvania
Marta J. Van Beek (2029)..... Iowa City, Iowa
David Welsh (2028)..... Batesville Indiana

**COUNCILS OF THE AMA**

**COUNCIL ON CONSTITUTION AND BYLAWS**
Jerry P. Abraham, Los Angeles, California, Chair (2029); Mary Ann Contogiannis, Greensboro, North Carolina, Vice Chair, (2029); John H. Armstrong, Ocala, Florida, Vice Speaker: Ex Officio (2026); Mark N. Bair, Highland, Utah (2027); Lisa Bohman Egbert, Dayton, Ohio, Speaker: Ex Officio (2026); Christopher E. Gribbin, Princeton, New Jersey (2028); Helene Nepomuceno, Las Vegas, Nevada (Resident) (2027); Kevin C. Reilly, Sr., Grovetown, Georgia (2026); Steven C. Thornquist, Bethany, Connecticut (2026); Natasha L. Topolski, Houston, Texas (Student) (2026).
Secretary: Janice Robertson, Chicago, Illinois.

**COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS**
Rebecca W. Brendel, Brookline, Massachusetts, Chair (2026); Larry E. Reaves, Fort Worth, Texas, Vice Chair (2027); Arthur R. Derse, Shorewood, Wisconsin (2030); Charles J. Hickey, Mechanicsburg, Ohio (2031); Michael G. Knight, Washington, District of Columbia (2029); Kelsey C. Mumford, Pflugerville, Texas, (Resident) (2026); Michael J. Redinger, Vicksburg, Michigan (2032); Ishaan Rischie, Alpharetta, Georgia (Student) (2027); Daniel P. Sulmasy, Washington, District of Columbia (2028).
Secretary: Amber Comer, Chicago, Illinois.

**COUNCIL ON LEGISLATION**
Tripti C. Kataria, Chicago, Illinois, Chair (2026); Vijaya L. Appareddy, Chattanooga, Tennessee, Vice Chair (2026); Jacob M. Altholz, Denver, Colorado (Resident) (2026); Maryanne C. Bombaugh, Falmouth, Massachusetts (2026); Claude D. Brunson, Ridgeland, Mississippi (2026); Michael D. Chafty, Kalamazoo, Michigan (2026); Hilary E. Fairbrother, Houston, TX (2026); Merrilee Aynes Gober, Atlanta, Georgia (Alliance Rep) (2026); Ross F. Goldberg, Miami, Florida (2026); Loralie Ma, Fulton, Maryland (2026); Adrienne Q. Nguyen, West Allis, Wisconsin (Student) (2026); Ann Rosemarie Stroink, Heyworth, Illinois (2026); J. Elizabeth Struble, North Manchester, Indiana (2026).
Secretary: George Cox, Washington, District of Columbia.

**COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT**
Jan M. Kief, Merritt Island, Florida, Chair (2027); G. Sealy Massingill, Fort Worth, Texas, Vice Chair (2027); Michelle A. Berger, Austin, Texas (2026); Erin K. Harnish, Longview, Washington (2028); Moudi K. Hubeishy, Chicago, Illinois (Resident) (2026); Gary R. Katz, Dublin, OH (2027); Samuel Lin, Issaquah, Washington (2029); Bhushan H. Pandya, Danville, Virginia (2029); Shilpen A. Patel, San Francisco, California (2028); Lauren E. St. Peter, Kansas City, Missouri (Student) (2026).
Secretary: Susan Close, Chicago, Illinois.

**COUNCIL ON MEDICAL EDUCATION**
Kelly J. Caverzagie, Omaha, Nebraska, Chair (2027); Shannon M. Kilgore, Los Altos, California Chair-Elect (2027); Sherri S. Baker, Edmond, Oklahoma (2029); Ricardo R. Correa Marquez, Phoenix, Arizona (2027); Louito C. Edje, Cincinnati, Ohio (2029); Suja M. Mathew, Hinsdale, Illinois (2026); Rianna K. McNamee, Paramus, New Jersey (2026); Scott H. Pasichow, Maplewood, New Jersey (2029); David J. Savage, La Jolla, California (2029); Seema Sidhu, Morgan Hill California (2028); Joseph T. Whelihan, Philadelphia, Pennsylvania (Resident) (2027); Daniel M. Young, Vestal, New York (2027).
Secretary: Tanya Lopez, Chicago, Illinois.

**COUNCIL ON MEDICAL SERVICE**
Betty S. Chu, Birmingham, Michigan, Chair (2026); A. Patrice Burgess, Boise, Idaho, Chair-Elect (2027); Alain A. Chaoui, Boxford, Massachusetts (2029); Steven L. Chen, San Diego, California (2028); Alice Coombs, Richmond, Virginia (2027); Erick A. Eiting, New York, New York (2028); Stephen K. Epstein, Needham, Massachusetts (2026); Ryan P. Englander, New Britain, Connecticut (Student) (2026); Laura Faye Gephart, Temple, Texas (2029); Ravi Goel, Cherry Hill, New Jersey (2026); Hari S. Iyer Detroit, Michigan (Resident) (2027); Ezequiel Silva, III, San Antonio, Texas (2028).
Secretary: Linda Walsh, Chicago, Illinois.

**COUNCIL ON SCIENCE AND PUBLIC HEALTH**
Padmini D. Ranasinghe, Baltimore, Maryland, Chair (2026); Tamaan K. Osbourne-Roberts, Denver, Colorado, Chair-Elect (2027); Kavita Shah Arora, Philadelphia, Pennsylvania (2029); Ankush K. Bansal, Westlake, Florida (2027); Joanna Bisgrove, Evanston, Illinois (2026); Donald S. Bourne, Pittsburgh, Pennsylvania (Student) (2026); Jennifer J. Bryan, Brandon, Mississippi (2029); Joshua M. Cohen, New York, New York (2026); David R. Cundiff, Ilwaco, Washington (2026); Rachel Ekaireb, Sacramento, California (Resident) (2026); Marc Mendelsohn, St. Louis, MO (2027); Raymond K. Tu, Washington, DC (2028).
Secretary: Andrea Garcia, Chicago, Illinois.

**AMERICAN MEDICAL ASSOCIATION POLITICAL ACTION COMMITTEE**
John W. Poole, Ridgewood, New Jersey (Chair); Jordan M. Warchol, Omaha, Nebraska (Secretary); Hans C. Arora, Chapel Hill, North Carolina; Michael H. Brisman, Old Westbury, New York; Seemal R. Desai, Dallas, Texas; Victoria Gordon, Houston, Texas (Resident); Mary G. Lawrence, Minneapolis, Minnesota; George “Trey” R. Lee, Nashville, Tennessee; Likhit Agrawal, Flower Mound, Texas (Student); Ryan J. Ribeira, Los Gatos, California; Theresa M. Rohr-Kirchgraber, Athens, Georgia; Janice E. Tildon-Burton, Wilmington, Delaware.
Executive Director and Treasurer: Rob Jordan, Washington, District of Columbia.

## EX OFFICIO MEMBERS OF THE HOUSE OF DELEGATES

The Former Presidents and Former Trustees of the Association, the Chairs of the Councils of the AMA and the current General Officers, with the exception of the Speaker and Vice Speaker of the House of Delegates, are ex officio, nonvoting members of the House of Delegates.

### FORMER PRESIDENTS

| | | | | | |
|---|---|---|---|---|---|
| Susan R. Bailey | 2020-2021 | Gerald E. Harmon | 2021-2022 | Nancy H. Nielsen | 2008-2009 |
| David O. Barbe | 2017-2018 | Patrice A. Harris | 2019-2020 | Jack Resneck, Jr | 2022-2023 |
| Lonnie R. Bristow | 1995-1996 | J. Edward Hill | 2005-2006 | J. James Rohack | 2009-2010 |
| Peter W. Carmel | 2011-2012 | Ardis D. Hoven | 2013-2014 | Randolph D. Smoak, Jr. | 2000-2001 |
| Yank D. Coble, Jr. | 2002-2003 | Daniel H. Johnson, Jr. | 1996-1997 | Steven J. Stack | 2015-2016 |
| Richard F. Corlin | 2001-2002 | Jeremy A. Lazarus | 2012-2013 | Robert M. Wah | 2014-2015 |
| Nancy W. Dickey | 1998-1999 | Barbara L. McAneny | 2018-2019 | Cecil B. Wilson | 2010-2011 |
| Jesse Ehrenfeld | 2023-2024 | Alan R. Nelson | 1989-1990 | Percy Wootton | 1997-1998 |
| Andrew W. Gurman | 2016-2017 | John C. Nelson | 2004-2005 | | |

### FORMER TRUSTEES

| | | | | | |
|---|---|---|---|---|---|
| Herman I. Abromowitz | 1997-2005 | Patrice A. Harris | 2011-2018 | Albert J. Osbahr, III | 2011-2019 |
| Susan Hershberg Adelman | 1998-2002 | Alan C. Hartford | 1989-1990 | Harris Pastides | 2020-2024 |
| Kendall S. Allred | 2008-2009 | Drayton Charles Harvey | 2020-2023 | Rebecca J. Patchin | 1988-1989 |
| Raj S. Ambay | 2009-2011 | William A. Hazel, Jr | 2004-2009 | Rebecca J. Patchin | 2003-2011 |
| Joseph P. Annis | 2006-2014 | Cyril M. Hetsko | 2003-2011 | Stephen R. Permut | 2010-2018 |
| Grayson W. Armstrong | 2019-2021 | J. Edward Hill | 1996-2004 | Pamela Petersen-Crair | 1996-1998 |
| John H. Armstrong | 2002-2006 | Ardis D. Hoven | 2005-2012 | Dina Marie Pitta | 2015-2016 |
| Maya A. Babu | 2013-2017 | William E. Jacott | 1989-1998 | Stephen Pool | 1995-1996 |
| Susan R. Bailey | 2011-2018 | Hillary D. Johnson | 2001-2002 | Liana Puscas | 1999-2001 |
| Timothy E. Baldwin | 1987-1989 | Matthew D. Kagan | 1999-2000 | Kevin C. Reilly | 2003-2005 |
| David O. Barbe | 2009-2016 | Christopher K. Kay | 2008-2012 | Ryan J. Ribeira | 2013-2014 |
| Regina M. Benjamin | 1995-1998 | William E. Kobler | 2012-2020 | J. James Rohack | 2001-2008 |
| Scott L. Bernstein | 1991-1992 | Russell W.H. Kridel | 2014-2022 | David A. Rosman | 2002-2004 |
| Stefano M. Bertozzi | 1986-1988 | Pratistha Koirala | 2021-2025 | Samantha L. Rosman | 2005-2009 |
| David J. Brailer | 1985-1986 | Edward L. Langston | 2003-2011 | Raymond Scalettar | 1985-1994 |
| Lonnie R. Bristow | 1985-1994 | Matthew C. Lawyer | 2004-2005 | Bruce A. Scott | 1998-2002 |
| Madelyn E. Butler | 2021-2025 | Jeremy A. Lazarus | 2005-2011 | Aliya Siddiqui | 2024-2025 |
| Peter Carmel | 2002-2010 | W. J. Lewis | 1979-1984 | Carl A. Sirio | 2010-2018 |
| Alice A. Chenault | 1984-1985 | Audrey J. Ludwig | 1990-1991 | Sarah Mae Smith | 2019-2020 |
| Yank D. Coble | 1994-2001 | Thomas J. Madejski | 2020-2024 | Randolph D. Smoak, Jr. | 1992-1999 |
| David S. Cockrum | 1993-1994 | Justin B. Mahida | 2009-2010 | Steven J. Stack | 2006-2014 |
| MaryAnn Contogiannis | 1989-1993 | Omar Z. Maniya | 2016-2017 | Michael Suk | 1994-1995 |
| Malini Daniel | 2012-2013 | Barbara L. McAneny | 2010-2017 | Andrew M. Thomas | 1997-1999 |
| Christopher M. DeRienzo | 2006-2008 | William A. McDade | 2016-2020 | Jeffrey A. Towson | 1998-1999 |
| Nancy W. Dickey | 1989-1997 | Mary Anne McCaffree | 2008-2016 | Georgia A. Tuttle | 2011-2019 |
| Alexander Ding | 2011-2013 | Joe T. McDonald | 2005-2006 | Jordan M. VanLare | 2011-2012 |
| William A. Dolan | 2007-2011 | Samuel J. Mackenzie | 2014-2015 | Robert M. Wah | 2005-2013 |
| Jesse Ehrenfeld | 2014-2022 | Sandeep “Sunny” Mistry | 2000-2001 | Peter Y. Watson | 2001-2003 |
| Willarda Edwards | 2016-2024 | Mario Motta | 2018-2022 | Monica C. Wehby | 2011-2013 |
| Melissa J. Garretson | 1992-1993 | Elizabeth Blake Murphy | 2020-2021 | Kevin W. Williams | 2016-2020 |
| Michael S. Goldrich | 1993-1997 | Alan R. Nelson | 1980-1988 | Meredith C. Williams | 2010-2011 |
| Julie K. Goonewardene | 2012-2016 | John C. Nelson | 1994-2003 | Cecil B. Wilson | 2002-2009 |
| Andrew W. Gurman | 2007-2015 | Nancy H. Nielsen | 2005-2007 | Percy Wootton | 1991-1996 |

**SPECIALTY AND SERVICE SOCIETY REPRESENTATIVES**
**2025 Interim Meeting of the AMA House of Delegates**

*(The following are representatives of the following societies which are represented in the SSS but are not members of the House of Delegates.)*

| | |
|---|---|
| American Association of Endocrine Surgeons | Dina Elaraj, MD |
| American Association of Hip and Knee Surgeons | Beau Kildow, MD |
| American College of Correctional Physicians | Johnny Wu, MD |
| American College of Medical Toxicology | Jacob Altholz, MD |
| American Dermatological Association | Murad Alam, MD |
| American Epilepsy Society | David M. Labiner, MD |
| American Foregut Society | Jonathan Levy, MD |
| American Society of Nephrology | Jeffrey S. Berns, MD |
| American Society of Neuroimaging | Ryan Hakimi, MD |
| American Urogynecologic Society | Jennifer Wu, MD |
| Association of Physicians of Pakistani Descent of North America | Raffia Qutab, MD |
| Association of Professors of Dermatology | Christopher R. Shea, MD |
| International Academy of Independent Medical Evaluators | Diana Kraemer, MD |
| Korean American Medical Association | John Yun, MD, Jennifer Inhae Lee, MD |
| Skin of Color Society | |
| Society for Maternal-Fetal Medicine | Andrea L. Greiner, MD |
| Urgent Care College of Physicians | Lindsey Fish, MD |

**MEMBERS OF THE HOUSE OF DELEGATES - NOVEMBER 2025**
**The following is a list of credentialed delegates and alternate delegates to the House of Delegates as reported to the Executive Vice President**

**Medical Association of the State of Alabama**
**Delegates**
B Jerry Harrison, MD, Haleyville, AL
John Meigs Jr, MD, Brent, AL
William Schneider, MD, Huntsville, AL
George C. Smith Jr., MD, Lineville, AL
**Alternate Delegates**
Alexis Mason, MD, Tuscaloosa, AL
Charles Jeremy Thompson, MD, Sheffield, AL
Jane Weida, MD, Tuscaloosa, AL
Tom Weida, MD, Tuscaloosa, AL

**Alaska State Medical Association**
**Delegate**
Alex Malter, MD, MPH, Juneau, AK
**Alternate Delegate**
Rhene Merkouris, MD, Anchorage, AK

**Arizona Medical Association**
**Delegates**
Veronica K. Dowling, MD, Lakeside, AZ
Timothy Fagan, MD, Tucson, AZ
Gary R. Figge, MD, Tucson, AZ
M Zuhdi Jasser, MD, Phoenix, AZ
Marc Leib, MD, Phoenix, AZ
**Alternate Delegates**
Ilana Addis, MD, Tucson, AZ
David Baltazer, DO, Scottsdale, AZ
Stewart Goldman, MD, Phoenix, AZ
Nadeem Kazi, MD, Casa Grande, AZ

**Arkansas Medical Society**
**Delegates**
Omar Atiq, MD, Little Rock, AR
Stephen Magie, MD, Conway, AR
**Alternate Delegates**
Danny Wilkerson, MD, Little Rock, AR
Alan Wilson, MD, Monticello, AR

**California Medical Association**
**Delegates**
Barbara J. Arnold, MD, Sacramento, CA
Patricia L. Austin, MD, Alamo, CA
Dirk Stephen Baumann, MD, Burlingame, CA
Peter N. Bretan Jr., MD, Novato, CA
J Brennan Cassidy, MD, Newport Beach, CA
Maisha Draves, MD, Fairfield, CA
Suparna Dutta, MD, Oakland, CA
Kyle P. Edmonds, MD, San Diego, CA
Sergio Flores, MD, San Diego, CA
George Fouras, MD, Los Angeles, CA
Anjalee Galion, MD, Santa Ana, CA
Dev A. GnanaDev, MD, Upland, CA
Brian Grady, MD, San Francisco, CA
Donaldo Hernandez, MD, Seaside, CA
Robert Hertzka, MD, Rancho Santa Fe, CA
Jennifer Hone, MD, Santa Barbara, CA
Samuel Huang, MD, Los Angeles, CA
Jeff Klingman, MD, Orinda, CA
Raymond Ko, Walnut Creek, CA
Terence Lin, MD, Fremont, CA
John Maa, MD, San Francisco, CA
Ramin Manshadi, MD, Stockton, CA
Theodore Mazer, MD, Fort Myers, FL
Kelly McCue, MD, Davis, CA
Mihir Parikh, MD, La Jolla, CA
Stephen Parodi, MD, Oakland, CA
Albert Ray, MD, San Diego, CA
Daniel Resnick, Pomona, OR
Katrina Saba, MD, Oakland, CA
Ilan Shapiro Strygler, MD, Commerce, CA
Seema Sidhu, MD, Fremont, CA
Tanya W. Spirtos, MD, Redwood City, CA
James J. Strebig, MD, Irvine, CA
Shannon Udovic-Constant, MD, San Francisco, CA
Holly Yang, MD, San Diego, CA
Ryan J. Ribeira, MD, Mountain View, CA
**Alternate Delegates**
Ameena Ahmed, MD, Oakland, CA
Alpesh Amin, MD, Anaheim, CA
Jack Chou, MD, Baldwin Park, CA
Duc Chung, MD, Los Angeles, CA
James Cotter, MD, Napa, CA
Michele Evans, MD, Rocklin, CA
David Friscia, MD, San Diego, CA
Liliane Gibbs, MD, Anaheim, CA
Douglas Gibson, MD, Folsom, CA
Raminder Gill, MD, Sacramento, CA
Catherine Gutfreund, MD, Santa Rosa, CA
Eric Hansen, DO, Oak Hills, CA
Janet Jacobson, MD, Anaheim, CA
Scott Richard Karlan, MD, West Hollywood, CA
Mark H. Kogan, MD, San Pablo, CA
Sudeep Kukreja, MD, Orange, CA
Mehzabin Lala, Pomona, CA
Man Kit Leung, MD, San Francisco, CA
Stacey Ludwig, MD, Los Angeles, CA
Debbie Lupeika, MD, Redding, CA
Lindsay Mazotti, MD, Danville, CA
Linda Mirdamadi, MD, Los Angeles, CA
Chang Na, MD, Bakersfield, CA
Smita Rouillard, MD, Fresno, CA
Sion Roy, MD, Malibu, CA
Shivani Ruben, MD, Sacramento, CA
Samuel Santoro, DO, Vacaville, CA
Shireen Saxena, MD, Los Angeles, CA
Ryan Shanahan, MD, Ventura, CA
Raymond Tsai, MD, Lost Hills, CA
William Tseng, MD, San Diego, CA
Kurt VandeVort, MD, Saratoga, CA

Valencia Walker, MD, Los Angeles, CA
Christina Wang, MD, San Francisco, CA
Patricia Wang, MD, Antioch, CA
Barbara Weissman, MD, Pacifica, CA
Anna Yap, MD, Carmichael, CA

**Colorado Medical Society**
**Delegates**
David Downs, MD, Denver, CO
Jan Kief, MD, Merritt Island, FL
Rachelle M. Klammer, MD, Denver, CO
A. "Lee" Morgan, MD, Denver, CO
Tamaan Osbourne-Roberts, MD, FAAFP, Denver, CO
Lynn Parry, MD, Littleton, CO
**Alternate Delegates**
Amy Duckro, DO, Lafayette, CO
Carolynn Francavilla, MD, Dillon, CO
Mark Johnson, MD, Louisville, CO
Brigitta J. Robinson, MD, Centennial, CO
Michael Volz, MD, Englewood, CO
Patricia Weber, MD, Grand Jct, CO

**Connecticut State Medical Society**
**Delegates**
M. Natalie Achong, MD, Unionville, CT
Katherine L. Harvey, MD, Canton, CT
Kathleen A. LaVorgna, MD, Norwalk, CT
Steven C. Thornquist, MD, Bethany, CT
**Alternate Delegates**
Raymond Lorenzoni, MD, Woodbridge, CT
Stacy Taylor, MD, New Hartford, CT
Michael Virata, MD, Woodbridge, CT

**Medical Society of Delaware**
**Delegate**
Janice Tildon-Burton, MD, Newark, DE
**Alternate Delegate**
Matthew Burday, DO, Wilmington, DE

**Medical Society of the District of Columbia**
**Delegates**
Peter E. Lavine, MD, Washington, DC
Raymond K. Tu, MD, Washington, DC
**Alternate Delegates**
Neal D Barnard, MD, Washington, DC
Susanne Bathgate, MD, Arlington, VA

**Florida Medical Association**
**Delegates**
Ankush Bansal, MD, Westlake, FL
Rebekah Bernard, MD, Fort Myers, FL
Charles J. Chase, DO, Winter Park, FL
Andrew Cooke, MD, Mount Dora, FL
Eva Crooke, MD, Tampa, FL
Mark Dobbertien, DO, Orange Park, FL
Michelle Falcone, MD, Miami, FL
Shelley C. Glover, MD, Clermont, FL
Karen Harris, MD, Gainesville, FL
John Montgomery, MD, MPH, Fleming Island, FL
Ralph Jacinto Nobo Jr., MD, Bartow, FL
Vicki Norton, MD, Boca Raton, FL
Sanjay Pattani, MD, Windermere, FL
Thomas G. Peters, MD, Jacksonville, FL
Alan B. Pillersdorf, MD, Lake Worth, FL
Mark Rubenstein, MD, Jupiter, FL
Stacie Wenk, DO, Evansville, IN
**Alternate Delegates**
Rose Berkun, MD, Williamsville, NY
Michael Cromer, MD, Tampa, FL
Aaron Elkin, MD, Hollywood, FL
Ronald Frederic Giffler, MD, Davie, FL
Raphael C. Haciski, MD, Naples, FL
Lawrence S. Halperin, MD, Altamonte Spg, FL
Nariman Heshmati, MD, Fort Myers, FL
Tra'Chella Johnson Foy, MD, Jacksonville, FL
Rebecca Lynn Johnson, MD, Tampa, FL
Ali Kasraeian, MD, Jacksonville, FL
Arthur E. Palamara, MD, Hollywood, FL
Sergio B. Seoane, MD, Lakeland, FL
Natalia Solenkova, MD, Aventura, FL

**Medical Association of Georgia**
**Delegates**
John S. Antalis, MD, Dalton, GA
S William Clark III, MD, Waycross, GA
Shamie Das, MD, Atlanta, GA
Billie Luke Jackson, MD, Macon, GA
Zachary Lopater, MD, Macon, GA
Ali R Rahimi, MD, MPH, FACC, Atlanta, GA
Charles Wilmer, MD, Atlanta, GA
**Alternate Delegates**
Lethenia Baker, MD, Lagrange, GA
Keisha Callins, MD, Macon, GA
Samuel Church, MD, Hiawassee, GA
Phillip Coule, MD, Augusta, GA
Andrea Juliao, MD, Tucker, GA
Jin Lee, MD, Lawrenceville, GA
Fonda A. Mitchell, MD, Atlanta, GA

**Hawaii Medical Association**
**Delegates**
Elizabeth A. Ignacio, MD, Kahului, HI
Jerry Van Meter, MD, Honolulu, HI

**Idaho Medical Association**
**Delegate**
A. Patrice Burgess, MD, Boise, ID
**Alternate Delegate**
Zachary Warnock, MD, Pocatello, ID

**Illinois State Medical Society**
**Delegates**
Rodney Alford, MD, Watseka, IL
Howard Axe, MD, Grayslake, IL

Joseph Ballard, MD, Chicago, IL
Christine Bishof, MD, Elmhurst, IL
Howard Chodash, MD, Springfield, IL
Scott A. Cooper, MD, Chicago, IL
Niva Lubin-Johnson, MD, Chicago, IL
James L. Milam, MD, Grayslake, FL
Robert Panton, MD, Elmwood Park, IL
Shastri Swaminathan, MD, Westmont, IL
Piyush Vyas, MD, Lake Forest, IL
Steven D. Williams, MD, Bourbonnais, IL

**Alternate Delegates**

Aadil Ahmed, MD, Forest Park, IL
Richard C Anderson, MD, Peoria, IL
Thomas M. Anderson Jr., MD, Chicago, IL
Smitha Arekapudi, MD, Chicago, IL
Nancy Church, MD, Chicago, IL
Richard A. Geline, MD, Glenview, IL
Anne Langguth, MD, Hindsdale, IL
Christopher Martinez, Chicago, IL
Martha Menchaca, MD, Brookfield, IL
Vikram B. Patel, MD, South Barrington, IL
Holly Rosencranz, MD, Champaign, IL
Judith G Savage, MD, Tinley Park, IL

**Indiana State Medical Association**

**Delegates**

Heidi Dunniway, MD, Evansville, IN
Vidya S. Kora, MD, Michigan City, IN
William Mohr, MD, Kokomo, IN
Rhonda Sharp, MD, Lagrange, IN
Thomas Vidic, MD, Elkhart, IN

**Alternate Delegates**

Deepak Azad, MD, Floyds Knobs, IN
Roberto Darroca, MD, Muncie, IN
Lisa Hatcher, MD, Columbia City, IN
Tashera Perry, MD, Bloomington, IN

**Iowa Medical Society**

**Delegates**

Thomas Evans, MD, Johnston, IA
Douglas Martin, MD, Dakota Dunes, SD
Douglas Peters, MD, W Burlington, IA
Victoria Sharp, MD, Iowa City, IA

**Alternate Delegates**

Cynthia Hoque, DO, Des Moines, IA
Alison Lynch, MD, Iowa City, IA
Brian Privett, MD, Cedar Rapids, IA

**Kansas Medical Society**

**Delegates**

Gerhard A. Fast, MD, Hesston, KS
Robert Gibbs, MD, Parsons, KS
Arthur D. Snow Jr., MD, Shawnee Mission, KS

**Alternate Delegates**

Tessa Rohrberg, MD, Andover, KS
Kimberly Swan, MD, Overland Park, KS
Estephan Zayat, MD, Wichita, KS

**Kentucky Medical Association**

**Delegates**

Lee Dossett, MD, Lexington, KY
Shawn C. Jones, MD, Paducah, KY
Donald J. Swikert, MD, Edgewood, KY
Monalisa Tailor, MD, Louisville, KY
R. Brent Wright, MD, Glasgow, KY

**Alternate Delegates**

Evelyn M. Jones, MD, Paducah, KY
Christine Ko, MD, Lexington, KY
Michael K. Kuduk, MD, Lexington, KY
Neal J. Moser, MD, Taylor Mill, KY
John L. Roberts, MD, Louisville, KY

**Louisiana State Medical Society**

**Delegates**

Luis M. Alvarado, MD, Mandeville, LA
Kamel Brakta, MD, Shreveport, LA
George Ellis, MD, New Orleans, LA
Deborah Fletcher, MD, Shreveport, LA
William Freeman, MD, Prairieville, LA
Clayton Runfalo, MD, Prairieville, LA

**Alternate Delegates**

Donnie Batie, MD, Baton Rouge, LA
Kristin Lynch Grimes, DO, Baton Rouge, LA
Smita Prasad, MD, Springfield, LA

**Maine Medical Association**

**Delegates**

Richard A. Evans, MD, Dover Foxcroft, ME
Maroulla S. Gleaton, MD, Augusta, ME

**Alternate Delegates**

R. Scott Hanson, MD, Lewiston, ME
Dieter Kreckel, MD, Rumford, ME

**MedChi: The Maryland State Medical Society**

**Delegates**

Renee Bovelle, MD, Silver Spring, MD
Karen Dionesotes, MD, MPH, Baltimore, MD
Loralie Dawn Ma, MD, Fulton, MD
Gary Pushkin, MD, Baltimore, MD
Padmini Ranasinghe, MD, Baltimore, MD

**Alternate Delegates**

Renee Bovelle, MD, Silver Spring, MD
Karen Dionesotes, MD, MPH, Baltimore, MD
Loralie Dawn Ma, MD, Fulton, MD
Gary Pushkin, MD, Baltimore, MD
Padmini Ranasinghe, MD, Baltimore, MD

**Massachusetts Medical Society**

**Delegates**

David A. Rosman, MD, MBA, Stoneham, MA
Maryanne C. Bombaugh, MD, Mashpee, MA
Theodore A Calianos II, MD, Mashpee, MA
Alain A. Chaoui, MD, Boxford, MA
Dennis Dimitri, MD, Worcester, MA

Ronald Dunlap, MD, Weymouth, MA
Christopher Garofalo, MD, N Attleboro, MA
Michael Medlock, MD, Lexington, MA
Kenath Shamir, MD, Fall River, MA
Spiro Spanakis, MD, Shrewsbury, MA
Barbara A. Spivak, MD, Watertown, MA
Lynda M. Young, MD, Worcester, MA

**Alternate Delegates**

Mario E. Motta, MD, Salem, MA
Tiffany Bellomo, MD, Boston, MA
Eli Freiman, MD, Watertown, MA
Matthew Gold, MD, Winchester, MA
Afareen Jaleel, Lexington, MA
Olivia Liao, MD, Weston, MA
Maximilian J. Pany, MD, PhD, Brookline, MA

**Michigan State Medical Society**

**Delegates**

Nicklas C. Bara, East Lansing, MI
Paul D. Bozyk, MD, Beverly Hills, MI
T. Jann Caison-Sorey, MD, Bloomfield Heights, MI
Michael D. Chafty, MD, JD, Kalamazoo, MI
Betty S. Chu, MD, Detroit, MI
Pino D. Colone, MD, Howell, MI
Amit Ghose, MD, Okemos, MI
Theodore Jones, MD, Dearborn, MI
Mark C. Komorowski, MD, Essexville, MI
Christie L. Morgan, MD, Grosse Pointe Woods, MI
Rose M. Ramirez, MD, Belmont, MI
Krishna K. Sawhney, MD, Bloomfield Hills, MI
David T. Walsworth, MD, East Lansing, MI
John A. Waters, MD, Flint, MI

**Alternate Delegates**

Brooke M. Buckley, MD, Bloomfield Hills, MI
Edward Bush, MD, Grosse Ile, MI
Louito C Edje, MD, MHPE, FAAFP, Cincinnati, OH
Aliya Hines, MD, Grosse Pt Pk, MI
Mohammad Ibrahim, DO, Flint, MI
Courtland Keteyian, MD, Ann Arbor, MI
Patricia Kolowich, MD, Northville, MI
Michael J Redinger, MD, Kalamazoo, MI
M. Salim U Siddiqui, MD, PhD, Canton, MI
David Whalen, MD, Grand Rapids, MI

**Minnesota Medical Association**

**Delegates**

John Abenstein, MD, MSEE, Oronoco, MN
Andrea Hillerud, MD, Eagan, MN
Dennis O'Hare, MD, Minneapolis, MN
Cindy F. Smith, MD, Spicer, MN
David Thorson, MD, Mahtomedi, MN

**Alternate Delegates**

Lisa Mattson, MD, Plymouth, MN
George Morris, MD, Saint Cloud, MN
Ashok Patel, MD, Rochester, MN
Laurel Ries, MD, Saint Paul, MN

**Mississippi State Medical Association**

**Delegates**

Jennifer Bryan, MD, Brandon, MS
J Clay Hays Jr., MD, Jackson, MS
Avani Patel, MD, MHA, Jackson, MS

**Alternate Delegates**

Anita Henderson, MD, Hattiesburg, MS
Carlos Latorre, MD, Vicksburg, MS
Katherine Pannel, DO, Oxford, MS

**Missouri State Medical Association**

**Delegates**

Elie Azrak, MD, Saint Louis, MO
Peggy Barjenbruch, MD, Mexico, MO
Edmond Cabbabe, MD, St Louis, MO
Joseph Corrado, MD, Mexico, MO
Joanne Loethen, MD, MA, Prairie Village, KS
Charles W. Van Way, MD, Fairway, KS

**Alternate Delegates**

Brian Biggers, MD, Springfield, MO
Lacey Capetti, Columbia, MO
Ravi S Johar, MD, Chesterfield, MO

**Montana Medical Association**

**Delegate**

Nicole C. Clark, MD, Helena, MT

**Alternate Delegate**

Michael P Temporal, MD, Billings, MT

**Nebraska Medical Association**

**Delegates**

Jordan Warchol, MD, MPH, Omaha, NE
Robert Wergin, MD, Seward, NE

**Alternate Delegates**

Thomas Svolos, MD, Omaha, NE
John Trapp, MD, Lincoln, NE

**Nevada State Medical Association**

**Delegates**

Florence Jameson, MD, Boulder City, NV
Sowjanya Reganti, MD, Reno, NV

**Alternate Delegate**

Joseph A. Adashek, MD, Las Vegas, NV
Samantha Schneider, MD, Reno, NV

**New Hampshire Medical Society**

**Delegate**

P. Travis Harker, MD, Manchester, NH

**Alternate Delegate**

Alan C. Hartford, MD, PhD, Lyme, NH

**Medical Society of New Jersey**

**Delegates**

John W. Poole, MD, Ridgewood, NJ
Mary Campagnolo, MD, MBA, Bordentown, NJ
Joseph P. Costabile, MD, Marlton, NJ
Kennedy U. Ganti, MD, Chesterfield, NJ

Christopher Gribbin, MD, Princeton, NJ
Nicole A. Henry-Dindial, MD, Westfield, NJ
Nancy L. Mueller, MD, Englewood Cliffs, NJ
Niranjan V. Rao, MD, FACS, Somerset, NJ
David Swee, MD, Bradley Beach, NJ

**Alternate Delegates**

Peter Blumenthal, MD, Maplewood, NJ
Alan L Kenwood, MD, Morristown, NJ
Naveen Mehrotra, MD, Edison, NJ
Myrian Mondestin-Sorrentino, MD, Monroe Twp, NJ
Steven Orland, MD, Pennington, NJ
Inga Robbins, MD, Atlantic City, NJ

**New Mexico Medical Society**

**Delegates**

William Ritchie, MD, Albuquerque, NM
Nancy Wright, MD, Sapello, NM

**Alternate Delegates**

Robert Underwood, MD, Farmington, NM

**Medical Society of the State of New York**

**Delegates**

Michael Brisman, MD, Old Westbury, NY
Mark Adams, MD, Fairport, NY
Louis Auguste, MD, Manhasset, NY
Maria Basile, MD, East Setauket, NY
Sana Bloch, MD, Bronx, NY
Linda Clark, MD, Rochester, NY
Jerome C. Cohen, MD, Loch Sheldrake, NY
Joshua M. Cohen, MD, New York, NY
Frank G. Dowling, MD, Islandia, NY
Keneth Hall, MD, Rome, NY
Howard Huang, MD, Watertown, NY
David Jakubowicz, MD, Scarsdale, NY
Alyssa Lee, Bronxville, NY
Thomas T Lee, MD, Tarrytown, NY
Joseph R. Maldonado Jr., MD, Westernville, NY
Parag Mehta, MD, New Hyde Park, NY
Gregory L. Pinto, MD, Saratoga Springs, NY
Paul A. Pipia, MD, Syosset, NY
Myrna Sanchez, MD, Malone, NY
Corliss Varnum, MD, Oswego, NY
Jocelyn Young, DO, Vestal, NY
L. Carlos Zapata, MD, Plainview, NY
Michael Ziegelbaum, MD, Jericho, NY

**Alternate Delegates**

Niraj Acharya, MD, Brooklyn, NY
Daniel Eunsuk Choi, MD, Garden City Park, NY
Iris Danziger, MD, Seneca, NY
Janine Fogarty, MD, Rochester, NY
Robert A. Frankel, MD, Brooklyn, NY
Robert B. Goldberg, DO, Morristown, NJ
Carolyn Jones-Assini, MD, Schenectady, NY
Vilma Joseph, MD, Elmont, NY
Liana Leung, MD, Manhasset, NY
Bonnie L. Litvack, MD, Mont Kisco, NY
Charles Lopresto, DO, Long Is City, NY
John Maese, MD, Staten Island, NY
Sandhya Malhotra, MD, Forest Hills, NY
Adolph Meyer, MD, Flushing, NY
Brian Murray, MD, Albany, NY
Malcolm D. Reid, MD, Briarcliff Manor, NY
James Satterfield, MD, Jamaica, NY
Joseph Sellers, MD, Cobleskill, NY
Jane Simpson, DO, Johnson City, NY
Penny Stern, MD, Fresh Meadows, NY
Daniel M. Young, MD, Vesta, NY

**North Carolina Medical Society**

**Delegates**

Mary Ann Contogiannis, MD, Greensboro, NC
Arthur Apolinario, MD, MPH, Clinton, NC
E. Rebecca Hayes, MD, Charlotte, NC
Justin Hurie, MD, Winston Salem, NC
Karen Smith, MD, Raeford, NC
Royce Syracuse, MD, Huntersville, NC

**Alternate Delegates**

Tracy Eskra, MD, Goldsboro, NC
John Meier IV, MD, Raleigh, NC
Eileen Raynor, MD, Durham, NC
Carl Westcott, MD, Winston Salem, NC

**North Dakota Medical Association**

**Delegates**

Misty Anderson, DO, Valley City, ND
David Schmitz, MD, Grand Forks, ND

**Ohio State Medical Association**

**Delegates**

Lisa Bohman Egbert, MD, Dayton, OH
Robyn F Chatman, MD, MPH, FAAFP, Cincinnati, OH
John Corker, MD, Cincinnati, OH
Richard R. Ellison, MD, Fairlawn, OH
Gary R. Katz, MD, Powell, OH
Deepak Kumar, MD, Dayton, OH
Tani Malhotra, MD, Parma, OH
Christopher Paprzycki, MD, Cincinnati, OH
Alisha Reiss, MD, Greenville, OH
Andrew Rudawsky, MD, Lakewood, OH
Christopher Wee, MD, Shaker Hts, OH
Colette R. Willins, MD, Avon, OH

**Alternate Delegates**

Laurel Barr, MD, Columbus, OH
Amy Burkett, MD, Uniontown, OH
Akshaykumar Ganesh, Columbus, OH
Stephen House, MD, Dayton, OH
Maria Phillis, MD, Shaker Hts, OH
Elana Sitnik, MD, Syracuse, NY

**Oklahoma State Medical Association**

**Delegates**

Sherri Baker, MD, Edmond, OK
Jay A. Gregory, MD, Muskogee, OK
Woody Jenkins, MD, Stillwater, OK

Bruce Storms, MD, Chickasha, OK

**Alternate Delegates**

Geoffrey Chow, MD, Tulsa, OK
Mary Clarke, MD, Stillwater, OK
Matthew Jared, MD, Edmond, OK
Julie Strebel, MD, Oklahoma City, OK

**Oregon Medical Association**

**Delegates**

Peter A. Bernardo, MD, Salem, OR
Robert Dannenhoffer, MD, Roseburg, OR
Kevin Ewanchyna, MD, Corvallis, OR
Reva Ricketts-Loriaux, DO, Portland, OR

**Alternate Delegates**

Brian Duty, MD, Portland, OR
Amy Hinrichs, MD, Portland, OR

**Pennsylvania Medical Society**

**Delegates**

Victoria Cimino, MD, Newtown, PA
Michael A. DellaVecchia, MD, PhD, Berwyn, PA
Richard Eisenstaedt, MD, Abington, PA
Mark Friedlander, MD, Narberth, PA
Nathan Hoff, MD, Honesdale, PA
F. Wilson Jackson III, MD, Camp Hill, PA
Bindukumar Kansupada, MD, MBA, Yardley, PA
Dale M. Mandel, MD, Paoli, PA
Narayana Murali, MD, Old Forge, PA
Jill M. Owens, MD, Bradford, PA
Lorraine Rosamilia, MD, Port Matilda, PA
Scott E. Shapiro, MD, Lower Gwynedd, PA
John W. Spurlock, MD, Bethlehem, PA
John Michael Vasudevan, MD, Philadelphia, PA
John P. Williams, MD, Gibsonia, PA

**Alternate Delegates**

Addison Brearton, Philadelphia, PA
Theodore A. Christopher, MD, Maple Glen, PA
James A. Goodyear, MD, North Wales, PA
Sharon Griswold, MD, Hershey, PA
Andrew Lutzkanin III, MD, Elizabethtown, PA
Rafay Nasir, MD, Hershey, PA
Sebastiano Porcu, MD, Philadelphia, PA
Jay Rothkopf, MD, Ft Washington, PA
Neerav Sheth, MD, West Chester, PA
James W. Thomas, MD, North Wales, PA
Martin D. Trichtinger, MD, Hatboro, PA

**Puerto Rico Medical Association**

**Delegates**

Yussef Galib-Frangie Fiol, MD, San German, PR
Gonzalo V. Gonzalez-Liboy, MD, Carolina, PR

**Alternate Delegate**

Wanda Velez-Andujar, MD, Ponce, PR

**Rhode Island Medical Society**

**Delegates**

Sarah Fessler, MD, Riverside, RI
Peter A. Hollmann, MD, Cranston, RI

**Alternate Delegates**

Thomas Bledsoe, MD, Riverside, RI

**South Carolina Medical Association**

**Delegates**

Henry Butehorn, MD, Spartanburg, SC
Gary A. Delaney, MD, Orangeburg, SC
Bruce A. Snyder, MD, Greenville, SC
Greg Tarasidis, MD, Greenwood, SC

**Alternate Delegates**

Amanda Davis, MD, Anderson, SC
Wesley Frierson, MD, Lexington, SC
Stefanie M. Putnam, MD, Mauldin, SC
Christopher A Yeakel, MD, Elgin, SC

**South Dakota State Medical Association**

**Delegates**

Robert L. Allison, MD, Pierre, SD
Robert Summerer, DO, Madison, SD

**Alternate Delegates**

Mary Carpenter, MD, Winner, SD

**Tennessee Medical Association**

**Delegates**

VJ Appareddy, MD, Chattanooga, TN
O. Lee Berkenstock, MD, Memphis, TN
Landon S. Combs, MD, Gray, TN
Richard J. DePersio, MD, Knoxville, TN
Wiley T. Robinson, MD, Memphis, TN
Christopher E. Young, MD, Signal Mtn, TN

**Alternate Delegates**

George R. Lee III, MD, Nashville, TN
Adele Lewis, MD, Nashville, TN
John McCarley, MD, Chattanooga, TN

**Texas Medical Association**

**Delegates**

Michelle A. Berger, MD, Austin, TX
John T. Carlo, MD, Dallas, TX
Robert H. Emmick Jr., MD, Austin, TX
Diana Fite, MD, Magnolia, TX
John G. Flores, MD, Carrollton, TX
Gary Floyd, MD, Keller, TX
Gregory M. Fuller, MD, Keller, TX
William S. Gilmer, MD, Houston, TX
Steven R. Hays, MD, Dallas, TX
David N. Henkes, MD, San Antonio, TX
Bryan G. Johnson, MD, Frisco, TX
Cynthia Jumper, MD, MPH, Lubbock, TX
Kenneth L. Mattox, MD, Houston, TX
Kevin H. McKinney, MD, Galveston, TX
Jennifer Rushton, MD, San Antonio, TX
Leslie H. Secrest, MD, Dallas, TX
Jayesh Shah, MD, MHA, San Antonio, TX
Ezequiel "Zeke" Silva III, MD, San Antonio, TX
Elizabeth Torres, MD, Sugar Land, TX

Roxanne Tyroch, MD, El Paso, TX
E. Linda Villarreal, MD, Edinburg, TX
Sherif Z. Zaafran, MD, Houston, TX

**Alternate Delegates**

Mark A. Casanova, MD, Dallas, TX
Shanna Combs, MD, Fort Worth, TX
Deborah Fuller, MD, Dallas, TX
Grayson Jackson, Galveston, TX
Jonathan MacClements, MD, Austin, TX
Samuel Mathis, MD, Galveston, TX
Eddie Lee Patton, MD, Sugar Land, TX
M. Theresa Phan, MD, Austin, TX
Vivek Rao, MD, Odessa, TX
Mammen Sam, MD, Pearland, TX
Angela Self, MD, Grapevine, TX
Linda Siy, MD, Fort Worth, TX
Yasser Zeid, MD, Longview, TX

**Utah Medical Association**

**Delegates**

Mark Bair, MD, RPh, Highland, UT
Richard Labasky, MD, MBA, Salt Lake City, UT
Anne Lin, MD, Salt Lake Cty, UT

**Alternate Delegate**

Scott Jacob, MD, Provo, UT
Steven Miller, MD, Salt Lake Cty, UT

**Vermont Medical Society**

**Delegate**

Catherine Schneider, MD, Windsor, VT

**Alternate Delegate**

Simha Ravven, MD, Putney, VT

**Medical Society of Virginia**

**Delegates**

Alice Coombs-Tolbert, MD, Richmond, VA
Clifford L Deal III, MD, Richmond, VA
Thomas W. Eppes Jr., MD, Forest, VA
Michele A. Nedelka, MD, Virginia Beach, VA
Bhushan H. Pandya, MD, Danville, VA
Sterling N. Ransone Jr., MD, Deltaville, VA
Cynthia C. Romero, MD, Virginia Beach, VA

**Alternate Delegates**

Joshua Lesko, MD, Portsmouth, VA
Mohit Nanda, MD, Charlottesville, VA
Lee Ouyang, MD, Norfolk, VA
Mark Townsend, MD, Crozier, VA
Jan Willcox, DO, Blacksburg, VA

**Washington State Medical Association**

**Delegates**

Amish Dave, MD, Seattle, WA
Teresa Girolami, MD, Redmond, WA
Matthew Grierson, MD, Bothell, WA
Erin Harnish, MD, Longview, WA
L Elizabeth Peterson, MD, Spokane, WA
Rod Trytko, MD, Spokane, WA

**Alternate Delegates**

Colin Fields, MD, Seattle, WA
Carrie Horwitch, MD, Seattle, WA
Katherine Jong, MD, Seattle, WA
Rajneet Lamba, MD, Kirkland, WA
Vivienne Meljen, MD, Vancouver, WA
Elizabeth Parker, MD, Seattle, WA

**West Virginia State Medical Association**

**Delegates**

Hoyt Burdick, MD, Huntington, WV
Joseph Barry Selby, MD, Morgantown, WV

**Wisconsin Medical Society**

**Delegates**

Clarence W Brown, MD, Onalaska, WI
Barbara Hummel, MD, Muskego, WI
George Melvin Lange, MD, River Hills, WI
Don Lee, MD, Franklin, WI
Tosha Wetterneck, MD, Madison, WI

**Alternate Delegates**

Michelle Graham, MD, Oak Creek, WI
Thomas Joles, MD, Eleva, WI
Douglas Marx, DO, Waukesha, WI
Stephanie Strohbeen, MD, Milwaukee, WI
Michael J. White, MD, Mindoro, WI

**Wyoming Medical Society**

**Delegate**

Stephen Brown, MD, Casper, WY

**Alternate Delegate**

David Wheeler, MD, Casper, WY

**Academy of Consultation-Liaison Psychiatry**
**Delegate**
Lee Tynes, MD, New Orleans, LA
**Alternate Delegate**
Anna Dickerman, MD, New York, NY

**Academy of Physicians in Clinical Research**
**Delegate**
Peter Howard Rheinstein, MD, JD, Severna Park, MD
**Alternate Delegate**
Michael Ybarra, MD, Bethesda, MD

**Aerospace Medical Association**
**Delegate**
Hernando J Ortega Jr., MD, MPH, San Antonio, TX
**Alternate Delegate**
Robert Orford, MD, Fountain Hls, AZ

**Air Force**
**Delegate**
Reid Orth, MD, Goldsboro, NC

**American Academy of Addiction Psychiatry**
**Delegate**
Alëna Balasanova, MD, FAPA, Omaha, NE
**Alternate Delegate**
John J. Mariani, MD, Brooklyn, NY

**American Academy of Allergy, Asthma & Immunology**
**Delegate**
Lynda G. Kabbash, MD, Chestnut Hill, MA
**Alternate Delegate**
Steven G. Tolber, MD, Corrales, NM

**American Academy of Child and Adolescent Psychiatry**
**Delegates**
Adrienne Adams, MD, Chicago, IL
Clarence P. Chou, MD, Mequon, WI
**Alternate Delegates**
Myo Myint, MD, New Orleans, LA
Warren Ng, MD, New York, NY

**American Academy of Cosmetic Surgery**
**Delegate**
Anthony J. Geroulis, MD, Northfield, IL
**Alternate Delegate**
Samir Pancholi, DO, Las Vegas, NV

**American Academy of Dermatology Association**
**Delegates**
Jon "Klint" Peebles, MD, Washington, DC
Adam Rubin, MD, Philadelphia, PA
Sabra Sullivan, MD, Jackson, MS
Seemal Desai, MD, Frisco, TX
Hillary Johnson-Jahangir, MD, PhD, Iowa City, IA
**Alternate Delegates**
Lindsay Ackerman, MD, Phoenix, AZ

**American Academy of Emergency Medicine**
**Delegate**
Gary Gaddis, MD, St Louis, MO
Jonathan Jones, MD, Jackson, MS
Scott Rineer, MD, Clearwater, FL
**Alternate Delegate**
Leah Colucci, MD, Woodbridge, CT

**American Academy of Facial Plastic and Reconstructive Surgery**
**Delegate**
Scott Chaiet, MD, Madison, WI
**Alternate Delegate**
Emily Hrisomalos, MD, Zionsville, IN

**American Academy of Family Physicians**
**Delegates**
Kevin Bernstein, MD, Jacksonville, FL
Rupal Bhingradia, MD, Jersey City, NJ
Joanna T. Bisgrove, MD, Evanstan, IL
Emily Briggs, MD, New Braunfels, TX
Jennifer Brull, MD, Fort Collins, CO
Sarah Costello, MD, Solon, IA
Daron Gersch, MD, Avon, MN
Michael Hanak, MD, LaGrange, IL
Janice Heaton-Sheufelt, MD, Juneau, AK
Tate Hinkle, MD, Auburn, AL
Beulette Hooks, MD, Midland, GA
Tochi Iroku-Malize, MD, Islip, NY
Sabesan Karuppiah, MD, Overland Park, KS
Garrett Kneese, MD, San Diego, CA
Russell Kohl, MD, Stilwell, KS
Peter Koopman, MD, Blountstown, FL
Mary Krebs, MD, Dayton, OH
Evelyn Lynnette Lewis, MD, Newman, GA
Sarah Nosal, MD, Bronx, NY
Emma Phelps, Chico, CA
Anita Ravi, MD, New York, NY
LaTasha Seliby Perkins, MD, Alexandria, VA
Ada Stewart, MD, Columbia, SC
Prachi Thapar, Flower Mound, TX
Emma York, DO, Lorton, VA
Kim Yu, MD, Novi, MI

**American Academy of Hospice and Palliative Medicine**
**Delegates**
Chad D. Kollas, MD, Orlando, FL
Ruth M Thomson, DO, MBA, HMDC, Flat Rock, NC
**Alternate Delegate**
Ana Leech, MD, MS, Houston, TX
Kristina Newport, MD, Lancaster, PA

**American Academy of Insurance Medicine**
**Delegate**
Deborah Y. Smart, MD, Gurnee, IL
**Alternate Delegate**

Susan Stegman, MD, Franklin, WI

**American Academy of Neurology**
**Delegates**
Shannon Kilgore, MD, Palo Alto, CA
Mark Milstein, MD, New York, NY
Ann Murray, MD, Morgantown, WV
**Alternate Delegates**
Barry Czeisler, MD, Brooklyn, NY
Eva Ritzl, MD, Boston, MA
Jeremy Toler, MD, New Orleans, LA

**American Academy of Ophthalmology**
**Delegates**
Ravi D. Goel, MD, Cherry Hill, NJ
Joe Nezgoda Jr., MD, N Palm Beach, FL
Lisa Nijm, MD, Warrenville, IL
Mildred M G. Olivier, MD, Arlington Heights, IL
**Alternate Delegates**
Grayson W. Armstrong, MD, MPH, Boston, MA
Donald J. Cinotti, MD, Jersey City, NJ

**American Academy of Orthopaedic Surgeons**
**Delegates**
Andrew W. Gurman, MD, Altoona, PA
Heidi Hullinger, MD, New York, NY
Casey J. Humbyrd, MD, Narberth, PA
Kimberly Jo Templeton, MD, Leawood, KS
**Alternate Delegates**
Adam John Bruggeman, MD, San Antonio, TX
William R. Martin, MD, Chicago, IL
Anna Noel Miller, MD, Saint Louis, MO
David Teuscher, MD, Arlington, TX

**American Academy of Otolaryngic Allergy**
**Delegate**
Wesley Dean VanderArk, MD, Camp Hill, PA
**Alternate Delegate**
Alpen A. Patel, MD, Marriottsvl, MD

**American Academy of Otolaryngology-Head and Neck Surgery**
**Delegates**
Susan Dixon McCammon, MD, Birmingham, AL
Michael S. Goldrich, MD, E Brunswick, NJ
Douglas R. Myers, MD, Vancouver, WA
**Alternate Delegate**
Rahul Shah, MD, Alexandria, VA

**American Academy of Pain Medicine**
**Delegate**
Bob Wailes, MD, Carlsbad, CA
**Alternate Delegate**
Salman Hirani, MD, Portland, OR

**American Academy of Pediatrics**
**Delegates**
Brittany Bruggeman, MD, Gainesville, FL
Ariel Carpenter, MD, Vestavia, AL
Zarah Iqbal, MD, San Francisco, CA
Sarah Marsicek, MD, Gainesville, FL
Pam Shaw, MD, Kansas City, KS
**Alternate Delegates**
Susan Kressly, MD, St Augustine, FL
Matthew Lecuyer, MD, Washington, DC
Andrew Racine, MD, New York, NY
Joey Whelihan, MD, Philadelphia, PA

**American Academy of Physical Medicine and Rehabilitation**
**Delegates**
Stuart Glassman, MD, MBA, Concord, NH
Susan L. Hubbell, MD, Lima, OH
Carlo Milani, MD, Westport, CT
**Alternate Delegate**
Mona Amin, MD, Washington, DC

**American Academy of Psychiatry and the Law**
**Delegate**
Jennifer Piel, MD, Seattle, WA
**Alternate Delegate**
Patricia Westmoreland, MD, Denver, CO

**American Academy of Sleep Medicine**
**Delegates**
Sam Fleishman, MD, Fayetteville, NC
Patrick J. Strollo, MD, Gibsonia, PA
**Alternate Delegate**
Belen Esparis, MD, Bryn Mawr, PA

**American Association for Geriatric Psychiatry**
**Delegate**
Allan Anderson, MD, Tucson, AZ
**Alternate Delegate**
Vanessa A. Stan, MD, Chicago, IL

**American Association for Hand Surgery**
**Delegate**
Sonu Jain, MD, Cincinnati, OH
**Alternate Delegate**
Deana Mercer, MD, Albuquerque, NM

**American Association for Thoracic Surgery**
**Delegate**
Hannah Copeland, MD, Fort Wayne, IN

**American Association of Clinical Endocrinology**
**Delegate**
Jonathan D. Leffert, MD, Dallas, TX
**Alternate Delegate**
Pavan Chava, DO, New Orleans, LA

**American Association of Clinical Urologists, Inc.**
**Delegates**

Zachary Glaser, MD, Cullman, AL
William Reha, MD, Woodridge, VA
**Alternate Delegate**
John Lam, MD, Woodland Hls, CA

**American Association of Gynecologic Laparoscopists**
**Alternate Delegate**
Reilly Bealer, Spokane Vly, WA

**American Association of Neurological Surgeons**
**Delegates**
Joshua Rosenow, MD, Chicago, IL
Krystal L Tomei, MD, MPH, Cleveland, OH
**Alternate Delegate**
Brian Gantwerker, MD, Los Angeles, CA

**American Association of Neuromuscular & Electrodiagnostic Medicine**
**Delegate**
William S. David, MD, PhD, Lincoln, MA
**Alternate Delegate**
Ileana Howard, MD, Woodinville, WA

**American Association of Physicians of Indian Origin**
**Delegate**
Sunita Kanumury, MD, Randolph, NJ
**Alternate Delegate**
Soumya Neravetla, MD, Springfield, OH

**American Association of Plastic Surgeons**
**Delegate**
Gregory L. Borah, MD, Albuquerque, NM

**American Association of Public Health Physicians**
**Delegate**
Arlene Seid, MD, MPH, Grantham, PA
**Alternate Delegate**
Dave Cundiff, MD, MPH, Ilwaco, WA

**American Clinical Neurophysiology Society**
**Delegate**
Jaime Lopez, MD, Stanford, CA

**American College of Allergy, Asthma and Immunology**
**Delegate**
Alnoor A. Malick, MD, Houston, TX
**Alternate Delegate**
Purvi Parikh, MD, Bronx, NY

**American College of Cardiology**
**Delegates**
Nihar R Desai, MD, New Haven, CT
Jerry D. Kennett, MD, Columbia, MO
Jana E Montgomery, MD, Burlington, MA
M Eugene Sherman, MD, Englewood, CO
Suma Thomas, MD, Cleveland, OH
Annabelle Santos Volgman, MD, Chicago, IL
L. Samuel Wann, MD, Santa Fe, NM
Kim Allan Williams, MD, FACC, Louisville, KY
David Winchester, MD, Gainesville, FL
**Alternate Delegate**
Joseph E. Marine, MD, Baltimore, MD

**American College of Chest Physicians (CHEST)**
**Delegates**
Jon Iaccarino, MD, Glenview, IL
Daniel Pfeifle, MD, Indianapolis, IN
**Alternate Delegate**
John Studdard, MD, Jackson, MS

**American College of Emergency Physicians**
**Delegates**
Brooks F. Bock, MD, Vail, CO
Erick Eiting, MD, New York, NY
Stephen K Epstein, MD, MPP, Needham, MA
Hilary E. Fairbrother, MD, MPH, Houston, TX
Marc Mendelsohn, MD, St. Louis, MO
John C. Moorhead, MD, Portland, OR
Ashley Norse, MD, Jacksonville, FL
Scott Pasichow, MD, MPH, Mahomet, IL
Debra Perina, MD, Ruckersville, VA
**Alternate Delegates**
Erik Blutinger, MD, South Orange, NJ
Louis Anthony Cirillo, MD, Saunderstown, RI

**American College of Gastroenterology**
**Delegates**
R Bruce Cameron, MD, Shaker Heights, OH
March Seabrook, MD, West Columbia, SC

**American College of Legal Medicine**
**Delegate**
Ellia Ciammaichella, DO, JD, Reno, NV
**Alternate Delegate**
Stanley Fronczak, MD, Oak Brook, IL

**American College of Lifestyle Medicine**
**Delegates**
Catherine Collings, MD, Templeton, CA
Samuel Lin, MD, PhD, MBA, Issaquah, WA

**American College of Medical Genetics and Genomics**
**Delegate**
Susan Debra Klugman, MD, Bronx, NY
**Alternate Delegate**
Jerry Vockley, MD, PhD, Pittsburgh, PA

**American College of Medical Quality**
**Delegate**
Charles Gill, MD, Oklahoma City, OK
**Alternate Delegate**
Dan Westphal, MD, Deerfield Bch, FL

**American College of Mohs Surgery**

**Delegate**
Divya Srivastava, MD, Dallas, TX
**Alternate Delegate**
Eric Millican, MD, Sandy, UT

**American College of Nuclear Medicine**
**Delegate**
Alan Klitzke, MD, Buffalo, NY

**American College of Obstetricians and Gynecologists**
**Delegates**
Kavita Arora, MD, Chapel Hill, NC
Marygrace Elson, MD, Iowa City, IA
Coy Flowers, MD, Lexing, KY
Valerie French, MD, Parkville, MO
Laura Faye Gephart, MD, McAllen, TX
Cheryl Gibson Fountain, MD, Grosse Pointe, MI
Nita Kulkarni, MD, Flint, MI
Mary E. LaPlante, MD, Broadview Heights, OH
G. Sealy Massingill, MD, Fort Worth, TX
Diana Ramos, MD, MPH, Laguna Beach, CA
Brandi Ring, MD, MBA, Houston, TX
Kasandra Scales, MD, Alexandria, VA
Heather Smith, MD, Newport, RI
Robert Wah, MD, Thornton, CO
**Alternate Delegates**
Dana Block-Abraham, DO, Vienna, VA
Sandra Brooks, MD, Philadelphia, PA
Steven J. Fleischman, MD, Milford, CT
Andrea Greiner, MD, Iowa City, IA
Siri Holton, MD, Landenberg, PA
Nicole L. Plenty, MD, Marietta, GA
Peter Schwartz, MD, Heidelberg, PA
Ana Marie Tobiasz, MD, Mandan, ND
Eryn Wanyonyi, MD, Chicago, IL

**American College of Occupational and Environmental Medicine**
**Delegate**
Kenji Saito, MD, JD, Augusta, ME
**Alternate Delegate**
Romero N. Santiago, MD, MPH, Urbana, IL

**American College of Physicians**
**Delegates**
George Abraham, MD, MPH, Worcester, MA
Rebecca Andrews, MD, MS, Canton, CT
Micah Beachy, DO, Omaha, NE
Sue Bornstein, MD, Dallas, TX
Sarah G. Candler, MD, Houston, TX
Jan Carney, MD, S Burlington, VT
Elisa Choi, MD, Boston, MA
Colleen Christmas, MD, Baltimore, MD
Thomas Cooney, MD, Portland, OR
Ricardo Correa, MD, Westlake, OH
Charles Cutler, MD, Merion, PA
Noel N. Deep, MD, Antigo, WI
Yul D. Ejnes, MD, N Scituate, RI
Jacqueline Fincher, MD, Thomson, GA
Haidn Foster, MD, Hummelstown, PA
William E. Fox, MD, Charlottesville, VA
Richard S. Frankenstein, MD, Tustin, CA
Jason Goldman, MD, Coral Springs, FL
Charles Hamori, MD, La Mesa, CA
Angela Johnson, MD, Baton Rouge, LA
Janet Jokela, MD, Champaign, IL
Roger Khetan, MD, Dallas, TX
Suja M. Mathew, MD, Chicago, IL
Justin McCaskill, Orange, CA
Robert McLean, MD, New Haven, CT
Ryan Mire, MD, Nashville, TN
Darilyn Moyer, MD, Philadelphia, PA
Isaac Opole, MD, Overland Park, KS
Marianne Parshley, MD, Portland, OR
Ankita Sagar, MD, Monmouth Jct, NJ
Earl Stewart Jr., MD, Marietta, GA
Brittany K. Stovall, MD, Greenville, SC
Donna E. Sweet, MD, Wichita, KS

**American College of Preventive Medicine**
**Delegate**
Robert Gilchick, MD, MPH, Los Angeles, CA
**Alternate Delegate**
Wendy Braund, MD, Camp Hill, PA

**American College of Radiation Oncology**
**Delegate**
Mohamed Khan, MD, PhD, Gilbert, AZ
**Alternate Delegate**
Anna M. Brown, MD, MPhil, Memphis, TN

**American College of Radiology**
**Delegates**
Naiim S. Ali, MD, FRCPC, Winooski, VT
Tilden L Childs III, MD, Fort Worth, TX
Nancy Ellerbroek, MD, Valencia, CA
Steven Falcone, MD, Coral Springs, FL
Todd M. Hertzberg, MD, FACR, Pittsburgh, PA
Daniel H. Johnson Jr., MD, Metairie, LA
Gunjan Malhotra, MD, Ann Arbor, MI
Chris McAdams, MD, Atlanta, GA
**Alternate Delegates**
Christine Kim, MD, Los Angeles, CA
Alan Matsumoto, MD, Charlottesville, VA
Arl Van. Moore Jr., MD, Charlotte, NC
Adam Prater, MD, Fort Worth, TX
Dana Smetherman, MD, New Orleans, LA

**American College of Rheumatology**
**Delegates**
Gary L. Bryant, MD, Reno, NV
Eileen M. Moynihan, MD, Hadden Heights, NJ
**Alternate Delegates**
Cristina G Arriens, MD, Edmond, OK

Christina Downey, MD, Loma Linda, CA

**American College of Surgeons**
**Delegates**
John Armstrong, MD, Ocala, FL
Daniel Dent, MD, San Antonio, TX
Ross F. Goldberg, MD, Miami, FL
Jacob Moalem, MD, Rochester, NY
Lena M. Napolitano, MD, Ann Arbor, MI
Leigh A. Neumayer, MD, Jacksonville, FL
Naveen Sangji, MD, Ann Arbor, MI
Kenneth Sharp, MD, Nashville, TN
**Alternate Delegates**
Luke V Selby, MD, MS, Columbus, OH
Patricia Turner, MD, FACS, Chicago, IL

**American Contact Dermatitis Society**
**Delegate**
Bruce Brod, MD, Downingtown, PA
**Alternate Delegate**
James Taylor, MD, Pepper Pike, OH

**American Gastroenterological Association**
**Delegates**
Claudia Gruss, MD, Redding, CT
Lilani Perera, MD, Boston, MA

**American Geriatrics Society**
**Delegates**
Eugene Lammers, MD, Fairhope, AL
Elizabeth White-Chu, MD, Portland, OR

**American Hernia Society**
**Delegate**
Elizabeth Sodomin, MD, Hershey, PA

**American Medical Women's Association**
**Delegate**
Neelum Aggarwal, MD, Baltimore, MD
**Alternate Delegate**
Roberta Gebhard, DO, Grand Island, NY

**American Orthopaedic Association**
**Delegate**
Kevin Plancher, MD, New York, NY
**Alternate Delegate**
Frederick Flandry, MD, Columbus, GA

**American Orthopaedic Foot and Ankle Society**
**Delegate**
Mariam Hakim-Zargar, MD, Avon, CT
**Alternate Delegate**
Meghan Kelly, MD, PhD, New York, NY

**American Osteopathic Association**
**Delegate**
Robert G.G. Piccinini, DO, Romeo, MI
**Alternate Delegate**
Richard Thacker, DO, Dothan, AL

**American Psychiatric Association**
**Delegates**
Kenneth M. Certa, MD, Plymouth Meeting, PA
Sara Coffey, DO, Tulsa, OK
Laura Halpin, MD, PhD, Los Angeles, CA
Jerry L. Halverson, MD, Oconomowoc, WI
Dionne Hart, MD, Rochester, MN
Ray Hsiao, MD, Bellevue, WA
Cheryl Hurd, MD, Fort Worth, TX
Marketa Wills, MD, Washington, DC
**Alternate Delegates**
Adrian J. Ambrose, MD, New York, NY
Tiffani Bell, MD, Winston Salem, NC
Mark Rapaport, MD, Salt Lake Cty, UT

**American Roentgen Ray Society**
**Delegates**
Denise Collins, MD, Detroit, MI
Timothy Swan, MD, Marshfield, WI

**American Society for Aesthetic Plastic Surgery**
**Delegate**
Nicole Sommor, MD, Springfield, IL
**Alternate Delegate**
Mariam Awada, MD, Birmingham, MI

**American Society for Clinical Pathology**
**Delegates**
Edmund R. Donoghue Jr., MD, Paw Paw, MI
William G. Finn, MD, Ann Arbor, MI
Jennifer Nicole Stall, MD, Minneapolis, MN
**Alternate Delegates**
Steven H. Kroft, MD, Mequion, WI
Nirali M. Patel, MD, Durham, NC
H. Clifford Sullivan III, MD, Marietta, GA

**American Society for Dermatologic Surgery Association**
**Delegates**
M. Laurin Council, MD, St. Louis, MO
Jessica Krant, MD, New York, NY
Rachel Kyllo, MD, Saint Louis, MO
**Alternate Delegate**
Rachel Christensen, MD, New York, NY

**American Society for Gastrointestinal Endoscopy**
**Delegates**
Walter G. Park, MD, Los Altos, CA
Gary Richter, MD, Atlanta, GA
**Alternate Delegate**
Robin Mendelsohn, MD, New York, NY

**American Society for Laser Medicine and Surgery, Inc.**
**Delegate**
George Hruza, MD, Chesterfield, MO

**American Society for Metabolic and Bariatric Surgery**
**Delegate**
Samer Mattar, MD, Houston, TX

**American Society for Radiation Oncology**
**Delegates**
Shane Hopkins, MD, Ames, IA
Shilpen A. Patel, MD, San Francisco, CA

**American Society for Reconstructive Microsurgery**
**Delegate**
Lawrence J. Gottlieb, MD, Chicago, IL

**American Society for Reproductive Medicine**
**Delegate**
Ginny Ryan, MD, Seattle, WA
**Alternate Delegate**
Rachel Whynott, MD, Seattle, WA

**American Society for Surgery of the Hand**
**Delegate**
Robert C. Kramer, MD, Beaumont, TX
**Alternate Delegate**
Lindsey Urband, MD, San Diego, CA

**American Society of Addiction Medicine**
**Delegates**
Stuart Gitlow, MD, MPH, New York, NY
Stephen Taylor, MD, Atlanta, GA
**Alternate Delegates**
Seth Flagg, MD, Silver Spring, MD
Sophia Peng, MD, Chicago, IL

**American Society of Anesthesiologists**
**Delegates**
Randall M. Clark, MD, Denver, CO
James D. Grant, MD, MBA, Bloomfield Hills, MI
Ronald Harter, MD, Dublin, OH
Tripti C. Kataria, MD, Chicago, IL
Edward Mariano, MD, Palo Alto, CA
Michael B. Simon, MD, Jacksonville, FL
Robert Thomsen, MD, Baltimore, MD
Crystal C. Wright, MD, Houston, TX
**Alternate Delegates**
Patrick Giam, MD, Houston, TX
Jayme Looper, MD, Gainesville, FL
Neil Rens, MD, MBA MSc, Boston, MA

**American Society of Cataract and Refractive Surgery**
**Delegates**
Shruti Agarwal, MD, Baltimore, MD
Sandra Yeh, MD, Springfield, IL
**Alternate Delegates**
Susanne Hewitt, MD, Dunwoody, GA
Weijie Lin, MD, Long Island City, NY

**American Society of Colon and Rectal Surgeons**
**Delegate**
Anne Mongiu, MD, New Haven, CT
**Alternate Delegate**
Sachin Vaid, MD, MS, Wilmington, DE

**American Society of Cytopathology**
**Delegate**
Margaret Compton, MD, Nashville, TN
**Alternate Delegate**
Swati Mehrotra, MD, Maywood, IL

**American Society of Dermatopathology**
**Delegate**
Melissa Piliang, MD, Cleveland, OH
**Alternate Delegate**
Karl Napekoski, MD, Naperville, IL

**American Society of Echocardiography**
**Delegates**
Kameswari Maganti, MD, Chicago, IL
Peter S. Rahko, MD, Madison, WI

**American Society of Hematology**
**Delegates**
Chancellor Donald, MD, New Orleans, LA
Amar Kelkar, MD, Roxbury Xing, MA
**Alternate Delegates**
Ellen Fraint, MD, Bronx, NY
Kelsey Martin, MD, Westport, CT

**American Society of Interventional Pain Physicians**
**Delegate**
Lee Snook, MD, Sacramento, CA
**Alternate Delegate**
Sachin Jha, MD, Tustin, CA

**American Society of Maxillofacial Surgeons**
**Delegate**
Kant Lin, MD, Milwaukee, WI

**American Society of Neuroradiology**
**Delegates**
Jacqueline Anne Bello, MD, New York, NY
Melissa Chen, MD, Houston, TX

**American Society of Nuclear Cardiology**
**Delegate**
Ahmet Oktay, MD, Chicago, IL
Suman Tandon, MD, New York, NY

**American Society of Ophthalmic Plastic and Reconstructive Surgery**
**Delegate**
Erin Shriver, MD, Iowa City, IA

**American Society of Plastic Surgeons**

**Delegates**
Scot Glasberg, MD, New York, NY
Robert J. Havlik, MD, Milwaukee, WI
Michele Manahan, MD, Baltimore, MD
**Alternate Delegates**
Maristella Evangelista, MD, Birmingham, MI
Sean Li, MD, Philadelphia, PA
Raj Ambay, MD, DDS, Wesley Chapel, FL

**American Society of Regional Anesthesia and Pain Medicine**
**Delegates**
Richard Chou, MD, Vacaville, CA
Lee Tian, MD, Chicago, IL
**Alternate Delegates**
David Provenzano, MD, Bridgeville, PA
Gary Schwartz, MD, Melville, NY

**American Society of Retina Specialists**
**Delegate**
Michael J. Davis, MD, Los Angeles, CA
**Alternate Delegate**
Sarwar Zahid, MD, Queens, NY

**American Society of Transplant Surgeons**
**Delegate**
Stuart M. Greenstein, MD, Valhalla, NY
**Alternate Delegate**
Kenneth Andreoni, MD, Philadelphia, PA

**American Urological Association**
**Delegates**
Hans C. Arora, MD, PhD, Chapel Hill, NC
Jason Jameson, MD, Phoenix, AZ
**Alternate Delegates**
Yaw Nyame, MD, Seattle, WA
Ruchika Talwar, MD, Nashville, TN

**American Vein and Lymphatic Society**
**Delegate**
Vineet Mishra, MD, Franklin, TN
**Alternate Delegate**
Sreenivas Reddy, MD, Hinsdale, IL

**American Venous Forum**
**Delegate**
Loay Kabbani, MD, Detroit, MI

**Army**
**Delegate**
Erin Keyser, MD, San Antonio, TX

**Association for Clinical Oncology**
**Delegates**
Steve Y. Lee, MD, Oakland, CA
Barbara L. McAneny, MD, Albuquerque, NM
Kristina Novick, MD, West Chester, PA
Ray D. Page, DO, PhD, Fort Worth, TX
Erin Schwab, MD, Dillon, CO
**Alternate Delegates**
David J. Savage, MD, PhD, Albuquerque, NM
Ashley Sumrall, MD, Charlotte, NC

**Association of Academic Physiatrists**
**Delegate**
Prakash Jayabalan, MD, Glenview, IL
**Alternate Delegate**
Amber Clark, MD, Trussville, AL

**Association of Academic Radiology**
**Delegate**
Stephen Chan, MD, Closter, NJ
**Alternate Delegate**
Shyam Sabat, MD, Gainesville, FL

**College of American Pathologists**
**Delegates**
James L. Caruso, MD, Castle Rock, CO
Joe Saad, MD, Dallas, TX
Susan Strate, MD, Wichita Falls, TX
Mark S. Synovec, MD, Topeka, KS
**Alternate Delegates**
Diana Marcella Cardona, MD, Durham, NC
Jean Elizabeth Forsberg, MD, Oklahoma City, OK
Joseph Sanfrancesco, MD, Charleston, SC

**Congress of Neurological Surgeons**
**Delegates**
Jason Schwalb, MD, West Bloomfield, MI
Ann R. Stroink, MD, Heyworth, IL
**Alternate Delegates**
Maya A. Babu, MD, MBA, Englewood, FL
Laura Stone McGuire, MD, Chicago, IL

**Endocrine Society, The**
**Delegates**
Amanda Bell, MD, Kansas City, MO
Barbara Onumah, MD, Bowie, MD
**Alternate Delegate**
Daniel Spratt, MD, Portland, ME

**GLMA: Health Professionals Advancing LGBTQ+ Equality**
**Delegate**
Jason S. Schneider, MD, Atlanta, GA
**Alternate Delegate**
Frances Grimstad, MD, Boston, MA

**Heart Rhythm Society**
**Delegate**
Steve Hao, MD, San Francisco, CA
**Alternate Delegate**
Timothy Larsen, DO, Chicago, IL

**Infectious Diseases Society of America**
**Delegate**
Michael L. Butera, MD, San Diego, CA
**Alternate Delegate**
Megan Srinivas, MD, MPH, Fort Dodge, IA

**International College of Surgeons-US Section**
**Delegate**
Joshua Mammen, MD, Omaha, NE
**Alternate Delegate**
Rifat Latifi, MD, Valhalla, NY

**International Pain and Spine Intervention Society**
**Delegate**
William D. Mauck, MD, Rochester, MN
**Alternate Delegate**
Kate Sully, MD, Niceville, FL

**International Society for the Advancement of Spine Surgery**
**Delegate**
Anthony Digiorgio, DO, San Francisco, CA
**Alternate Delegate**
William Lavelle, MD, Syracuse, NY

**International Society of Hair Restoration Surgery**
**Delegate**
Carlos J. Puig, DO, Houston, TX
**Alternate Delegate**
Sara M Wasserbauer, MD, Walnut Creek, CA

**National Association of Medical Examiners**
**Delegate**
Michelle Jorden, MD, San Jose, CA
**Alternate Delegate**
Ponni Arunkumar, MD, Hinsdale, IL

**National Medical Association**
**Delegate**
Nelson Adams, MD, Miami Shores, FL
**Alternate Delegate**
Willarda V. Edwards, MD, MBA, Baltimore, MD

**North American Neuromodulation Society**
**Delegate**
Nameer R. Haider, MD, New Hartford, NY

**North American Neuro-Ophthalmology Society**
**Delegate**
Benjamin Frishberg, MD, Carlsbad, CA

**North American Spine Society**
**Delegates**
R Dale Blasier, MD, Little Rock, AR
William Mitchell, MD, Marlton, NJ

**Obesity Medicine Association**
**Delegate**
Ethan Lazarus, MD, Lone Tree, CO
**Alternate Delegate**
Jennifer Paisley, MD, Grinnell, IA

**Outpatient Endovascular and Interventional Society**
**Delegate**
Eric J. Dippel, MD, Davenport, IA
**Alternate Delegate**
Samuel Ahn, MD, Diamond Bar, CA

**Post-Acute and Long-Term Care Medical Association**
**Delegate**
Karl Steinberg, MD, Oceanside, CA
**Alternate Delegate**
Leslie Eber, MD, CMD, Golden, CO

**Radiological Society of North America**
**Delegates**
Kevin C. Reilly Sr., MD, Elizabethtown, KY
Jade Anderson, MD, Norwalk, CT
Nandini M. Meyersohn, MD, Cambridge, MA
**Alternate Delegate**
Laura E. Traube, MD, San Luis Obispo, CA

**Renal Physicians Association**
**Delegate**
Rebecca Schmidt, DO, Morgantown, WV
**Alternate Delegate**
Abigail Bradner, MD, Nashville, TX

**Society for Cardiovascular Angiography and Interventions**
**Delegates**
J. Jeffrey Marshall, MD, Atlanta, GA
Edward Tuohy IV, MD, Milford, CT

**Society for Cardiovascular Magnetic Resonance**
**Delegate**
Edward T. Martin, MD, Tulsa, OK
**Alternate Delegate**
Anthon Fuisz, MD, New York, NY

**Society for Investigative Dermatology**
**Delegate**
Erica Dommasch, MD, Boston, MA
**Alternate Delegate**
Daniel Bennett, MD, Madison, WI

**Society for Pediatric Dermatology**
**Delegate**
Dawn Davis, MD, Rochester, MN
**Alternate Delegate**
Marilyn Liang, MD, Boston, MA

**Society for Vascular Surgery**
**Delegate**
Nicolas J. Mouawad, MD, Bay City, MI

**Alternate Delegate**
Kaitlyn Dobesh, MD, Detroit, MI

**Society of American Gastrointestinal Endoscopic Surgeons**
**Delegates**
Kevin Reavis, MD, Portland, OR
Paresh Shah, MD, New York, NY
**Alternate Delegates**
Sierra Grasso, DO, New York, NY
Kellie Marie McFarlin, MD, Detroit, MI

**Society of Cardiovascular Computed Tomography**
**Delegate**
Kanae Mukai, MD, Salinas, CA
**Alternate Delegate**
Irfan Zeb, MD, Morgantown, WV

**Society of Critical Care Medicine**
**Delegates**
Kathleen Doo, MD, Orinda, CA
Tina R. Shah, MD, Westfield, NJ
**Alternate Delegates**
Devang Sanghavi, MD, Jacksonville, FL
Daniel Udrea, MD, Loma Linda, CA

**Society of Hospital Medicine**
**Delegates**
Steven Deitelzweig, MD, New Orleans, LA
Brad Flansbaum, DO, New York, NY
Ron Greeno, MD, Los Angeles, CA

**Society of Interventional Radiology**
**Delegate**
Meridith Englander, MD, FSIR, Albany, NY
**Alternate Delegate**
Charles Ray, MD, Chicago, IL

**Society of Nuclear Medicine and Molecular Imaging**
**Delegate**
Gary L. Dillehay, MD, Chicago, IL
**Alternate Delegate**
Benjamin Franc, MD, Menlo Park, CA

**Society of Thoracic Surgeons**
**Delegates**
Jeffrey P. Gold, MD, Omaha, NE
David D. Odell, MD, Ann Arbor, MI

**The American Society of Breast Surgeons**
**Delegate**
Steven Chen, MD, MBA, San Diego, CA
**Alternate Delegate**
David Rubin Brenin, MD, Charlottesville, VA

**The Society of Laparoscopic and Robotic Surgeons**
**Delegate**
Camran Nezhat, MD, Redwood City, CA
**Alternate Delegate**
Ceana Nezhat, MD, Atlanta, GA

**Triological Society, The**
**Delegate**
Michael E. Hoffer, MD, Miami, FL

**Undersea and Hyperbaric Medical Society**
**Delegate**
Laurie Gesell, MD, Brookfield, WI
**Alternate Delegate**
Helen Gelly, MD, Marietta, GA

**US Public Health Service**
**Delegate**
Elizabeth Davlantes, MD, Atlanta, GA
**Alternate Delegate**
Joseph Hutter, MD, Middleburg, VA

**Veterans Affairs**
**Delegate**
Carolyn M. Clancy, MD, Silver Spring, MD

**Academic Physicians Section**
**Delegate**
Mark Meyer, MD, Kansas City, KS
**Alternate Delegate**
Kamalika Roy, MD, Wilsonville, OR

**Integrated Physician Practice Section**
**Delegate**
Luis Garcia, MD, Chicago, IL
**Alternate Delegate**
Steven Wang, MD, Bakersfield, CA

**International Medical Graduates Section**
**Delegate**
Deepu Sudhakaran, MD, Chesterfield, MO
**Alternate Delegate**
Roopa Naik, MD, S Abingtn Twp, PA

**LGBTQ+ Section**
**Delegate**
Carl Streed Jr., MD, MPH, Boston, MA
**Alternate Delegate**
Hailey Greenstone, Boston, MA

**Medical Student Section**
**Delegate**
Jared Buteau, Greenville, SC
**Alternate Delegate**
Sneha Kapil, St Augustine, FL

**Organized Medical Staff Section**
**Delegate**
Nancy Fan, MD, Wilmington, DE
**Alternate Delegate**
Nita Shumaker, MD, Hixson, TN

**Private Practice Physician Section**
**Delegate**
Timothy G. Mc Avoy, MD, Waukesha, WI
**Alternate Delegate**
Kieran McAvoy, MD, Brookfield, WI

**Resident and Fellow Section**
**Delegate**
Nikita Sood, MD, Providence, RI
**Alternate Delegate**
Sarah Mae Smith, MD, PhD, Anaheim, CA

**Senior Physicians Section**
**Delegate**
Virginia E. Hall, MD, Hummelstown, PA
**Alternate Delegate**
Douglas M. DeLong, MD, Cherry Valley, NY

**Underrepresented in Medicine Advocacy Section**
**Delegate**
Luis Seija, MD, Philadelphia, PA
**Alternate Delegate**
Josephine Fowler, MD, Marlborough, MA

**Women Physicians Section**
**Delegate**
Shazia Pathan, MD, Las Vegas, NV
**Alternate Delegate**
Rachel Solnick, MD, New York,

**Young Physicians Section**
**Delegate**
Sean Figy, MD, Omaha, NE
**Alternate Delegate**
Christopher Libby, MD, Anaheim, CA

**Sectional Resident and Fellows with Endorsing Society**

**Delegates**

Oluwasegun Emenogu, MD, Chicago, IL (Endorsed by American Academy of Neurology)
Laila Koduri, MD, MPH, New Orleans, LA (Endorsed by American Academy of Neurology)
Daniel Lee, MD, Mobile, AL (Endorsed by American Academy of Neurology)
Ida Vaziri, MD, Washington, DC (Endorsed by American Academy of Neurology)
Rohan Khazanchi, MD, MPH, Boston, MA (Endorsed by American Academy of Pediatrics)
Rosalynn Conic, MD PhD MPH, Gainesville, FL (Endorsed by American Academy of Physical Medicine & Rehabilitation)
Sarah Mae Smith, MD, PhD, Anaheim, CA (Endorsed by American Association of Public Health Physicians)
Anna Heffron, MD, PhD, New, York, NY (Endorsed by American College of Emergency Physicians)
Sophia Spadafore, MD, New, York, NY (Endorsed by American College of Emergency Physicians)
Allie Conry, MD, Memphis, TN (Endorsed by American College of Obstetricians and Gynecologists)
Rachel Ekaireb, MD, Sacramento, CA (Endorsed by American College of Surgeons)
Michael Visenio, MD, MPH, Omaha, NE (Endorsed by American College of Surgeons)
Danielle Rivera, MD, Albuquerque, NM (Endorsed by American Psychiatric Association)
Karthik Sarma, MD, PhD, San, Francisco, CA (Endorsed by American Psychiatric Association)
Neil Rens, MD, MBA, MSc, Boston, MA (Endorsed by American Society of Anesthesiologists)
Dayna Isaacs, MD, MPH, Sacramento, CA (Endorsed by Association for Clinical Oncology)
Abhishek Dharan, MD, Redlands, CA (Endorsed by California Medical Association)
Pauline Huynh, MD, Oakland, CA (Endorsed by California Medical Association)
Helene Nepomuceno, MD, Union, City, CA (Endorsed by California Medical Association)
Jacob Altholz, MD, Denver, CO (Endorsed by Colorado Medical Society)
Lavanya Easwaran, MD, MPH (Endorsed by Colorado Medical Society)
Daniel Kerekes, MD, MHS, New, Haven, CT (Endorsed by Connecticut State Medical Society)
Pawan Mathew, MD, New, Haven, CT (Endorsed by Connecticut State Medical Society)
Jacob Cabrejas, MD, Chicago, IL (Endorsed by Illinois State Medical Society)
Hussein Antar, MD, MPh, Worcester, MA (Endorsed by Massachusetts Medical Society)
Elizabeth Conner, MD, MPH, Boston, MA (Endorsed by Massachusetts Medical Society)
Katherine Russell, DO, MSPH, Decatur, GA (Endorsed by Medical Association of Georgia)
Kylee Borger, MD, MPH, New, York, NY (Endorsed by Medical Society of the State of New York (MSSNY)
Nicolas Fletcher, MD, MHSA, Detroit, MI (Endorsed by Michigan State Medical Society)
Lauren Benning, DO, Minneapolis, MD (Endorsed by Minnesota State Medical Association)
Megan Chiu, MD (Endorsed by Ohio State Medical Association)
Brandon Francis, MD, Cleveland, OH (Endorsed by Ohio State Medical Association)
Samantha Beck, MD, Tulsa, Oklahoma (Endorsed by Oklahoma State Medical Association)
Nikita Deval, DO, Tulsa, Oklahoma (Endorsed by Oklahoma State Medical Association)
Brady Iba, DO, Edmond, OK (Endorsed by Oklahoma State Medical Association)
Revati Gummaluri, DO, Danville, PA (Endorsed by Pennsylvania Medical Society)
Nikita Sood, MD, Providence, RI (Endorsed by Rhode Island Medical Society)
Victoria Gordon, DO, Houston, TX (Endorsed by Texas Medical Association)
Christopher Wong, MD, MSc, Houston, TX (Endorsed by Texas Medical Association)
Abbigayle Willgruber, MD, Madison, WI (Endorsed by Wisconsin Medical Society)

**Alternate Delegates**

Shreya Mandava Mandava, MD, Ann Arbor, MI (Endorsed by American Academy of Otolaryngology-Head and Neck Surgery)
Reilly Bealer Bealer, MD, Chapel Hill, NC (Endorsed by American Association Of Gynecologic Laparoscopists)
Frank Zhou Zhou, MD, New York, NY (Endorsed by American Association of Public Health Physicians)
Allison Young Young, MD, Chicago, IL (Endorsed by American College of Emergency Physicians)
Rijul Asri Asri, MD, Jersey City, NJ (Endorsed by American College of Legal Medicine)
Laurie Lapp Lapp, MD, Columbia, SC (Endorsed by American College Of Obstetricians And Gynecologists)
Anirudh Gautam Gautam, MD, Burlington, MA (Endorsed by American College of Radiology)
Katerina Kearns Kearns, MD, Philadelphia, PA (Endorsed by American Society for Clinical Pathology)
Dhruv Puri Puri, MD, San Diego, CA (Endorsed by American Urological Association)
Oladimeji Lanade Lanade, MD, Charlotte, NC (Endorsed by Association For Clinical Oncology)
Elisa Quince Quince, MD, Fresno, CA (Endorsed by California Medical Association)
Joshua Bilello Bilello, MD, Denver, CO (Endorsed by Colorado Medical Society)
Arya Dadhania Dadhania, MD, Peoria, IL (Endorsed by Illinois State Medical Society)
Apoorva Tummala Tummala, MD, Indianapolis, IN (Endorsed by Indiana State Medical Association)
Andrew Ray Ray, MD, Louisville, KY (Endorsed by Kentucky Medical Association)
Robert Dunn Dunn, MD, Baltimore, MD (Endorsed by MedChi: The Maryland State Medical Society)
Kelly Schmidt Schmidt, MD, Columbia, MO (Endorsed by Missouri State Medical Association)
Mollie Dreicer Dreicer, MD, Omaha, NE (Endorsed by Nebraska Medical Association)
James Mossner Mossner, MD, Chicago, IL (Endorsed by North American Neuromodulation Society)
Britney Bernal Bernal, MD, Oklahoma City, OK (Endorsed by Oklahoma State Medical Association)
Nidhi Reddy Reddy, MD, Chicago, IL (Endorsed by Society for Vascular Surgery)
Shaminy Manoranjithan Manoranjithan, MD, Grand Rapids, MI (Endorsed by Society forVascular Surgey)
Caleb Atkins Atkins, MD, Watertown, NY (Endorsed by Medical Society of the State of New York (MSSNY)

Zachary Dunton Dunton, MD, Arlington, VA (Endorsed by Medical Society of Virginia)
Terry Henry Jr, MD, Richmond, VA (Endorsed by Medical Society of Virginia)

**Regional Medical Students with Endorsing Society**

**Delegates**

Sweta Parija, LaJolla, CA (Endorsed by California Medical Association)
Phanisri Tummala, San Jose, CA (Endorsed by California Medical Association)
Pritika Parmar, Greenwood, CO (Endorsed by Colorado Medical Society)
Jessica Macintyre, Farmington, CT (Endorsed by Connecticut Medical Society)
Sneha Kapil, St. Augustine, FL (Endorsed by Florida Medical Association)
Sami Muslmani, Chicago, IL (Endorsed by Illinois State Medical Society)
Daniel Wilmot, Brownsburg, IN (Endorsed by Indiana State Medical Association)
Kaitlyn Hanson, Des Moines, IA (Endorsed by Iowa Medical Society
Lauren St. Peter, Kansas City, KS (Endorsed by Kansas Medical Society)
Isabel Ball, Somerville, MA (Endorsed by Massachusetts Medical Society)
Sriharsha Sripadrao, Augusta, GA (Endorsed by Medical Association of Georgia)
Rianna McNamee, Paramus, NJ (Endorsed by Medical Society of New Jersey)
Rohini Guin, Cetereach, NJ (Endorsed by Medical Society of the State of New York)
Akhil Mahant, Rochester, NY (Endorsed by Medical Society of the State of New York)
Rusty Hawes, Charlottesville, VA (Endorsed by Medical Society of Virginia)
Joshua A. Hartley, Jackson, MS (Endorsed by Mississippi State Medical Society)
Hunter Olstad, Valley City, ND (Endorsed by North Dakota Medical Association)
Shalmali Bhadkamkar, Toledo, OH (Endorsed by Ohio State Medical Association)
Lily Robistow, Owasso, OK (Endorsed by Oklahoma State Medical Association)
Donald Bourne, Pittsburgh, PA (Endorsed by Pennsylvania Medical Society)
Jared Buteau, Greenville, SC (Endorsed by South Carolina Medical Association)
Austin Thomas, Knoxville, TN (Endorsed by Tennessee Medical Association)
Likhit Agrawal, Flower Mountain, TX (Endorsed by Texas Medical Association)
Chance Anderson, Huntington, WV (Endorsed by West Virginia State Medical Association)
Kylie Ruprecht, Madison, WI (Endorsed by Wisconsin Medical Society)

**Alternate Delegates**

Satya Bandaru, Riverside, CA (Endorsed by California Medical Association)
Thomas S. Issa, Lancaster, CA (Endorsed by California Medical Association)
Isabel Nguyen, Pomona, CA (Endorsed by California Medical Association)
Ty Thompson, Colton, CA (Endorsed by California Medical Association)
Bhavana Gunda, Farmington, CT (Endorsed by Connecticut State Medical Society)
Sumeet Kadian, Farmington, CT (Endorsed by Connecticut State Medical Society)
Wyatt Reed, Indianapolis, IN (Endorsed by Indiana State Medical Association)
Abby Davison, North Liberty, IA (Endorsed by Iowa Medical Society)
Jack Litwin, Prairie Village, KS (Endorsed by Kansas Medical Society)
Brynne Tynes, Lafayette, LA (Endorsed by Louisiana State Medical Society)
Priscilla McElhinney, Boston, MA (Endorsed by Massachusetts Medical Society)
Brittny Garcia, Boston, MA (Endorsed by Massachusetts State Medical Society)
Preetham Bachina, Baltimore, MD (Endorsed by Medchi: The Maryland State Medical Society)
Marc Erickson, Dothan, AL (Endorsed by Medical Association for the State of Alabama)
Rhea Nichani, Dothan, AL (Endorsed by Medical Association of the State of Alabama)
Yumna Rahman, Richmond, VA (Endorsed by Medical Society of Virginia)
Kai Jillson, Hattiesburg, MS (Endorsed by Mississippi State Medical Society)
Mason Tuttle, Kansas City, MO (Endorsed by Missouri State Medical Association)
Michael C. Shukis, Cincinnati, OH (Endorsed by Ohio State Medical Association)
Jessy Silfer, Cleveland, OH (Endorsed by Ohio State Medical Association)
Denise Ocampo, Hummelstown, PA (Endorsed by Pennsylvania Medical Society)
Kayla Jernigan, Greenville, SC (Endorsed by South Carolina Medical Association)
Paneeta Mohapatra, Memphis, TN (Endorsed by Tennessee Medical Association)
Andrew Ibrahim, Lubbock, TX (Endorsed by Texas Medical Association)
Lyiba Malik, Franklin, WI (Endorsed by Wisconsin Medical Society)

**Reference Committee Hearing Room Assignments**
**Saturday, November 15**

| **15 minutes after HOD second session close** | | **Room** |
|---|---|---|
| Ethics & Bylaws | | National Harbor 10/11 |
| B | Legislative advocacy | Potomac Ballroom B |
| C | Advocacy on medical education | Potomac Ballroom C |
| F | AMA governance and finance | Maryland Ballroom |
| J | Advocacy on medical service, practice, and insurance | Potomac Ballroom D |
| K | Advocacy on science and public health | Potomac Ballroom A |

# AMERICAN MEDICAL ASSOCIATION
# HOUSE OF DELEGATES

## 2025 Interim Meeting
## Notes on Orders of Business

**Gaylord National Resort & Convention Center, Maryland**
**Maryland Ballroom**

FIRST SESSION, Friday, November 14, 6:00pm

SECOND SESSION, Saturday, November 15, 12:30pm

THIRD SESSION, Monday, November 17, 10:00am

FOURTH SESSION, Tuesday, November 18, 8:30am

## Summary of Fiscal Notes I-25

**Report(s) of the Board of Trustees**

| | | |
|---|---|---|
| 01 | Calling for a Multifaceted Approach to the Illicit Fentanyl Crisis | Minimal |
| 02 | Laser Surgery | Minimal |
| 03 | Stark Law Self-Referral Ban | Minimal |
| 04 | Addressing and Reducing Patient Boarding in Emergency Departments (EDs) | Minimal |
| 05 | Addressing the Unregulated Body Brokerage Industry | Moderate |
| 06 | Information Blocking Rule | Minimal |
| 07 | Codification of the Chevron Deference Doctrine | Minimal |
| 08 | On the Ethics of Human Lifespan Prolongation | Minimal |
| 09 | 2025 AMA Advocacy Efforts | Info. Report |
| 10 | Improving Usability of Electronic Health Records (EHRs) for Transgender and Gender Diverse Patients | Moderate |
| 11 | Supporting Diversity in Research | Minimal |
| 12 | Support For Doula Care Programs | Minimal |
| 13 | Antidiscrimination Protections for LGBTQ+ Youth in Foster Care | To Be Determined |
| 14 | AMA Efforts on Medicare Payment Reform and Increasing Transparency of AMA Medicare Payment Reform Strategy | Info. Report |
| 15 | Protecting Evidence-Based Medicine, Public Health Infrastructure and Biomedical Research Report | Minimal |
| 16 | Preservation of Medicaid | Minimal |
| 17 | Establishing an Advisory Committee on AI/AN Affairs | |
| 18 | Published Metrics for Hospitals and Hospital Systems | Minimal |
| 19 | Addressing the Historical Injustices of Anatomical Specimen Use | Minimal |
| 20 | AMA Reimbursement of Necessary HOD Business Meeting Expenses for Delegates and Alternates | Info. Report |

**Report(s) of the Council on Constitution and Bylaws**

| | | |
|---|---|---|
| 01 | Bylaws Review Report | Minimal |
| 02 | Bylaws Clarifications Subsequent to A-25 House of Delegates Meeting | Minimal |
| 03 | Credentialing of Temporary Delegates and Alternate Delegates | |

**Report(s) of the Council on Ethical and Judicial Affairs**

| | | |
|---|---|---|
| 01 | Amendment to Opinion 1.1.1 “Patient-Physician Relationships” | Minimal |
| 02 | Supporting Efforts to Strengthen Medical Staffs Through Collective Actions and/or Unionization | Minimal |
| 03 | Ethical Impetus for Research in Pregnant and Lactating Individuals | Minimal |

**Opinion(s) of the Council on Ethical and Judicial Affairs**

| | | |
|---|---|---|
| 01 | Contracts to Deliver Health Care Services | Info. Report |
| 02 | Organ Transplantation Allocation Decisions | Info. Report |

# Summary of Fiscal Notes I-25

**Report(s) of the Council on Long Range Planning and Development**

| | | |
|---|---|---|
| 01 | Private Practice Physicians Section Five-Year Review | Minimal |
| 02 | Evaluation of the Structure of the AMA House of Delegates | Minimal |

**Report(s) of the Council on Medical Education**

| | | |
|---|---|---|
| 01 | Additional Pathways for International Medical Graduates | Minimal |

**Report(s) of the Council on Medical Service**

| | | |
|---|---|---|
| 01 | Health Savings Account Reform | Minimal |
| 02 | Telehealth Licensure | Minimal |
| 03 | Payment Models to Sustain Rural Hospitals | Minimal |
| 04 | Payment for Biosimilars | Minimal |

**Report(s) of the Council on Science and Public Health**

| | | |
|---|---|---|
| 01 | Drug Shortages: 2025 Update | Info. Report |
| 02 | Regulation of Ionizing Radiation Exposure for Health Care Professionals | Minimal |
| 03 | Plastic Pollution Reduction | Minimal |

**Report(s) of the HOD Committee on Compensation of the Officers**

| | | |
|---|---|---|
| 01 | Report of the House of Delegates Committee on the Compensation of the Officers | |

**Report(s) of the Speakers**

| | | |
|---|---|---|
| 01 | Online Reference Committees | Minimal |
| 02 | Election Committee Review of Election Rules for Clarification | Minimal |
| 03 | Speaker Recorded Interviews for AMA Elections | Info. Report |

**Resolutions**

| | | |
|---|---|---|
| 001 | Clarifying Conscientious Objection | Modest |
| 002 | Ensuring Ethical Use of Wearable Recording Devices in Clinical Encounters | Modest |
| 003 | Report on Gender-Based Pay Equity in Medicine | Modest |
| 004 | Patient Options to Restrict Secondary Use of Their Healthcare Data | Minimal |
| 005 | Preserving Autonomy in the Patient-Physician Relationship | Modest |
| 006 | Amendment to AMA Bylaws to Enable Continuity of Leadership | Minimal |
| 007 | Improving Protection for Reproductive Health Information | Minimal |
| 008 | Health Plan In-Network Steering of Pathology/Laboratory Services | Modest |
| 009 | Gender Equity in Disability Insurance for Physicians | Minimal |
| 201 | Model State Legislation incorporating Medical Malpractice Tort Reform Based on Utah H.B. 503 (2025) | Modest |
| 202 | Deepfake Technology and Harm to Physicians and Patients | Moderate |
| 203 | Restore and Enhance Federal Loan Programs for Medical Education | Modest |
| 204 | Addressing Anti-Physician Contractual Provisions | Moderate |
| 205 | Restoring Balance Billing and Allowing Copay Forgiveness to Preserve Independent Practice and Improve Access to Care | Moderate |
| 206 | Restore Funding to USAID | Moderate |
| 207 | Support for a Federal Tax Incentive for Volunteer Community Preceptors | Modest |

| | | |
|---|---|---|
| 208 | Centralization of Medicare Provider Data Sources | Moderate |
| 209 | Support for Legislative Changes Allowing Partial Medicare Opt-Out for Physicians | Moderate |
| 210 | PBM Divestiture and Transparency | Moderate |
| 211 | Access to, and Retention of, Electronic Medical Records | Modest |
| 212 | Acknowledging Flexibility on Buprenorphine Mono-product Use for Opioid Use Disorder | Modest |
| 213 | Pathways to U. S. Permanent Residency for H-1B Physicians | Moderate |
| 214 | Physician Visa Protection and Pathway to Serve Underserved Communities | Modest |
| 215 | Extending the Medicaid Work Requirement Exemption up to 12 Months Postpartum | Minimal |
| 216 | Ensuring Timely J-1 Visa Processing to Protect IMG Participation in Residency Programs | Moderate |
| 217 | Protecting Access to Public Service Loan Forgiveness (PSLF), Income-Driven Repayment (IDR), and Direct Plus Loans for Graduate or Professional Students (Grad PLUS Loans) | Modest |
| 218 | Amend AMA Policy D-160.921 on Sensitive Locations to Protected Areas | Minimal |
| 219 | Addressing the Harms and Misleading Nature of Medicare Advantage Plans | Modest |
| 220 | Medicare Should not Unfairly Penalize Physicians | Modest |
| 221 | Not-for-Profit Status | Modest |
| 222 | Tackling Administrative Waste—Let Us Be Part of the Solution to Putting Our Health System on a Sustainable Path | Moderate |
| 223 | Halt the Rollout of New Payment Models by the Center for Medicare & Medicaid Innovation (CMMI)—A New Administration Offers an Opportunity | Modest |
| 224 | Recoupment by CMS Recovery and Audit Contractors (RAC)—Due Process | Modest |
| 225 | Federal Legislation to Prohibit the Corporate Practice of Medicine | Modest |
| 226 | Transparency with the Term “Emergency Department” | Modest |
| 227 | Call for Immediate and Aggressive Action by the AMA to Reverse Medicaid Cuts Impacting Seniors | $88,442 - create and compile report |
| 228 | Support Permanent Funding and Expansion of Native Hawaiian Healthcare | Minimal |
| 229 | Protection of Medicaid Beneficiaries’ Private Health Information from Immigration Enforcement | Modest |
| 230 | Banning Non-compete Agreements in States | Modest |
| 231 | Ensuring Equitable and Timely Medical Licensure for Physicians Providing Abortion and Gender-Affirming Care | Moderate |
| 232 | Safeguarding Access to IVF Amid Restorative Reproductive Medicine Legislation | Modest |
| 233 | Renewing Mental Health Infrastructure in the School System | Moderate |
| 234 | Study on Impact of Inflation Reduction Act on Oncology, Other Physician Practices | Moderate |
| 236 | Deceptive Advertising in Accredited Allied Health Professional, Non-Physician Graduate Programs | Modest |
| 237 | Protecting and Improving Rural Health | Moderate |
| 301 | Preventing Sleep Deprivation and Supporting Medical Student Wellness | Minimal |
| 304 | Systemic Exclusion of IMGs from Residency Programs | Minimal |
| 305 | Paid Sick Leave and Flexible Work Arrangements for Caregivers of Individuals with Special Needs, Chronic Illness, or Elderly Parents | Minimal |

## Summary of Fiscal Notes I-25

| | | |
|---|---|---|
| 306 | Support for Paid Prenatal Leave | Minimal |
| 307 | Integrating Artificial Intelligence (AI) Literacy Into UME, GME, and CME | Moderate |
| 308 | Enhancing the Pathway for Black Male Medical Students | Modest |
| 311 | Gender and URiM Disparities in Surgical Training Volumes | Minimal |
| 601 | Reimagining and Modernizing the U.S. Healthcare Delivery System | $240,365 - convene task force (similar expected for subsequent years) |
| 602 | Standardizing the Appointment Process for AMA Councils | Moderate |
| 802 | Patient Choice of Physician | Minimal |
| 804 | Medicare Advantage Filing Limit | Modest |
| 805 | Shared Medical Appointments | Moderate |
| 806 | Insurance Coverage for Colonoscopy Preparation Cost | Modest |
| 807 | Protecting Hospitals and Patients from Inappropriate Denials of Inpatient Admissions | Minimal |
| 808 | No Prior Authorization for Inexpensive Medications | Modest |
| 809 | Ensuring Patient Safety and Physician Oversight in the Integration of Hospital Inpatient Virtual Nursing | Moderate |
| 811 | Non-Medical Switching | Modest |
| 812 | Discontinue Review Choice Demonstration Project for Inpatient Rehabilitation Hospital Admissions | Modest |
| 813 | Increased Regulation of For-Profit Healthcare Insurance | Moderate |
| 814 | Mandate for Insurance Companies to Assist in the Transition of Patients to Alternative Participating Physicians Upon Contract Termination | Modest |
| 815 | Mandating Health Insurers to Provide a Real-Time Online Tool for Coverage and Payment Policies, Integrated into Electronic Health Records (EHRs) | Moderate |
| 816 | Prohibit Arbitrary Time Limits on Preauthorizations | Modest |
| 817 | Prohibiting Insurers from Denying Payment for Procedures Based on Site of Service | Moderate |
| 818 | Universal Out-of-Network Benefits | Modest |
| 819 | Update the status of Virtual Credit card policy, EFT fees, and lack of Enforcement of Administrative Simplification Requirements by CMS | Modest |
| 821 | Improving Access to Emergency Ophthalmologic Surgical Care | Modest |
| 822 | Improving Home or Community-Based Services Waiver Waiting List Management | Minimal |
| 823 | Accountability in the Use of Augmented Intelligence for Prior Authorization | Modest |
| 824 | Equitable Payment and Increased Access for In-Office Pediatric Lead Screening and Testing | Modest |
| 825 | Ensuring Coverage for In-Office Point-of-Care (POC) Testing in Outpatient Medical Practices | Modest |
| 826 | Increase National Immunization Rates by Advocating for Equitable Vaccine Payments | Minimal |
| 827 | Opposition to Prior Authorization in Medicare Fee-for-Service, Burdensome Administrative Requirements | Modest |
| 828 | Creating a Public Scorecard on Insurer Delays in Care and Payment Caused by Prior Authorization | Moderate |
| 829 | Publicize Insurer Financial Gains from Delayed Care and Payment Caused by Prior Authorization | Minimal |

## Summary of Fiscal Notes I-25

| | | |
|---|---|---|
| 901 | Distinction Between Healthful and Unhealthful "Ultraprocessed" Foods | Minimal |
| 903 | Nitrous Oxide Inhalant Abuse | Minimal |
| 904 | Supporting Certification of the Public Health Workforce | Minimal |
| 905 | Standardizing Brain Death Policies | Modest |
| 906 | Rethink the Medicare Annual Wellness Visit | Modest |
| 907 | In-Office Dispensing of Generic Medications | Modest |
| 908 | Support of Access to Insulin-Detemir | Moderate |
| 909 | Clinical Significance of Sleepiness | Minimal |
| 911 | Safeguarding NIH-Funded and Other Women's Health Research in Peer-Reviewed Publishing | Modest |
| 912 | Increasing Access through Federated Healthcare Data Architecture | Moderate |
| 917 | Urging Comprehensive Research and Safety Testing of Industry-Engineered Food Additives (IEFAs), Including High Fructose Corn Syrup | Modest |
| 918 | Remove Outdated Barriers to Genetic Testing | Modest |
| 919 | Strengthening Trust through AMA-Based Leadership for Evidence-Based Vaccines (STABLE Vaccines) | $3.1 million annually -research and develop public facing materials |
| 920 | Alcohol and Aging: Educating Physicians and Advocating for Safer Warnings | Modest |
| 921 | Prioritizing Deprescribing in Seniors | Modest |
| 922 | Addressing Health Impacts of Indian Boarding Schools | Minimal |
| 923 | Enhancing Disaster Preparedness Mechanisms for People with Disabilities | Modest |
| 924 | Preserving Access to Gamete Donation and Gestational Carriers and Protecting Parental Rights | Modest |
| 925 | Evidence-Based Vaccine and Preventive Services Recommendations | Modest |
| 926 | Establishment of Federal and State Offices of Men's Health | Minimal |
| 927 | Battlefield Acupuncture – An Educational Call to Arms | Minimal |
| 929 | Protecting Access to Evidence-based Psychotropic Medication for the Treatment of Pediatric Mental Illness | Modest |
| 930 | Establishing Fire Risk Standards for Civilian and Non-Industrial Clothing | Moderate |
| 931 | Preserving Evidence-Based, Equitable Grooming Standards in Military Service | Modest |
| 932 | Shared Decision-Making and Low Dose CT Lung Cancer Screening in Clinical Practice | Moderate |
| 933 | Addressing Gaps in National Healthcare Safety Network (NHSN) Data Quality | Modest |

## RESOLUTIONS – BY SPONSOR (I-25)

| SPONSOR | Reso # | TITLE |
|---|---|---|
| Academic Physicians Section | 203 | Restore and Enhance Federal Loan Programs for Medical Education |
| American Academy of Child and Adolescent Psychiatry | 233 | Renewing Mental Health Infrastructure in the School System |
| | 929 | Protecting Access to Evidence-based Psychotropic Medication for the Treatment of Pediatric Mental Illness |
| American Academy of Dermatology | 931 | Preserving Evidence-Based, Equitable Grooming Standards in Military Service |
| American Academy of Emergency Medicine | 225 | Federal Legislation to Prohibit the Corporate Practice of Medicine |
| | 226 | Transparency with the Term “Emergency Department” |
| American Academy of Family Physicians | 207 | Support for a Federal Tax Incentive for Volunteer Community Preceptors |
| | 602 | Standardizing the Appointment Process for AMA Councils |
| American Academy of Ophthalmology | 311 | Gender and URiM Disparities in Surgical Training Volumes |
| American Academy of Physical Medicine and Rehabilitation | 812 | Discontinue Review Choice Demonstration Project for Inpatient Rehabilitation Hospital Admissions |
| American Academy of Sleep Medicine | 909 | Clinical Significance of Sleepiness |
| American Association of Clinical Urologists | 201 | Model State Legislation incorporating Medical Malpractice Tort Reform Based on Utah H.B. 503 (2025) |
| American Association of Public Health Physicians | 919 | Strengthening Trust through AMA-Based Leadership for Evidence-Based Vaccines (STABLE Vaccines) |
| American College of Radiology | 932 | Shared Decision-Making and Low Dose CT Lung Cancer Screening in Clinical Practice |
| American College of Rheumatology | 230 | Banning Non-compete Agreements in States |
| | 823 | Accountability in the Use of Augmented Intelligence for Prior Authorization |
| American College of Surgeons | 933 | Addressing Gaps in National Healthcare Safety Network (NHSN) Data Quality |
| American Society for Reproductive Medicine | 232 | Safeguarding Access to IVF Amid Restorative Reproductive Medicine Legislation |

| SPONSOR | Reso # | TITLE |
|---|---|---|
| American Society of Addiction Medicine | 212 | Acknowledging Flexibility on Buprenorphine Mono-product Use for Opioid Use Disorder |
| American Urological Association | 926 | Establishment of Federal and State Offices of Men's Health |
| Association for Clinical Oncology | 234 | Study on Impact of Inflation Reduction Act on Oncology, Other Physician Practices |
| | 827 | Opposition to Prior Authorization in Medicare Fee-for-Service, Burdensome Administrative Requirements |
| California | 007 | Improving Protection for Reproductive Health Information |
| | 237 | Protecting and Improving Rural Health |
| | 828 | Creating a Public Scorecard on Insurer Delays in Care and Payment Caused by Prior Authorization |
| | 829 | Publicize Insurer Financial Gains from Delayed Care and Payment Caused by Prior Authorization |
| College of American Pathologists | 008 | Health Plan In-Network Steering of Pathology/Laboratory Services |
| | 236 | Deceptive Advertising in Accredited Allied Health Professional, Non-Physician Graduate Programs |
| Colorado | 206 | Restore Funding to USAID |
| Connecticut | 004 | Patient Options to Restrict Secondary Use of Their Healthcare Data |
| | 912 | Increasing Access through Federated Healthcare Data Architecture |
| Federal Services | 927 | Battlefield Acupuncture – An Educational Call to Arms |
| Florida | 209 | Support for Legislative Changes Allowing Partial Medicare Opt-Out for Physicians |
| | 210 | PBM Divestiture and Transparency |
| | 811 | Non-Medical Switching |
| | 907 | In-Office Dispensing of Generic Medications |
| International Medical Graduates Section | 213 | Pathways to U. S. Permanent Residency for H-1B Physicians |
| | 214 | Physician Visa Protection and Pathway to Serve Underserved Communities |
| | 216 | Ensuring Timely J-1 Visa Processing to Protect IMG Participation in Residency Programs |
| | 304 | Systemic Exclusion of IMGs from Residency Programs |

| SPONSOR | Reso # | TITLE |
|---|---|---|
| LGBTQ+ Section | 231 | Ensuring Equitable and Timely Medical Licensure for Physicians Providing Abortion and Gender-Affirming Care |
| | 924 | Preserving Access to Gamete Donation and Gestational Carriers and Protecting Parental Rights |
| Medical Society of the District of Columbia | 930 | Establishing Fire Risk Standards for Civilian and Non-Industrial Clothing |
| | 901 | Distinction Between Healthful and Unhealthful “Ultraprocessed” Foods |
| Medical Student Section | 822 | Improving Home or Community-Based Services Waiver Waiting List Management |
| | 922 | Addressing Health Impacts of Indian Boarding Schools |
| | 923 | Enhancing Disaster Preparedness Mechanisms for People with Disabilities |
| Michigan | 202 | Deepfake Technology and Harm to Physicians and Patients |
| | 301 | Preventing Sleep Deprivation and Supporting Medical Student Wellness |
| | 802 | Patient Choice of Physician |
| Mississippi | 806 | Insurance Coverage for Colonoscopy Preparation Cost |
| | 807 | Protecting Hospitals and Patients from Inappropriate Denials of Inpatient Admissions |
| | 904 | Supporting Certification of the Public Health Workforce |
| New England Delegation | 001 | Clarifying Conscientious Objection |
| | 009 | Gender Equity in Disability Insurance for Physicians |
| | 601 | Reimagining and Modernizing the U.S. Healthcare Delivery System |
| | 804 | Medicare Advantage Filing Limit |
| | 805 | Shared Medical Appointments |
| New Jersey | 217 | Protecting Access to Public Service Loan Forgiveness (PSLF), Income-Driven Repayment (IDR), and Direct Plus Loans for Graduate or Professional Students (Grad PLUS Loans) |
| | 307 | Integrating Artificial Intelligence (AI) Literacy Into UME, GME, and CME |
| | 824 | Equitable Payment and Increased Access for In-Office Pediatric Lead Screening and Testing |
| | 825 | Ensuring Coverage for In-Office Point-of-Care (POC) Testing in Outpatient Medical Practices |
| | 826 | Increase National Immunization Rates by Advocating for Equitable Vaccine Payments |
| | 917 | Urging Comprehensive Research and Safety Testing of Industry-Engineered Food Additives (IEFAs), Including High Fructose Corn Syrup |

| SPONSOR | Reso # | TITLE |
|---|---|---|
| New York | 218 | Amend AMA Policy D-160.921 on Sensitive Locations to Protected Areas |
| | 219 | Addressing the Harms and Misleading Nature of Medicare Advantage Plans |
| | 220 | Medicare Should not Unfairly Penalize Physicians |
| | 221 | Not-for-Profit Status |
| | 308 | Enhancing the Pathway for Black Male Medical Students |
| | 813 | Increased Regulation of For-Profit Healthcare Insurance |
| | 814 | Mandate for Insurance Companies to Assist in the Transition of Patients to Alternative Participating Physicians Upon Contract Termination |
| | 815 | Mandating Health Insurers to Provide a Real-Time Online Tool for Coverage and Payment Policies, Integrated into Electronic Health Records (EHRs) |
| | 816 | Prohibit Arbitrary Time Limits on Preauthorizations |
| | 817 | Prohibiting Insurers from Denying Payment for Procedures Based on Site of Service |
| | 818 | Universal Out-of-Network Benefits |
| | 819 | Update the status of Virtual Credit card policy, EFT fees, and lack of Enforcement of Administrative Simplification Requirements by CMS |
| | 918 | Remove Outdated Barriers to Genetic Testing |
| Oklahoma | 821 | Improving Access to Emergency Ophthalmologic Surgical Care |
| Organized Medical Staff Section | 204 | Addressing Anti-Physician Contractual Provisions |
| | 808 | No Prior Authorization for Inexpensive Medications |
| | 809 | Ensuring Patient Safety and Physician Oversight in the Integration of Hospital Inpatient Virtual Nursing |
| | 905 | Standardizing Brain Death Policies |
| Private Practice Physicians Section | 205 | Restoring Balance Billing and Allowing Copay Forgiveness to Preserve Independent Practice and Improve Access to Care |
| | 222 | Tackling Administrative Waste—Let Us Be Part of the Solution to Putting Our Health System on a Sustainable Path |
| | 223 | Halt the Rollout of New Payment Models by the Center for Medicare & Medicaid Innovation (CMMI)—A New Administration Offers an Opportunity |
| | 224 | Recoupment by CMS Recovery and Audit Contractors (RAC)—Due Process |
| | 906 | Rethink the Medicare Annual Wellness Visit |

| SPONSOR | Reso # | TITLE |
|---|---|---|
| Resident and Fellow Section | 006 | Amendment to AMA Bylaws to Enable Continuity of Leadership |
| Senior Physicians Section | 227 | Call for Immediate and Aggressive Action by the AMA to Reverse Medicaid Cuts Impacting Seniors |
| | 920 | Alcohol and Aging: Educating Physicians and Advocating for Safer Warnings |
| | 921 | Prioritizing Deprescribing in Seniors |
| Tennessee | 208 | Centralization of Medicare Provider Data Sources |
| | 903 | Nitrous Oxide Inhalant Abuse |
| Underrepresented in Medicine Advocacy Section | 228 | Support Permanent Funding and Expansion of Native Hawaiian Healthcare |
| | 229 | Protection of Medicaid Beneficiaries' Private Health Information from Immigration Enforcement |
| Utah | 211 | Access to, and Retention of, Electronic Medical Records |
| | 908 | Support of Access to Insulin-Detemir |
| Washington | 925 | Evidence-Based Vaccine and Preventive Services Recommendations |
| Women Physicians Section | 002 | Ensuring Ethical Use of Wearable Recording Devices in Clinical Encounters |
| | 003 | Report on Gender-Based Pay Equity in Medicine |
| | 215 | Extending the Medicaid Work Requirement Exemption up to 12 Months Postpartum |
| | 305 | Paid Sick Leave and Flexible Work Arrangements for Caregivers of Individuals with Special Needs, Chronic Illness, or Elderly Parents |
| | 306 | Support for Paid Prenatal Leave |
| | 911 | Safeguarding NIH-Funded and Other Women's Health Research in Peer-Reviewed Publishing |
| Young Physicians Section | 005 | Preserving Autonomy in the Patient-Physician Relationship |

## Reference Committee on Ethics and Bylaws

**Report(s) of the Board of Trustees**

05 Addressing the Unregulated Body Brokerage Industry
08 On the Ethics of Human Lifespan Prolongation
10 Improving Usability of Electronic Health Records (EHRs) for Transgender and Gender Diverse Patients
11 Supporting Diversity in Research
19 Addressing the Historical Injustices of Anatomical Specimen Use

**Report(s) of the Council on Constitution and Bylaws**

01 Bylaws Review Report
02 Bylaws Clarifications Subsequent to A-25 House of Delegates Meeting
03 Credentialing of Temporary Delegates and Alternate Delegates

**Report(s) of the Council on Ethical and Judicial Affairs**

01 Amendment to Opinion 1.1.1 "Patient-Physician Relationships"
02 Supporting Efforts to Strengthen Medical Staffs Through Collective Actions and/or Unionization
03 Ethical Impetus for Research in Pregnant and Lactating Individuals

**Resolutions**

001 Clarifying Conscientious Objection
002 Ensuring Ethical Use of Wearable Recording Devices in Clinical Encounters
003 Report on Gender-Based Pay Equity in Medicine
004 Patient Options to Restrict Secondary Use of Their Healthcare Data
005 Preserving Autonomy in the Patient-Physician Relationship
006 Amendment to AMA Bylaws to Enable Continuity of Leadership
007 Improving Protection for Reproductive Health Information
008 Health Plan In-Network Steering of Pathology/Laboratory Services
009 Gender Equity in Disability Insurance for Physicians

REPORT OF THE BOARD OF TRUSTEES

B of T Report 05-I-25

Subject: Addressing the Unregulated Body Brokerage Industry

Presented by: David H. Aizuss, MD, Chair

Referred to: Reference Committee on Ethics and Bylaws

---

At the 2024 Interim Meeting, Resolution 212, "Addressing the Unregulated Body Brokerage Industry," was introduced by Illinois and was referred. It asked the following:

> RESOLVED, that our American Medical Association amend existing policy H-460.890, Improving Body Donation Regulation,"[1] by addition to read as follows:
>
> Our AMA: (1) recognizes the need for ethical, transparent, and consistent body and body part donation regulations.; (2) will collaborate with interested organizations to actively advocate for the passage of federal legislation to provide necessary minimum standards, oversight, and authority over body broker entities that receive donated human bodies and body parts for education and research; (3) will develop model state legislation to provide necessary minimum standards, oversight, and authority over body broker entities that receive donated human bodies and body parts for education and research; and (4) encourages state medical societies to advocate legislation or regulations in their state that are consistent with the AMA model state legislation. (Modify Current HOD Policy)

BACKGROUND

Body-brokers are individuals or businesses who procure bodies through soliciting donations (usually at funeral homes and hospices) and then sell or lease the donated bodies or parts of the body to other entities for a variety of purposes. Brokers will typically sell a body for $3,000 to $5,000; however, bodies have been sold for upwards of $10,000. Individual body parts are sold for a range of prices, e.g., "$350 for a foot, $300 for a spine."[2] The clients of body brokers include emergency services such as fire departments and paramedics, medical schools, medical researchers, and the military.[3]

In recent years, the body-brokerage industry has come under increased scrutiny due to claims that the autonomy and dignity of the person who donated their body was not respected or upheld. For example, in 2021, the body of a man who died of COVID-19, which was donated to a body-broker, was used in a "Cadaver Class" where people could pay money to see a live autopsy performed.[4] The family of the man was furious when they found out his body was used in this public way for monetary gain and asserted that the transaction was a breach of informed consent.[4] In another incident, a man who donated his mother's body for use in medical research sued a body-broker because her body was instead used to test "bomb impact" in experiments conducted by the U.S. Army.[5]

© 2025 American Medical Association. All rights reserved.

Notably, the industry is one whose "business model hinges on access to a large supply of free bodies, which often come from the poor." Brokers often offer "free cremation" in exchange for access to bodies as a way to appeal to "low-income families at their most vulnerable".[2] Those whose bodies go unclaimed often have their bodies sold to body-brokers without consent. For example, the unclaimed body of a veteran in Texas who "was entitled to a burial with military honors", was instead sold by the county medical examiner's office to a broker without the man's consent or his family's knowledge. Subsequently, the man's body was "cut into pieces and leased out across the country."[6] Critics, like Angela McArthur from the University of Minnesota Medical School, have likened the body-brokerage industry to a "free-for-all" and have stated that brokers are similar to "grave-robbers" of the 19th-century who are "profiting from the sale of humans."[2] It is against this backdrop that serious ethical concerns have been illuminated and have increased the demand for greater industry regulation.

DISCUSSION

Despite major ethical concerns, the legal landscape does not adequately address concerns of bodies being used in ways in which the donator did not consent. Importantly, there are no federal laws governing the sale of cadavers or body parts for use in research or education and few state laws provide adequate oversight.[2] The most common statutory guidance resides in the Uniform Anatomical Gift Act (UAGA), a model law adopted by the majority of states which "allows a descendant or surviving relatives to donate certain parts of the decedent's organs for certain purposes", i.e., organ donation or medical research.[11] The UAGA states that an anatomical gift can be made to a "university; organ procurement organization; or other appropriate person for research or education." However, the scope of who is deemed an "appropriate person for research or education" is left undefined. The result of this ambiguity is that any "commercial entity may obtain a donated body so long as they use it in some form of activity that is considered educational or research oriented." In many cases, the educational or research purpose is dubious or of minimal value.[12]

In response to the lack of legal oversight, the National Funeral Directors Association is supporting a bill they dub the "Body Broker Bill", officially known as the Consensual Donation & Research Integrity Act of 2025, which has been introduced in Congress but has not yet passed.[13,14] The bill claims to "protect the dignity of donors and give families peace of mind by creating standards for inspection; chain of custody; labeling and packaging; and proper disposition."[13] While the Body Broker Bill takes an important step toward regulating the industry, the bill is not as comprehensive as recent best practice guidance and standards on human body donation from the American Association for Anatomy (AAA).[15] The AAA guidelines call for body donation policies to include a mandatory standard for informed consent and outline core operational practices intended to ensure transparency and accountability during every aspect of the body donation process that are more ethically rigorous than those included in the Body Broker Bill. For example, the AAA advises against body part solicitation from terminal patients in hospitals or hospice care and that documentation be secured to ensure that all uses match the donation consent agreement.

Lastly, the for-profit acquisition and sale of donated human bodies and body parts for research and education also creates ethical concerns. While neither the UAGA nor Body Broker Bill prohibit the sale of body parts for profit, AAA best practices recommend that body donation should operate on a non-for-profit model. However, regardless of the financial model used, it is crucial to address the ethical concerns surrounding the body-brokerage industry by establishing stronger legal protections to ensure oversight and ethical accountability. While the resolution called for development of model state legislation, to most efficiently address these issues in upcoming state legislative sessions, the AAA policy guidelines should be utilized to guide advocacy.

CONCLUSION

Although the body broker industry has faced scrutiny, the industry does provide a necessary service which benefits both medical research and education. However, despite its necessity, the body brokerage industry must operate in an ethical and transparent manner.

RECOMMENDATION

The Board of Trustees recommends that the following be adopted in lieu of Resolution 212-I-24 and the remainder of the report be filed.

1. That Policy H-460.890, Improving Body Donation Regulation," be amended by addition and deletion as follows:

   1. Our AMA recognizes the need for ethical, and transparent~~,~~ regulations for body and body part donation ~~regulations~~ consistent with body donation best practices including:

      a. *Outreach:* This covers all communications with body donors and their families, beginning with the initial engagement to request donations. Ethical outreach is premised on transparency and accountability, free from any form of coercion or enticement.

      b. *Registration:* A registration process is imperative for ensuring accurate and transparent informed consent during the body donation decision process. Pertinent information which should be conveyed during the registration process includes any disposition and distribution of bodies or body parts, including the locations, possible uses of the body or body parts (i.e., military, education, forensic, etc.), and financial aspects of body donation. Additionally, the registration process should outline the body donor eligibility and suitability criteria.

      c. *Custody:* A transparent custody process is imperative for ensuring the ethical stewardship and management of the body entrusted to the end user (e.g., researchers, educators, clinicians).

      d. *Tracking:* A tracking system should be put in place to ensure the proper governance, oversight, and infrastructure (including registration and informed consent) during the use of donated bodies. Tracking systems should include a mechanism for monitoring body donation policies and procedures and a reporting mechanism for violations of these policies.

      e. *Use:* Bodies should be used in a respectful, dignified, and ethical manner for education and research purposes.

      f. *Disposition:* Final disposition of the body should be made in accordance with the wishes of the donor and their families.

      g. *Memorialization:* A respectful memorial ceremony for the family in which the body donor is honored for their "altruism and commitment to education and research" should be held at the conclusion of the use of the body as well as governing oversight of the body donation policies.

2. Supports federal and state legislation consistent with body donation best practices that require all body donation programs adopt and implement policies which uphold informed consent, transparency, and accountability during the process of human body donation and use.

3. Encourages state medical societies to advocate for legislation consistent with body donation best practices. (Modify Current HOD Policy)

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

REFERENCES


1. "H-460.890 Improving Body Donation Regulation | AMA," accessed June 16, 2025, https://policysearch.ama-assn.org/policyfinder/detail/460.890?uri=%2FAMADoc%2FHOD.xml-H-460.890.xml.
2. B Grow and J Shiffman, "In the U.S. Market for Human Bodies, Anyone Can Sell the Donated Dead," *Reuters*, October 24, 2017, http://www.reuters.com/investigates/special-report/usa-bodies-brokers/.
3. John Hubbard, "Don't Be Grossed out. Those Who Donate Their Bodies to Science Deserve Our Respect | Opinion," Austin American-Statesman, accessed July 9, 2025, https://www.statesman.com/story/opinion/2025/06/09/don-t-be-grossed-out-those-who-donate-their-bodies-to-science-deserve-our-respect-opinion/84112885007/.
4. Beresford J, "Live Autopsy of COVID Victim Allegedly Took Place Without Family's Consent," Newsweek, November 3, 2021, https://www.newsweek.com/live-autopsy-covid-victim-took-place-without-family-consent-1645353.
5. O'Kane C, "Stephen Gore Biological Resource Center: Man Suing Body Donation Company after Mother's Corpse Was Sold to Military for Blast Testing - CBS News," August 1, 2019, https://www.cbsnews.com/news/man-suing-body-donation-company-after-mothers-corpse-was-sold-to-military-for-blast-testing/.
6. Hixenbaugh M, Schuppe J , and Carroll S, "As Families Searched, a Texas Medical School Cut up Their Loved Ones," NBC News, September 16, 2024, https://www.nbcnews.com/news/us-news/university-north-texas-corpses-dissected-unclaimed-bodies-rcna170478.
7. "H-140.820 Addressing the Historical Injustices of Anatomical Specimen Use | AMA," accessed June 17, 2025, https://policysearch.ama-assn.org/policyfinder/detail/body%20donation?uri=%2FAMADoc%2FHOD.xml-H-140.820.xml.
8. "Studying Financial Incentives for Cadaveric Organ Donation | AMA-Code," accessed June 17, 2025, https://code-medical-ethics.ama-assn.org/ethics-opinions/studying-financial-incentives-cadaveric-organ-donation.
9. "Patient-Physician Relationships | AMA-Code," accessed June 17, 2025, https://code-medical-ethics.ama-assn.org/chapters/patient-physician-relationships.
10. "Informed Consent | AMA-Code," accessed June 17, 2025, https://code-medical-ethics.ama-assn.org/ethics-opinions/informed-consent.
11. "Uniform Anatomical Gift Act," LII / Legal Information Institute, accessed June 17, 2025, https://www.law.cornell.edu/wex/uniform_anatomical_gift_act.
12. Andrew Y Schiefer, "Robbing the Grave: Amending the Uniform Anatomical Gift Act to Curtail Abuses Within the Whole-Body Donation Industry," *Health Matrix* 29, no. 1 (n.d.).
13. "Body Broker Bill," accessed June 16, 2025, https://nfda.org/advocacy/current-issues/body-broker-bill.
14. "Bilirakis and Fletcher Introduce Bipartisan Bill to Stop Brokering of Body Parts, Preserve Integrity of Organ Donation Process | Congressman Gus Bilirakis," April 3, 2025, http://bilirakis.house.gov/media/press-releases/bilirakis-and-fletcher-introduce-bipartisan-bill-stop-brokering-body-parts.
15. Balta J. Champney TH, et. al. Human body donation programs best practices and recommended standards: A task force report from the American Association for Anatomy. *Anat Sci Educ.* 2025;18:8–26.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 08-I-25

Subject: On the Ethics of Human Lifespan Prolongation

Presented by: David H. Aizuss, MD, Chair

Referred to: Reference Committee on Ethics and Bylaws

---

At the 2024 Interim Meeting, the House of Delegates (HOD) adopted policy D-140.947, "On the Ethics of Human Lifespan Prolongation," which directs our AMA to:

> undertake an evaluation of the ethics of extension of the human lifespan, currently considered to be 120 years, with the goal of providing guidance and/or guidelines for clinical practice, research and potential regulatory challenges.

This report provides background and ethical analysis in fulfillment of the directive.

## BACKGROUND

Investment in longevity research has surged in recent years, increasing from half of a billion dollars in 2013 to $6.2 billion in 2021.[1] This longevity market includes not only longevity biotech firms and startups, but also regenerative medicine providers, AI-driven drug discovery platforms, biomarker discovery and diagnostic platforms, and novel therapeutic technologies, such as stem cell-, gene-, and immunotherapy. These technologies are often aimed at ultimately improving the human lifespan and healthspan. While life expectancy is a statistical measure of the average years of life someone can expect to live, the human lifespan refers to the maximum length of life a person can potentially achieve, while healthspan refers to the portion of life a person spends in a healthy state free of chronic diseases and disability. The interdisciplinary field of research dedicated to studying the biological mechanisms of aging and how they contribute to age-related diseases is known as geroscience.[2]

With the advent of modern medicine, life expectancy has nearly doubled in the U.S. since 1900, reaching an average of approximately 78.4 years in 2023.[2,3] Unlike life expectancy, the human lifespan appears to be biologically fixed, with a ceiling around 125 years.[4] However, some people believe that this biological limit can be overcome. Often referred to as radical life extension, some adherents believe that the human lifespan might someday be extended to 150 years, 300 years, or even thousands of years.[4] Importantly, a central goal of radical life extension is to increase not only the human lifespan but also the human healthspan. In the U.S., the lifespan-healthspan gap has been increasing over the past two decades, meaning that while life expectancy has increased, there has also been growth in the number of years people live impacted by chronic disease or disability.[5] Successful radical life extension would thus enable humans to live beyond their current biological limits and do so while experiencing optimal health.

Proponents of radical life extension often view disease, aging, and even death as obstacles to overcome, and argue that such technologies will ease human suffering and drive innovations in

© 2025 American Medical Association. All rights reserved.

disease prevention and treatment.[2] Opponents typically cite concerns regarding demographics and sustainability, questions of equitable access and social justice, and fears of negative social impacts as views on aging and death change.[4,6,7] Because the technology for radical life extension is still hypothetical, any ethical analysis and debate is inherently speculative; however, as the possibility of such technology increasingly moves from the realm of science fiction to scientific reality, it is important that ethical guidance related to its development, clinical use, and regulation be established.

## ETHICS ANALYSIS & DISCUSSION

Achieving radical life extension technologies would be a monumental scientific breakthrough with dramatic impacts. The potential to eradicate chronic diseases and disability while also extending lifespans would represent an enormous reduction in human harm and illness. However, the development of such technologies also has the potential to drastically increase existing inequalities and destabilize existing social norms. Much of the ethical debate regarding whether radical life extension technologies should be developed utilizes a utilitarian approach, arguing that only if the benefits to society are greater than the harms should such innovations be pursued.[8,9]

### *Aging as a Disease & the Scope of Biomedical Research*

Proponents of radical life extension advocate a certain pathologization of aging, representing it as a disease that should be treated. In contrast, critics typically represent aging as a natural part of human life and argue that biomedical interventions should focus on shrinking the human healthspan-lifespan gap rather than on increasing longevity.[6,9] Currently, the Food and Drug Association (FDA) considers aging a natural process and does not recognize aging as a disease, which makes it difficult to get FDA approval for drugs that specifically target aging.[10] However, researchers have found ways to still pursue studies of geroscience. For example, Metformin, an FDA-approved first-line treatment for type 2 diabetes, is also being investigated for its potential not to delay aging specifically but to delay the onset of age-related diseases.[11] If current trials are successful, it could lead to a paradigm shift in how aging is recognized by the FDA and pave the way for the approval of drugs that directly target aging and not just individual diseases. The World Health Organization (WHO) has already begun to move in this direction with regard to the deterioration associated with aging, implying that againg is a disease by including “aging associated decline in intrinsic capacity” as a disease code in their 11$^{th}$ edition of the International Classification of Diseases (ICD).[10] As scientific pressure grows in the US, the FDA is likely to revisit the issue and reevaluate their stance towards aging. If the FDA does change its position, however, the question will remain whether (and how much) funding for clinical research should be diverted from other pursuits towards studies on how to slow or prevent aging.

### *Equality of Access and Social Justice*

A primary ethical concern regarding radical life extension is the possibility that it would exacerbate inequality.[9,12,13] Critics argue that radical life extension technologies would be unethical if they were only available to wealthy individuals. In this view, because such technologies would likely be quite expensive, at least initially, only some members of society would be able to benefit from them.[12] Additionally, there is concern that a focus on longevity technologies would tie up limited resources for improving health in other domains and, as a result, other issues that impact health would be ignored (such as education, pollution, and climate change).[14] Opponents also claim that health research should focus on closing current healthspan-lifespan gaps, rather than on increasing human longevity.[15] On the other hand, proponents argue that combating aging may in fact be far

more cost-effective because aging is the most significant risk factor for disability and most prevalent chronic diseases. They also suggest that while radical life extension technologies are likely to be expensive and not widely available to everyone at first, there is no reason to believe that this situation would persist for long.[9] Some even advocate that, eventually, everyone globally should have access to any interventions that promote healthy aging regardless of socio-economic status.[9]

When weighing the benefits and burdens of radical life extension, the question becomes one of equity, and more specifically, how much social inequality society is willing to accept. There is general agreement that developing longevity technologies would be unethical if doing so greatly increased inequalities over a long period of time, creating two castes of people (those who can access such technologies and those who cannot). However, there is less agreement regarding whether increasing inequalities in the immediate would be unethical if the long-term results were that everyone benefited and lived longer, healthier lives.

*Demographic and Resource Concerns*

Another important ethical concern has to do with the demographic implications of people living longer. If people die less frequently, populations are likely to grow larger, resulting in a society that consists of an older populous.[15] Increased longevity could also result in longer reproductive years and lead to people having more children. This jump in population could in turn place an unsustainable strain on available resources.[4] Alternatively, some critics have voiced concerns that radially extending life might result in a decreased sense of purpose and thus lead to reductions in social commitments and engagement, eventually leading to decreases in childbearing and reproduction.[7]

*Changing Social Values and Norms*

Concerns regarding the demographic impact of radical life extension highlight the fact that such innovations would initiate radical social changes. The potential impacts on social values and norms are perhaps the most common yet most amorphous ethical concerns. If radical life extension were to be achieved, it would mean a collision of far more generations than exists in parallel today, which could lead to generational divides and contentions over status and social roles.[6] A rising share of older voters could lead to growing political tensions, as policies favoring the young shift to policies that favor the old.[16] Alternatively, extending the years of youth could lead to a devaluation of the elderly as fundamentally inadequate or defective.[12,14] These tensions could be exacerbated if a generation feels that there is no need to make room for younger generations. Other concerns include fears that radical life extension would diminish the sacredness of life;[4] that altering the human lifespan beyond its biological limits would represent a reconstruction of what it means to be human;[17] and that the slowing of successive generational cycles could lead to the slowing of cycles of innovation and adaptation.[7]

## CONCLUSION

Because research on radical life extension is currently situated within a capitalist enterprise, longevity projects and issues of inequality are inherently interconnected.[12] Moreover, the possibility of radical life extension has attracted heavy involvement by the ultra-wealthy, including Larry Page (cofounder of Google) and Jeff Bezos (Amazon's founder), both of whom have significantly invested in longevity research (conducted by Calico Labs and Altos Labs, respectively).[14] Such investments have raised concerns that should these technologies prove

successful, they will only be accessible to a select few and will fuel an ever increasing social divide. If radical life extension were achieved, it would also require significant changes within society to ensure that the future elderly are as healthy and as supported as possible. There would also be a need to ensure that social institutions such as education, jobs, health insurance, and social security are able to support the longer lives of the young.[16]

If radical life extension becomes a reality, society is likely to be divided into the Haves (those who extend their lives), the Have-nots (those who would like to but can't afford to extend their lives), and the Will-nots (those who refuse to extend their lives). Proponents view that in this dynamic, so long as the harms to the Have-nots and the Will-nots are minimal, the significant benefits to the Haves justify pursuit of radical life extension.[8] The argument in favor hinges on the belief that it is always ethical to seek to alleviate suffering and improve the human condition, and this is exactly what radical life extension would achieve.[7] However, this still does not address issues of equity; for radical life extension to be ethical, the medical treatments must be made available to every person and distributed equitably across the globe.[4] What this would look like in practice, however, and how much inequity is socially acceptable in pursuit of radical life extension, is still up for debate.

Due to the currently hypothetical nature of radical life extension technology, developing specific guidelines or regulations at this time presents a challenge, as the technology itself and any impacts it may have remain purely theoretical. However, as is the case with any emerging medical technology, all research on radical life extension should adhere to the appropriate ethical standards set forth by the AMA *Code of Medical Ethics* and the research ethics outlined in the World Medical Association's Declaration of Helsinki. Furthermore, regardless of the form such technology may take or the duration of extended life it may grant, radical life extension, if it were to become a reality, should be made accessible in an ethical, equitable, and just manner.

RECOMMENDATIONS

The Board of Trustees recommends that Policy D-140.947 be rescinded as having been accomplished by this report and the remainder of the report be filed.

Fiscal Note: Minimal – less than $500

REFERENCES


1. Annual longevity investment report 2022 Archives. Longevity.Technology. Accessed May 1, 2025. https://longevity.technology/investment/report/annual-longevity-investment-report/.
2. DeVito LM, Barzilai N, Cuervo AM, et al. Extending human healthspan and longevity: a symposium report. *Ann N Y Acad Sci*. 2022;1507(1):70-83. doi:10.1111/nyas.14681.
3. How does U.S. life expectancy compare to other countries? Peterson-KFF Health System Tracker. Accessed May 1, 2025. https://www.healthsystemtracker.org/chart-collection/u-s-life-expectancy-compare-countries/.
4. Haker H, Schweiker W, Hamalis P, Renaud M. The Ethics of Radical Life Extension: Catholic, Protestant, Orthodox Christian, and Global Ethic Perspectives. *J Soc Christ Ethics*. 2021;41(2):315-330.
5. Garmany A, Terzic A. Global Healthspan-Lifespan Gaps Among 183 World Health Organization Member States. *JAMA Netw Open*. 2024;7(12):e2450241. doi:10.1001/jamanetworkopen.2024.50241.
6. Mitrovic V. Bioethical and social constructions of life extension and longevity. *Stanovnistvo*. 2022;60(2):107-120. doi:10.2298/STNV2202107M.
7. Bohrer RA. Longevity Research and Bioethics. *Biotechnol Law Rep*. 2004;23(5):542-547. doi:10.1089/blr.2004.23.542.
8. Mehlman MJ. The Haves, the Have-nots, and the Will-nots. *Hastings Cent Rep*. 2019;49(4):42-43. doi:10.1002/hast.1035.
9. Farrelly C. Aging, Equality and the Human Healthspan. *HEC Forum*. 2024;36(2):187-205. doi:10.1007/s10730-022-09499-3.
10. FDA and the Fountain of Youth: Regulatory Hurdles in the Longevity Biotech Community | Womble Bond Dickinson. Accessed June 27, 2025. https://www.womblebonddickinson.com/us/insights/blogs/fda-and-fountain-youth-regulatory-hurdles-longevity-biotech-community.
11. Cheng FF, Liu YL, Du J, Lin JT. Metformin's Mechanisms in Attenuating Hallmarks of Aging and Age-Related Disease. *Aging Dis*. 2022;13(4):970-986. doi:10.14336/AD.2021.1213.
12. Hurtado Hurtado J. Exploited in immortality: techno-capitalism and immortality imaginaries in the twenty-first century. *Mortality*. 2024;29(4):903-920. doi:10.1080/13576275.2023.2266373.
13. McConnel C, Turner L. Medicine, ageing and human longevity. *EMBO Rep*. 2005;6(S1):S59-S62. doi:10.1038/sj.embor.7400431.
14. Levin SB. The irrationality of human confidence that an ageless existence would be better. *Theor Med Bioeth*. 2024;45(4):277-301. doi:10.1007/s11017-024-09674-2.
15. Scarre G, ed. *The Palgrave Handbook of the Philosophy of Aging*. 1st ed. 2016. Palgrave Macmillan UK : Imprint: Palgrave Macmillan; 2016. doi:10.1057/978-1-137-39356-2.
16. Scott AJ. The longevity society. *Lancet Healthy Longev*. 2021;2(12):e820-e827. doi:10.1016/S2666-7568(21)00247-6.
17. Partridge B, Underwood ,Mair, Lucke ,Jayne, Bartlett ,Helen, and Hall W. Ethical Concerns in the Community About Technologies to Extend Human Life Span. *Am J Bioeth*. 2009;9(12):68-76. doi:10.1080/15265160903318368.

REPORT OF THE BOARD OF TRUSTEES 10 (I-25)
Improving Usability of Electronic Health Records for Transgender and Gender Diverse Patients
(Reference Committee E&B)

## EXECUTIVE SUMMARY

At the 2024 American Medical Association (AMA) Interim Meeting, Resolution 004, "Improving Usability of Electronic Health Records (EHRs) for Transgender and Gender Diverse Patients", was introduced by the LGBTQ Section and referred for report back at the 2025 Interim Meeting. The resolution directs the promotion of inclusive gender, sex, and sexual orientation options on medical documentation and proposes amendments to Policy H-315.967, "Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation", to recommend broader reforms to EHR systems to better serve transgender and gender-diverse individuals.

This report provides detailed information about efforts taken and challenges presented by the AMA, physicians, practices, EHR vendors, and other stakeholders to address the needs of transgender and gender-diverse individuals. This includes the following considerations:

1. Linking cancer screenings and preventive services to a patient's current anatomical inventory reduces the risk of care gaps. This approach builds on Health Level 7 standards that distinguish "Sex for Clinical Use" from legal sex and gender identity, which is already supported in many EHRs.
2. Gaps exist in how health information technology vendors handle gender and sex data and work collaboratively to ensure systems treat all patients equitably. Structured and standardized fields for sexual orientation and gender identity (SOGI) and organ data are necessary for both research and patient safety.
3. Leveraging personal health records may ease the documentation burden on physicians by allowing patients to input and manage aspects of their identity data directly, so long as interoperability and privacy safeguards are in place.
4. Gender-inclusive data capabilities in EHR systems must be implemented at no added cost to providers, aligning with broader health equity goals without increasing administrative strain.
5. Patient data collection must be opt-in and based on informed consent. Patients should have the ability to opt out without compromising access to care or services. This is especially critical given privacy concerns and legal inconsistencies across states.

Further collection of gender-affirming care data risks exposing patients, families, and physicians to civil liability and criminal prosecution, as current EHRs lack reliable data segmentation and may inadvertently disclose information in states where such care is banned. This report underscores a growing consensus that inclusive EHR documentation enhances clinical safety and patient well-being, while also raising privacy concerns. Despite expanded SOGI and organ inventory fields in EHRs, usage and training remain inconsistent. The report recommends not adopting Resolution 004 (I-24) but supporting the use of "chosen name" over "preferred name"; reaffirming Policy H-315.967; and engaging relevant stakeholders to improve EHR usability for this patient population with strong privacy protections and ensure respectful and up-to-date AMA terminology.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 10-I-25

Subject: Improving Usability of Electronic Health Records (EHRs) for Transgender and Gender Diverse Patients

Presented by: David H. Aizuss, MD, Chair

Referred to: Reference Committee on Ethics and Bylaws

---

INTRODUCTION

At the 2024 Interim meeting of the American Medical Association (AMA) the House of Delegates (HOD), Resolution 004, "Improving Usability of Electronic Health Records for Transgender and Gender Diverse Patients," was referred for report back at the Interim 2025 meeting. This resolution was introduced by the LGBTQ Section and called for the following:

> RESOLVED, that our American Medical Association amend Policy H-315.967 "Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation" by addition and deletion to read as follows:
>
> **Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation, H315.967**
>
> Our AMA: (1) supports the voluntary inclusion of a patient's ~~biological sex~~current clinical sex, sex assigned at birth, current gender identity, legal sex on identification documents, sexual orientation, ~~preferred~~ gender pronoun(s), ~~preferred~~ chosen name, and clinically relevant, sex specific anatomy in medical documentation, and related forms, including in electronic health records, in a culturally-sensitive and voluntary manner, with efforts to improve visibility and awareness of transgender and gender diverse patients' chosen name and pronouns in all relevant EHR screens and to de-emphasize or conceal legal name except when required for insurance and billing purposes; (2) Will advocate for the inclusion of an organ inventory encompassing medical transition history and a list of current present organs in EHRs, with efforts to link organ-specific examinations and cancer screenings to the current organ inventory rather than sex or gender identity; (~~2~~3). Will advocate for collection of patient data in medical documentation and in medical research studies, according to current best practices, that is inclusive of sexual orientation, gender identity, and other sexual and gender minority traits for the purposes of research into patient and population health; (~~3~~4) Will research the problems related to the handling of sex and gender within health information technology (HIT) products and how to best work with vendors so their HIT products treat patients equally and appropriately, regardless of sexual or gender identity; (~~4~~5) Will investigate the use of personal health records to reduce physician burden in maintaining accurate patient information instead of having to query each patient regarding sexual orientation and gender identity at each

encounter; and (~~5~~6) Will advocate for the incorporation of recommended best practices into electronic health records and other HIT products at no additional cost to physicians automatically. (7) Will advocate for patient informed consent regarding how gender identity and related data will be used with the ability to opt out of recording aforementioned data without compromising patient care; (Modify Current HOD Policy); and be it further

RESOLVED, that our AMA supports the use of the term "chosen name" over "preferred name," recognizing the value of the term "chosen name" to transgender and gender diverse patients (New HOD Policy).

While testimony on this resolution was mostly supportive, there were concerns about terminology and minors' privacy.

This report seeks to advance proposals aligned with best practices for inclusive health documentation, including adoption of the term, "chosen name", and the development of an organ inventory within EHRs—documenting both a patient's medical transition history and current present organs—to ensure anatomically appropriate preventive care, screenings, and treatment. Building on these priorities, the report emphasizes the importance of ensuring that transgender and gender-diverse patients' chosen names are visible across health records, while also acknowledging the challenges to adopting the resolution given the current health care information technology (IT) and political landscape. It further highlights the need for inclusive and standardized data collection practices, equitable treatment in health care technology systems, and expanded use of personal health records to reduce the administrative burden on physicians.

BACKGROUND

Sexual orientation and gender identity (SOGI) data is information collected by health care organizations about a person's sexual orientation and gender identity to help providers and researchers better understand gender-diverse patients, enable culturally-responsive, patient-centered care, and monitor and improve access to quality care.[1] The AMA supports the voluntary, culturally sensitive inclusion of patient data on sex, gender identity, and sexual orientation in medical records[2,3], and is committed to equitable, inclusive care for transgender and gender-diverse patients. In medical contexts, the terminology used to refer to transgender patients' names carries significant weight. Specifically, the term "chosen name" is preferred over "preferred name" due to its affirmation of identity and the mental health benefits associated with its use.[4] Policy H-315.967 underscores the idea of informed consent, including transparent discussions on who can access a patient's data and how it will be used, extending beyond clinical interventions to data privacy and sharing policies. Focus groups revealed that transgender patients appreciated two-step gender identity questions in EHRs, but expressed concern about privacy and desired greater control, including opt-out options, especially in contexts where data might be shared.[5] Guidance on collecting sexual orientation and gender identity emphasizes offering an opt-out ("Choose not to disclose") option.[6] Patients must be informed about why data is collected, how it will be used, and that refusal will not affect their treatment. A recent study showed that patients of sexual and gender minority expect informed consent before capturing SOGI data, prefer to choose when and how to share it, and are more comfortable when staff understand its relevance and patients have the option to decline.[7]

The term “clinical sex” goes beyond a medically convenient label; it’s a contextual, biologically informed data element designed to ensure precise, safe, and inclusive health care. It is important to recognize that ongoing efforts have aimed to make EHRs more inclusive and clinically relevant by bridging the gap between patient identity, clinical accuracy, and respectful care. Sex for Clinical Use (SFCU) and Sex Parameter for Clinical Use (SPCU) are standardized health data elements that captures the sex classification most relevant to a specific clinical context (e.g., lab reference ranges, imaging studies, and medication dosing), as defined by the Health Level 7 (HL7) Gender Harmony Project.[8] SFCU/SPCU reflects the biological characteristics relevant to clinical care—such as anatomy, hormones, organs, chromosomes—as opposed to legal sex, sex assigned at birth, or gender identity. The HL7 Fast Healthcare Interoperability Resources standard includes an extension usable in patient portal or laboratory resources.[9] It supports the four-value schema: male, female, specified, and unknown. Health care providers are encouraged to adopt practices that respect and affirm patients' identities. The addition of SOGI fields over the last ten years have already established a basis of improving health care for the gender-expansive patient population.[10] This includes updating EHRs to distinguish between legal and chosen names, ensuring that staff are trained to use patients' chosen names and pronouns, and creating an inclusive environment that acknowledges and supports transgender patients.

EHR systems have been required to be capable of collecting SOGI data since a ruling by the Center of Medicare and Medicaid Services (CMS) in 2015[11], but reliability of these infrastructures have remained questionable by gender-diverse communities. Studies have shown that over 60 percent of adult EHRs are missing SOGI information[12], impeding the ability to identify and address health disparities within LGBTQ+ populations. Most EHRs now support distinct fields for legal sex, sex assigned at birth, gender identity, organ inventories (e.g., presence/absence of uterus, prostate, etc.), and context-specific sex fields that inform lab reference ranges, clinical decision support, and alerts.[13] This ensures correct testing and screening, and supports health equity and interoperability. Organ inventories are proven tools to ensure equitable, anatomy-based care. They are increasingly supported by leading EHR vendors and adopted by institutions like Epic[14], Geisinger[15], Allscripts[16], Department of Veterans Affairs[17], and Fenway Health.[17] Recommendations from the LGBTQ Primary Care Toolkit endorse voluntary SOGI and organ inventory disclosure through patient portals or clinic tablets[18], with clear messaging that patients may update or decline to provide this information—supporting autonomy and mental comfort. Successful integration depends on standardizing data, aligning workflows, providing training, and addressing anatomical complexity. Continued expansion is essential to close care gaps for transgender, gender-diverse, and all individuals with diverse anatomical realities.[19] While further EHR modifications[20] and staff training[21] to promote collection of more inclusive data have been a continued suggestion amongst those in the medical community, the quantifiable impact of these changes has yet to be determined.

## DISCUSSION

Referring to a transgender individual's "chosen name" acknowledges their self-identified name as their actual name, not merely a preference. The term "preferred name" can imply that the name is optional or less legitimate, which may undermine the individual's identity. Queering Medicine, a grassroots advocacy organization for improving health outcomes, notes that the term "preferred name" is considered offensive by many in the transgender and nonbinary communities, as it suggests that others have the discretion to use or ignore it.[22] Additionally, using a transgender person's chosen name has been linked to significant reductions in mental health risks. A study

published in the *Journal of Adolescent Health* found that transgender youth who could use their chosen name in multiple contexts experienced 71 percent fewer symptoms of severe depression, 34 percent less instances of reported suicidal ideation, and 65 percent reduction in suicide attempts.[23] Ensuring the correct terminology is being used in the clinician's office is the first step increasing the patient's comfort, ensuring mutual trust, and improving health outcomes.

Data Interoperability

A lack of documenting gender (and related data like SFCU or organ inventory) can lead to clinical errors, poor patient experiences, and long-term harm. Systems and clinicians who thoughtfully record and use this information provide better, safer, and more affirming care.[24–26] A qualitative study of transgender individuals in Chicago found that structured gender identity fields (e.g., two-step questions) improved perceived provider competence, but also highlighted serious risks around privacy violations, misinterpretation, and compromised safety when disclosures were mishandled.[5] As part of another qualitative study, transgender patients who were asked to discuss their experiences reviewing their EHRs reported experiencing harm via various aspects of EHR documentation, including frequent use of incorrect names, pronouns, or gender; stigmatizing or blaming language in clinical notes; and limited system capabilities that hinder quality, equitable care.[27] According to a US Transgender Survey conducted by the National Center for Transgender Equality, 33 percent of transgender respondents reported a negative experience with a health care provider in the past year.[28] Using the 2015 U.S. Transgender Survey, a study that explored avoidance of health care due to anticipated discrimination among transgender adults found that almost one-quarter of participants (22.8 percent) avoided health care due to anticipated discrimination, deepening gaps in trust and care. Although legislative and regulatory efforts surrounding transgender care are rapidly evolving, several of these entities have, in the past, recommended structured collection of gender identity, sex assigned at birth, and related EHR data fields to protect privacy and support clinical decision-making. For example, a 2011 Institute of Medicine (now the National Academy of Medicine) report titled, "The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding", recommended that SOGI data be collected in EHRs with consideration for privacy concerns.[29] In 2023, the Department of Health and Human Services (HHS) published its SOGI Data Action Plan to improve data collection for the LGBTQ+ community and in turn, support more equitable representation and care.[30] Further, the Assistant Secretary for Technology Policy/Office of the National Coordinator for Health Information Technology (ASTP/ONC) mandated in 2015 that certified EHR systems support the recording and display of gender identity, sex, "name to use", and pronouns, requiring full support for these fields by January 2026.[31]

EHRs not adequately accommodating both legal and chosen names not only creates significant challenges for transgender and gender diverse patients, but for the physicians and practices caring for them as well. Current systems often fail to record patients' names and pronouns appropriately, conflate sex and gender, and treat sex and gender as binary concepts. Many EHRs lack distinct fields for capturing both legal and chosen names, leading to chosen names being reverted to legal names previously stored in the system, repeated misnaming, and confusion during care—even when patients have clearly communicated their chosen name.[32] For example, many EHRs have historically used a single field that mixes administrative sex, clinical sex, gender identity, and pronouns under one category like "sex" or "gender".[33] Even when systems do provide multiple fields for this information, issues arise due to the need for different names in different settings such

as in the case of radiology information systems being linked to other medical records like Medicare. [32] A 2020 study at Rush University found that 76 percent of inpatient records lacked gender identity data, and a 2023 study at an academic medical center in New York found six discrepancies in transgender patients' documented gender identities[34]. Even when features (e.g., multi-part fields and dropdowns for pronouns) exist, they're not uniformly activated or used across vendor installations, meaning many users never see or use them. Additionally, sensitivity for identifying transgender individuals using EHR gender fields was remarkably low for data quality standards. These inconsistencies can result in administrative complications, as insurance billing and certain services (e.g., lab, x-ray, or procedures) all are governed by safety practices, the Health Insurance Portability and Accountability Act (HIPAA), and the Red Flag Rule, thus requiring verification of legal identity.[35] Furthermore, inconsistent documentation across systems can inadvertently expose a patient's transgender identity to providers, family, or friends, particularly in emergent situations, increasing the risk of discrimination and undermining trust in the health care system.[36]

To capture more accurate details, many EHRs enable free-text responses in the EHR SOGI field for patients to indicate their gender identity and pronouns in cases where an applicable option wasn't available. In a study that assessed how well SOGI fields, International Statistical Classification of Diseases and Related Health Problems, 10th Revision codes, and medication records identified gender-expansive patients, researchers reviewed free text responses from participants who selected "Other" in the SOGI field and responses included, "agender", "gender fluid", "gender nonconforming", "gender queer", indications of pronouns other than "he/him" or "she/hers", and "transfeminine" or "transmasculine".[10] However, free-text fields in EHRs have been reported to contribute to data overflow.[37] Information in these fields can become unmanageable for providers and potentially be overlooked. Managing this information also adds to physicians' time in the EHR, contributing to increased burnout. To address this burden, along with noisy SOGI data and incomplete and inconsistent gender identity documentation, researchers developed and validated a deep-learning natural language processing pipeline to accurately predict patient gender identity. Using a list of 109 expert-curated and literature-reported gender-related keywords, their model screened both structured data and free-text notes from over 3,000 patients in a large Boston health system to identify transgender and gender-diverse individuals. Compared with rule-based methods, the deep-learning model achieved substantially higher-accuracy, sensitivity, and precision.[38] However, a key limitation of such models is their reliance on existing EHR data, which may reflect provider biases and system constraints in capturing gender identity. As a result, these models risk reinforcing biases caused by inconsistent or inaccurate documentation, misgendering, and limited data fields. The Boston study experienced this challenge: in some cases, the model misclassified patients as transgender/gender-diverse based solely on procedures like a hysterectomy or vaginectomy, due to insufficient training data. Similarly, errors occurred when patients used they/them pronouns, reflecting an overgeneralization caused by limited training exposure to gender-diverse language.[38]

Without structured and manageable fields for sex assigned at birth, gender identity, SFCU, and organ inventory, clinical decision supports—a health IT tool that provides clinicians with knowledge and person-specific information to enhance care (e.g., computerized alerts, clinical guidelines, reminders, documentation templates, and condition-specific order sets)[39]—may miss important health risks such as cancer screenings, titrated lab interpretation, or medication needs.

Adopting and properly leveraging HL7 Gender Harmony and vendor toolkits is crucial, but must be paired with staff training, governance, and careful configuration to prevent implementation gaps.

Addressing Privacy Concerns

The collection of SOGI data in the United States is crucial for addressing health inequities and ensuring high quality care for LGBTQ+ populations. The terminology used in EHRs to refer to a patient's name—specifically, the distinction between "chosen name" and "preferred name"—has significant implications for privacy, security, and the well-being of gender-diverse individuals.

While HIPAA provides a framework for protecting patient information, it has limitations concerning SOGI data. For instance, certain legal interpretations have allowed for the disclosure of SOGI information without explicit patient consent, especially when such data are collected as part of demographic information rather than clinical record.[40] This was the case in Vanderbilt University Medical Center's (VUMC's) 2023 disclosure of the full medical records of transgender and gender-diverse patients to the Tennessee Attorney General amid an anti-LGBTQ+ political climate. The probe was prompted by claims that VUMC had improperly billed Medicaid for gender-affirming care. This disclosure was made without patient consent and sparked significant backlash, with critics arguing that it jeopardized the safety, privacy, and trust of transgender patients.[40,41]

The case also exposed broader vulnerabilities in federal privacy protections for this patient population. Under the HIPAA Privacy Rule, covered entities may disclose protected health information (PHI) without patient authorization if required by another law (provided such disclosure complies with the requirements of that law). In such cases, health care providers are not liable for these disclosures and often cannot prevent them. This loophole was a key factor in the VUMC case, raising concerns about the adequacy of federal safeguards for this kind of sensitive health data.[41] Compounding the issue, in early 2025, HHS rescinded its 2022 guidance that had previously offered protections for gender-affirming care and patient privacy[42], leaving transgender and gender-diverse patients and their providers with less clarity and even fewer protections to rely on.

Under HIPAA, a patient's name is considered PHI. This designation requires health care providers to implement safeguards to protect the confidentiality and integrity of patient names. However, HIPAA does not specifically address the nuances of chosen names for transgender individuals, potentially leaving gaps in protection when legal and chosen names differ.

The absence of comprehensive federal privacy legislation results in a patchwork of state laws, leading to inconsistent protections for SOGI data. In some states, there are no explicit safeguards against discrimination based on sexual orientation or gender identity, increasing the risk of data misuse. For example, in states without protective laws, individuals may face discrimination in housing, employment, or education if their SOGI information is disclosed.[43] Smaller practices are at higher risk of being unable to protect this data against federal threats, such as digital surveillance and geofencing of reproductive or gender-affirming care sites. Collecting gender and sexual orientation and gender identity data requires strong appropriate technical safeguards and privacy protocols to prevent trauma for LGBTQ+ patients, especially those with past misgendering or being outed in care settings.[44] Fenway Health and the VA implement EHR fields for gender

identity, anatomical inventories, and affirmation history, coupled with staff training, clearly explained data use, and privacy protections. These measures help prevent “re-traumatization” and enhance mental well-being.[15] Respect and transparency around data handling reduce the risk of re-traumatization and support positive patient outcomes. Oregon’s Equity & Inclusion Division highlights that collecting SOGI data demonstrates care and safety for LGBTQ+ individuals.[45] Paired with staff training and community-led input, it helps build trust, especially important in mental health screenings and identity disclosure contexts.

Even when minors can consent to sensitive care (e.g. sexual/mental health), EHR portals often default to giving guardians full access, risking unwanted disclosure of SOGI data.[46] A 2023 JAMA Pediatrics survey showed that approximately 50 percent of young adults avoid portal use and omit sensitive information for fear parents might see it, citing threats to their physical well-being if revealed to be transgender.[47] While collecting minors' SOGI data supports personalized care, privacy protections are often insufficient, leading to coerced disclosures, harmful breaches, and emotional risk. The Privacy Rule allows parents to access their minor children’s medical records as their personal representative when access isn’t inconsistent with state or other law. Exceptions to this are when parental consent is required by law; when the minor is directed by the court to obtain care; and when—and to the extent that—the parent agrees that the minor and provider may have a confidential relationship.[48] Additionally, even when state law permits confidential care, legislation like the 21st Century Cures Act still pose challenges. For example, the Cures Act’s open notes policy can unintentionally expose minors’ sensitive information to parents.[49] While the Cures Act builds on HIPAA to improve access to electronic health information, it doesn’t override HIPAA’s core privacy protections which allows disclosure of PHI for billing without consent.[50] Though data is limited, AMA physicians report such disclosures are common due to the lack of alternative workflows. Protecting minor privacy must extend to payers’ billing systems, not just providers and EHR vendors.[51] More robust technical, legal, and workflow standards must be researched to aid data collection and improve current systems.

Historical and ongoing discrimination against LGBTQ+ individuals fosters a climate of mistrust, making individuals hesitant to share SOGI information. Concerns about confidentiality breaches and potential repercussions can lead to underreporting or refusal to disclose such data, hindering efforts to gather accurate information for public health and policy-making purposes. Using "preferred name" instead of "chosen name" can inadvertently suggest that the name is optional or less legitimate, potentially leading to misidentification and privacy breaches. For transgender patients, being addressed by their legal name rather than their chosen name can result in unintended disclosure of their gender identity, especially in environments where they may not have disclosed this information. This misidentification can lead to emotional distress and a reluctance to seek necessary medical care–broadening the health disparity gap.

Unstable Political Landscape

The current political landscape in the United States has introduced a series of legislative and executive actions that have significant adverse effects on the rights and well-being of gender-diverse individuals and the physicians that care for them.

As of early 2025, 27 states have enacted bans on gender-affirming care for minors, with 26 of these 27 states prohibiting hormone therapy and surgeries for minors, and one state (Arizona) prohibiting

only surgical care.[52] Such bans are typically enforced by criminal, civil, and professional penalties for providers who furnish gender-affirming care services, as well as sometimes penalties for parents of children who support their children's access to this care.[53] Notably, these restrictions do not apply to services provided for purposes other than gender affirmation, such as treatments for disorders of sexual development and precocious puberty. As of July 2025, 40.1 percent (120,400) of trans youth aged 13-17 are living in the 27 states that have passed bans on gender-affirming care.[54] Despite the protections afforded in states with "shield laws" designed to protect access to abortion and gender-affirming care, these laws are currently being challenged.[55–57] Given the strong correlation between transgender individuals and mental health, state-level anti-transgender policies exacerbate these issues. Public health experts warn that such policies not only harm individual well-being but also strain health care systems and exacerbate inequities.[58] The denial of gender-affirming care and the erosion of legal protections necessitate urgent attention and intervention.

On January 20, 2025, Executive Order 14168 was signed, mandating federal agencies to recognize only a binary definition of sex based on biological attributes assigned at birth. This order rescinded federal recognition of transgender identities, ceased funding for gender-affirming care, and prohibited the use of gender self-identification on federal documents.[59] Additionally, it called for a reevaluation of Title VII protections concerning gender identity. Subsequent directives led to the removal of federal data sets and resources related to sexual orientation and gender identity from government websites, hindering research and public health initiatives aimed at addressing the needs of LGBTQ+ populations. These events reflect a broader trend of institutional censorship affecting educational resources related to gender diversity.

The politicization of transgender rights has broad societal implications, including intensified stigma and marginalization, and the undermining of the rights, health care access, and well-being of these communities. These challenges underscore the urgent need for informed advocacy and policy reform, especially efforts that address how inadequate privacy protections leave LGBTQ+ individuals vulnerable. Navigating the shifting political landscape requires careful attention to evolving attitudes—as well as emerging knowledge and best practices—from LGBTQ+ communities and their providers.

## CONCLUSION

Aligning medical documentation with the needs of transgender and gender-diverse patients is a critical step toward addressing long-standing health inequities. This report highlights the importance of supporting the voluntary, culturally sensitive inclusion of gender identity, "chosen names", and organ inventories to promote safer, more accurate, and affirming care. Many EHR vendors have already made strides in supporting this type of data collection, but more research is likely needed on specific efforts and impact of use across the health care system.

Affirming practices—such as using "chosen names" and linking screenings to anatomy rather than gender identity—are supported by strong clinical and mental health evidence, but ongoing challenges highlight the need for robust privacy protections. While some federal protections have been rolled back or face legal threats, laws like HIPAA and state confidentiality statutes still mandate safeguards, though they may be limited in their protection of transgender patients. Smaller practices may also lack the resources to implement optimal data protections. Informed consent and the option to opt out without compromising care are essential to maintaining patient trust.

In addition, there is a lack of consensus and consistent use of key terms such as clinical sex, raising concerns about the longevity of this resolution if adopted. Improving the usability of EHRs for transgender and gender diverse patients requires ongoing collaboration among the LGBTQ+ community, physicians, health systems and practices, and EHR vendors. Medical documentation that appropriately supports this patient population while upholding the highest privacy standards to protect these patients and the physicians that care for them, would be a vital step toward a more equitable and responsive health care delivery system.

AMA POLICY

The AMA has adopted several policies to support gender-diverse individuals in health care, foster care, and legal protections.

The AMA (1) supports the voluntary inclusion of a patient's biological sex, current gender identity, sexual orientation, preferred gender pronoun(s), preferred name, and clinically relevant, sex specific anatomy in medical documentation, and related forms, including in electronic health records, in a culturally-sensitive and voluntary manner; (2) will advocate for collection of patient data in medical documentation and in medical research studies, according to current best practices, that is inclusive of sexual orientation, gender identity, and other sexual and gender minority traits for the purposes of research into patient and population health; (3) will research the problems related to the handling of sex and gender within health information technology (HIT) products and how to best work with vendors so their HIT products treat patients equally and appropriately, regardless of sexual or gender identity; (4) will investigate the use of personal health records to reduce physician burden in maintaining accurate patient information instead of having to query each patient regarding sexual orientation and gender identity at each encounter; and (5) will advocate for the incorporation of recommended best practices into electronic health records and other HIT products at no additional cost to physicians (Policy H-315.967, "Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation")

The AMA will also advocate: (1) for the inclusion of demographic data inclusive of sexual orientation and gender identity in national and state surveys, surveillance systems, and health registries; including but not limited to the Current Population Survey, United States Census, National Survey of Older Americans Act Participants, all-payer claims databases; and (2) against the removal of demographic data inclusive of sexual orientation and gender identity in national and state surveys, surveillance systems, and health registries without plans for updating measures of such demographic data (Policy H-440.817, "Protecting the Integrity of Public Health Data Collection").

Additionally—given the medical spectrum of gender identity and sex—the AMA: (1) will work with appropriate medical organizations and community based organizations to inform and educate the medical community and the public on the medical spectrum of gender identity; (2) will educate state and federal policymakers and legislators on and advocate for policies addressing the medical spectrum of gender identity to ensure access to quality health care; and (3) affirms that an individual's genotypic sex, phenotypic sex, sexual orientation, gender and gender identity are not always aligned or indicative of the other, and that gender for many individuals may differ from the sex assigned at birth (Policy D-295.312, "Medical Spectrum of Gender").

The AMA opposes mandated reporting or disclosure of patient information related to sexual orientation, gender identity, gender dysphoria, intersex identity, and any information related to gender transition for all individuals, including minors (Policy H-65.959, "Opposing Mandated Reporting of People Who Question Their Gender Identity").

Further, the AMA continues to (1) support the dignity of the individual, human rights and the sanctity of human life; (2) reaffirm its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges and responsibilities commensurate with individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity or transgender status, race, religion, disability, ethnic origin, national origin or age; (3) oppose any discrimination based on an individual's sex, sexual orientation, gender identity, race, appearance, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies; and recognize that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage for appropriate hate crimes prevention legislation in accordance with our AMA's policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States (Policy H-65.965, "Support of Human Rights and Freedom (H-65.965)

The AMA encourages physician practices, medical schools, hospitals, and clinics to broaden any nondiscriminatory statement made to patients, health care workers, or employees to include "sexual orientation, sex, or gender identity" in any nondiscrimination statement (Policy H-65.976, "Nondiscriminatory Policy for the Health Care Needs of LGBTQ Populations").

Additionally, AMA affirms that it has not been its policy now or in the past to discriminate with regard to sexual orientation or gender identity (Policy H-65.983, "Nondiscrimination Policy") Regarding LGBTQ+ older adults, AMA will disseminate educational content to increase awareness and understanding of LGBTQ++ health aging issues among the general public, health care professionals, and policy makers; promote cultural competency training for clinicians in caring for LGBTQ++ older adults; promote policies and practices for implementation within all health care settings that are inclusive and affirming for LGBTQ++ older adults; and advocate for increased funding and resources for research into health issues of LGBTQ++ older adults (Policy D-65.979, "LGBTQ+ Older Adults")

Moreover, our AMA:

1. Believes that the physician's nonjudgmental recognition of patients' sexual orientations, sexual behaviors, and gender identities enhances the ability to render optimal patient care in health as well as in illness. In the case of lesbian, gay, bisexual, transgender, queer/questioning, and other (LGBTQ) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBTQ; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of LGBTQ Health and the need to elicit relevant gender and sexuality information from our patients; these efforts should start in medical school, but must also be a part of continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of LGBTQ patients; (iii) encouraging the development of educational programs in LGBTQ Health; (iv) encouraging physicians to seek out local or national experts in the health care needs of LGBTQ people so that all

physicians will achieve a better understanding of the medical needs of these populations; and (v) working with LGBTQ communities to offer physicians the opportunity to better understand the medical needs of LGBTQ patients; and (c) opposes, the use of "reparative" or "conversion" therapy for sexual orientation or gender identity.

2. Will collaborate with our partner organizations to educate physicians regarding: (i) the need for sexual and gender minority individuals to undergo regular cancer and sexually transmitted infection screenings based on anatomy due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases; and (iv) that individuals who identify as a sexual and/or gender minority (lesbian, gay, bisexual, transgender, queer/questioning individuals) experience intimate partner violence, and how sexual and gender minorities present with intimate partner violence differs from their cisgender, heterosexual peers and may have unique complicating factors.
3. Will continue to work alongside our partner organizations, including GLMA, to increase physician competency on LGBTQ health issues.
4. Will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-date education and information to enable the provision of high quality and culturally competent care to LGBTQ people (Policy H-160.991, "Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations").

Further, AMA will partner with public and private organizations dedicated to public health and public policy to reduce lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth suicide and improve health among LGBTQ youth (Policy H-60.927, "Reducing Suicide Risk Among Lesbian, Gay, Bisexual, Transgender, and Questioning Youth Through Collaboration with Allied Organizations").

AMA will also develop and implement a plan with input from the Advisory Committee on LGBTQ Issues and appropriate medical and community based organizations to distribute and promote the adoption of the recommendations pertaining to medical documentation and related forms in AMA policy H-315.967, "Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation," to our membership (Policy D-315.974, "Promotion of LGBTQ+ Friendly and Gender-Neutral Intake Forms" ).

Regarding research and the LGBTQ+ communities, AMA will work with appropriate stakeholders to support the creation of model training for Institutional Review Boards to use and/or modify for their unique institutional needs as it relates to research collecting data on Lesbian, Gay, Bi-sexual, Transgender and Queer populations (Policy D-460.966, "Endorsing LGBTQ+ Research IRB Training").

In addition, AMA will: (1) partner with other medical organizations and stakeholders to immediately increase efforts to educate the general public, legislators, and members of law enforcement using verified data related to the hate crimes against transgender individuals highlighting the disproportionate number of Black transgender women who have succumbed to violent deaths; (2) advocate for federal, state, and local law enforcement agencies to consistently

collect and report data on hate crimes, including victim demographics, to the FBI; for the federal government to provide incentives for such reporting; and for demographic data on an individual's birth sex and gender identity be incorporated into the National Crime Victimization Survey and the National Violent Death Reporting System, in order to quickly identify positive and negative trends so resources may be appropriately disseminated; (3) advocate for a central law enforcement database to collect data about reported hate crimes that correctly identifies an individual's birth sex and gender identity, in order to quickly identify positive and negative trends so resources may be appropriately disseminated; (4) advocate for stronger law enforcement policies regarding interactions with transgender individuals to prevent bias and mistreatment and increase community trust; and (5) advocate for local, state, and federal efforts that will increase access to mental health treatment and that will develop models designed to address the health disparities that LGBTQ individuals experience (Policy H-65.957, "Preventing Anti-Transgender Violence").

Further, AMA:

1. Recognizes child, youth and young adult suicide as a serious health concern in the US.
2. Encourages the development and dissemination of educational resources and tools for physicians, especially those more likely to encounter child, youth or young adult patients, addressing effective suicide prevention, including screening tools, methods to identify risk factors and acuity, safety planning, and appropriate follow-up care including treatment and linkages to appropriate counseling resources.
3. Supports collaboration with federal agencies, relevant state and specialty societies, schools, public health agencies, community organizations, and other stakeholders to enhance awareness of the increase in child, youth and young adult suicide and to promote protective factors, raise awareness of risk factors, support evidence-based prevention strategies and interventions, encourage awareness of community mental health resources, and improve care for children, youth and young adults at risk of suicide.
4. Encourages (a) efforts to provide children, youth and young adults better and more equitable access to treatment and care for depression, substance use disorder, and other disorders that contribute to suicide risk; as well as (b) continued research to better understand suicide risk and effective prevention efforts in children, youth and young adults, especially in higher risk sub-populations such as those with a history of childhood trauma and adversity, Black, LGBTQ+, Hispanic/Latinx, Indigenous/Native Alaskan youth and young adult populations, and children in the welfare system.
5. Supports the development of novel technologies and therapeutics, along with improved utilization of existing medications to address acute suicidality and underlying risk factors in children, youth and young adults; and research to identify evidence-based universal and targeted suicide prevention programs for implementation in middle schools and high schools.
6. Will publicly call attention to the escalating crisis in children, youth and young adult mental health in this country in the wake of the Covid-19 pandemic.
7. Will advocate at the state and national level for policies to prioritize children's, youth's, and young adult's mental, emotional, and behavioral health.
8. Will advocate for comprehensive system of care including prevention, management, and crisis care to address mental and behavioral health needs for children, youth, and young adults

9. Will advocate for a comprehensive approach to the youth, and young adult mental and behavioral health crisis when such initiatives and opportunities are consistent with AMA policy (Policy H-60.937, "Youth and Young Adult Suicide Prevention").

RECOMMENDATIONS

The Board of Trustees recommends that the following be adopted in lieu of Resolution 004-I-24 and the remainder of the report be filed:

1. Our AMA reaffirm Policy H-315.967, "Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation." (Reaffirm HOD Policy)

2. Our AMA support the use of the term "chosen name" over "preferred name," recognizing its importance to transgender and gender-diverse patients. (New HOD Policy)

3. Our AMA acknowledge the evolving nature of language and engage appropriate stakeholders to ensure the continued relevance and accuracy of terminology used across AMA resources and advocacy. (New HOD Policy)

4. Our AMA continue to support efforts by EHR vendors, health systems, and physician practices, and work with relevant stakeholders (e.g., the ASTP/ONC, LGBTQIA+ advocacy groups, and minors' privacy experts), to improve EHR usability for transgender and gender-diverse patients, with attention to strong privacy protections, and report back on this progress by I-26. (New HOD Policy)

Fiscal Note: Moderate

REFERENCES

1. National LGBTQIA+ Health Education Center. *Ready, Set, Go!: A Guide for Collecting Data on Sexual Orientation and Gender Identity*.; 2022. Accessed August 4, 2025. https://www.lgbtqiahealtheducation.org/publication/ready-set-go-a-guide-for-collecting-data-on-sexual-orientation-and-gender-identity-2022-update/

2. American Medical Association (AMA). *Promotion of LGBTQ-Friendly and Gender-Neutral Intake Forms D-315.974*. Vol D-315.974.; 2018. Accessed July 28, 2025. https://policysearch.ama-assn.org/policyfinder/detail/Promotion%20of%20LGBTQ-Friendly%20and%20Gender-Neutral%20Intake%20Forms%20D-315.974?uri=%2FAMADoc%2Fdirectives.xml-D-315.974.xml

3. American Medical Association (AMA). *Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation H-315.967*. Vol H-315.967.; 2019. Accessed July 28, 2025. https://policysearch.ama-assn.org/policyfinder/detail/Promoting%20Inclusive%20Gender,%20Sex,%20and%20Sexual%20Orientation%20Options%20on%20Medical%20Documentation%20H-315.967?uri=%2FAMADoc%2FHOD-315.967.xml

4. Pollitt AM, Ioverno S, Russell ST, Li G, Grossman AH. Predictors and Mental Health Benefits of Chosen Name Use among Transgender Youth. *Youth Soc*. 2019;2019. doi:10.1177/0044118X19855898

5. Thompson HM. Patient Perspectives on Gender Identity Data Collection in Electronic Health Records: An Analysis of Disclosure, Privacy, and Access to Care. *Transgender Health*. 2016;1(1):205-215. doi:10.1089/trgh.2016.0007

6. National LGBT Health Education Center. *Collecting Sexual Orientation and Gender Identity Data in Electronic Health Records*.; 2016. Accessed July 28, 2025. https://www.lgbtqiahealtheducation.org/wp-content/uploads/Collecting-Sexual-Orientation-and-Gender-Identity-Data-in-EHRs-2016.pdf

7. Schmidt S, Fazio T, D'Souza AN, et al. Capturing sexual orientation and gender identity information in electronic medical records to inform the person-centred care of sexual and gender minority people. *BMC Public Health*. 2025;25(1):1015. doi:10.1186/s12889-025-22190-9

8. HealthIT.gov. Sex For Clinical Use. Health IT.gov. April 16, 2024. Accessed July 28, 2025. http://www.healthit.gov/isp/uscdi-data-class/sex-clinical-use

9. HL7 International. HL7 Cross Paradigm Implementation Guide: Gender Harmony - Sex and Gender Representation, Edition 1. HL7 FHIR. November 6, 2023. Accessed July 29, 2025. https://build.fhir.org/ig/HL7/fhir-gender-harmony/background.html

10. Hines NG, Greene DN, Imborek KL, Krasowski MD. Patterns of gender identity data within electronic health record databases can be used as a tool for identifying and estimating the

prevalence of gender-expansive people. *JAMIA Open*. 2023;6(2):ooad042. doi:10.1093/jamiaopen/ooad042

11. Center for American Progress (CAP). STATEMENT: New HHS Rules Require Sexual Orientation and Gender Identity Data Collection in Electronic Health Records Program. CAP. October 7, 2015. Accessed August 7, 2025. https://www.americanprogress.org/press/statement-new-hhs-rules-require-sexual-orientation-and-gender-identity-data-collection-in-electronic-health-records-program/

12. May JT, Myers J, Noonan D, McConnell E, Cary MP Jr. A call to action to improve the completeness of older adult sexual and gender minority data in electronic health records. *J Am Med Inform Assoc*. 2023;30(10):1725-1729. doi:10.1093/jamia/ocad130

13. Landman K. The Battle to Get Gender Identity Into Your Health Records. *Wired*. Published online June 30, 2017. Accessed July 29, 2025. https://www.wired.com/story/the-battle-to-get-gender-identity-into-your-health-records/

14. Nelson H. Anatomy, Gender EHR Integrations Boost Clinical Decision Support. TechTarget. July 9, 2021. Accessed July 29, 2025. https://www.techtarget.com/searchhealthit/news/366579110/Anatomy-Gender-EHR-Integrations-Boost-Clinical-Decision-Support

15. Nelson H. Data Standards Key for EHR Documentation of Gender Minority Patients. TechTarget. November 15, 2021. Accessed July 29, 2025. https://www.techtarget.com/searchhealthit/news/366578923/Data-Standards-Key-for-EHR-Documentation-of-Gender-Minority-Patients

16. Scott R. 'Anatomy inventory' fosters more inclusive care for transgender, non-binary patients. Healio Rheumatology. November 13, 2022. Accessed July 29, 2025. https://www.healio.com/news/rheumatology/20221112/anatomy-inventory-fosters-more-inclusive-care-for-transgender-nonbinary-patients

17. Lau F, Antonio M, Davison K, Queen R, Devor A. A rapid review of gender, sex, and sexual orientation documentation in electronic health records. *J Am Med Inform Assoc JAMIA*. 2020;27(11):1774-1783. doi:10.1093/jamia/ocaa158

18. Willging C, Sturm R, Sklar M, Kano M, Davies S, Eckstrand K. Section 3. Documenting sexual orientation and gender identity information. In: *LGBTQ Primary Care Toolkit: A Guide for Primary Care Clinics to Improve Services for Sexual and Gender Minority (SGM) Patients*. Pacific Institute for Research and Evaluation; 2021. Accessed July 29, 2025. https://lgbtqprimarycare.com/chapter-9/section-3-documenting-sexual-orientation-and-gender-identity-information/

19. National Academies of Sciences, Engineering, and Medicine. 4. Data on Sex and Gender Identity: Collection Across the U.S. Health Care System. In: *Sex and Gender Identification and Implications for Disability Evaluation*. National Academies Press; 2024. Accessed July 29, 2025. https://nap.nationalacademies.org/read/27775/chapter/6#104

20. Grutman AJ. Use of chosen names in electronic health records to promote transgender inclusivity. *J Am Med Inform Assoc JAMIA*. 2023;30(6):1219-1221. doi:10.1093/jamia/ocad047

21. Erritt A. Gender health: Use chosen pronouns for more inclusive care. Children's Minnesota. June 23, 2023. Accessed July 29, 2025. https://www.childrensmn.org/blog/gender-health-use-chosen-pronouns-inclusive-care/

22. Queering Medicine. Intake Form Guidance for Providers. Queering Medicine. July 8, 2021. Accessed July 29, 2025. https://www.queeringmedicine.com/resources/intake-form-guidance-for-providers

23. Russell ST, Pollitt AM, Li G, Grossman AH. Chosen Name Use Is Linked to Reduced Depressive Symptoms, Suicidal Ideation, and Suicidal Behavior Among Transgender Youth. *J Adolesc Health*. 2018;63(4):503-505. doi:10.1016/j.jadohealth.2018.02.003

24. Whitman-Walker Institute's LGBTQ+, HIV Care and Prevention Training, Schanfield A, Brooks B. Collecting Data to Address Health Inequities. AMA Ed Hub. March 21, 2023. Accessed August 7, 2025. https://edhub.ama-assn.org/whitman-walker-institute-training/module/2802606

25. Grasso C, Goldhammer H, Brown RJ, Furness BW. Using sexual orientation and gender identity data in electronic health records to assess for disparities in preventive health screening services. *Int J Med Inf*. 2020;142:104245. doi:10.1016/j.ijmedinf.2020.104245

26. Whitman-Walker Health, National Committee for Quality Assurance (NCQA). *Empowering Health Care Organizations to Improve Care for LGBTQ+ Populations: HIPAA Protections for Responsible Sexual Orientation and Gender Identity Data Stewardship*. NCQA; 2024. Accessed August 7, 2025. https://wpcdn.ncqa.org/www-prod/wp-content/uploads/NCQA-Whitman-Walker-SOGI-Issue-Brief-Final.pdf

27. Alpert AB, Mehringer JE, Orta SJ, et al. Experiences of Transgender People Reviewing Their Electronic Health Records, a Qualitative Study. *J Gen Intern Med*. 2023;38(4):970-977. doi:10.1007/s11606-022-07671-6

28. Beayno A, Angelova Y. The Health Care Experience of a Transgender Woman: The Role of the Consultation-Liaison Psychiatrist in Advocacy Against Discrimination in the Hospital Setting. *J Acad Consult-Liaison Psychiatry*. 2022;63(4):400-403. doi:10.1016/j.jaclp.2021.10.001

29. Institute of Medicine (US) Board on the Health of Select Populations. *Collecting Sexual Orientation and Gender Identity Data in Electronic Health Records: Workshop Summary*. National Academies Press (US); 2013. Accessed July 30, 2025. http://www.ncbi.nlm.nih.gov/books/NBK132859/

30. Department of Health and Human Services (HHS). Data Collection and the Paperwork Reduction Act– SOGI Data Checklist For HHS Operating and Staff Divisions. Published online July 6, 2024. Accessed July 30, 2025.

https://aspe.hhs.gov/sites/default/files/documents/a447871fd163f178ecc5207791261fdb/data-collection-paperwork-reduction-act-sogi-data-checklist.pdf

31. Assistant Secretary for Technology Policy/ Office of the National Coordinator for Health Information Technology (ASTP/ONC). *§170.315(a)(5) Patient Demographics and Observations*. Vol §170.315(a)(5).; 2015. Accessed July 30, 2025. https://www.healthit.gov/test-method/patient-demographics-and-observations?utm_source=chatgpt.com

32. Ho N, Williams A, Sun Z. Improving radiology information systems for inclusivity of transgender and gender-diverse patients: what are the problems and what are the solutions? A systematic review. *J Med Radiat Sci*. 2024;71(4):591-607. doi:10.1002/jmrs.808

33. Foer D, Rubins DM, Almazan A, Chan K, Bates DW, Hamnvik OPR. Challenges with Accuracy of Gender Fields in Identifying Transgender Patients in Electronic Health Records. *J Gen Intern Med*. 2020;35(12):3724-3725. doi:10.1007/s11606-019-05567-6

34. Proumen R, Connolly H, Debick NA, Hopkins R. Assessing the accuracy of electronic health record gender identity and REaL data at an academic medical center. *BMC Health Serv Res*. 2023;23(1):884. doi:10.1186/s12913-023-09825-6

35. Deutsch MB, Buchholz D. Electronic Health Records and Transgender Patients—Practical Recommendations for the Collection of Gender Identity Data. *J Gen Intern Med*. 2015;30(6):843-847. doi:10.1007/s11606-014-3148-7

36. Hao S. Inclusivity in the EHR Gone Wrong. Doximity. July 15, 2021. Accessed July 29, 2025. https://opmed.doximity.com/articles/inclusivity-in-the-ehr-gone-wrong

37. Tsai CH, Eghdam A, Davoody N, Wright G, Flowerday S, Koch S. Effects of Electronic Health Record Implementation and Barriers to Adoption and Use: A Scoping Review and Qualitative Analysis of the Content. *Life*. 2020;10(12):327. doi:10.3390/life10120327

38. Hua Y, Wang L, Nguyen V, et al. A deep learning approach for transgender and gender diverse patient identification in electronic health records. *J Biomed Inform*. 2023;147:104507. doi:10.1016/j.jbi.2023.104507

39. Assistant Secretary for Technology Policy (ASTP). Clinical Decision Support. HealthIT.gov. 2025. Accessed August 4, 2025. https://www.healthit.gov/topic/safety/clinical-decision-support

40. Zayhowski K, Roth S, Westerfield MJ, et al. Navigating sexual orientation and gender identity data privacy concerns in United States genetics practices. *J Genet Couns*. 2025;34(2):e70008. doi:10.1002/jgc4.70008

41. Alder S. VUMC Faces Lawsuit Over Disclosure of Medical Records of Transgender Patients to State AG. The HIPAA Journal. July 25, 2023. Accessed July 30, 2025. https://www.hipaajournal.com/vumc-faces-lawsuit-over-disclosure-of-medical-records-of-transgender-patients-to-state-ag/

42. Department of Health and Human Services (HHS). Recission of "HHS Notice and Guidance on Gender Affirming Care, Civil Rights, and Patient Privacy" (issued March 2, 2022). Published online February 20, 2025. Accessed July 30, 2025. https://www.hhs.gov/sites/default/files/ocr-rescission-february-20-2025-notice-guidance.pdf

43. Oda FS, Stiehl CM. Sexual Orientation and Gender Identity (SOGI): A Tutorial on Ethical Data Practices. *Behav Anal Pract*. 2025;18:275-290. doi:10.1007/s40617-024-01014-z

44. Davison K, Queen R, Lau F, Antonio M. Culturally Competent Gender, Sex, and Sexual Orientation Information Practices and Electronic Health Records: Rapid Review. *JMIR Med Inform*. 2021;9(2):e25467. doi:10.2196/25467

45. Das LT. We Need More Covid-19 Data on the LGBTQ+ Community. WIRED. March 11, 2021. Accessed July 30, 2025. https://www.wired.com/story/covid-19-data-lgbtq-community/

46. American College of Obstetricians and Gynecologists (ACOG). Confidentiality in Adolescent Health Care. Published online April 2020. Accessed July 30, 2025. https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2020/04/confidentiality-in-adolescent-health-care/

47. Forward Pathway. Challenges and Solutions for Young Adults' Health Information Sharing. Forward Pathway. October 8, 2024. Accessed July 30, 2025. https://www.forwardpathway.us/challenges-and-solutions-for-young-adults-health-information-sharing

48. Office for Civil Rights (OCR). Does the HIPAA Privacy Rule allow parents the right to see their children's medical records? HHS. December 19, 2002. Accessed July 30, 2025. https://www.hhs.gov/hipaa/for-professionals/faq/227/can-i-access-medical-record-if-i-have-power-of-attorney/index.html

49. Carlson J, Goldstein R, Hoover K, Tyson N. NASPAG/SAHM Statement: The 21st Century Cures Act and Adolescent Confidentiality. *J Adolesc Health*. 2021;68(2):426-428. doi:10.1016/j.jadohealth.2020.10.020

50. McCormack M. The 21st Century Cures Act and The HIPAA Privacy Rule. Compliancy Group. 2025. Accessed July 30, 2025. https://compliancy-group.com/21st-century-cures-act-and-hipaa-privacy-rule/

51. English A, Benson Gold R, Nash E, Levine J. Confidentiality for Individuals Insured as Dependents: A Review of State Laws and Policies. Published online July 2012. Accessed July 30, 2025. https://www.guttmacher.org/sites/default/files/pdfs/pubs/confidentiality-review.pdf

52. Dawson L, Kates J. Policy Tracker: Youth Access to Gender Affirming Care and State Policy Restrictions. 2025. Accessed July 30, 2025. https://www.kff.org/other/dashboard/gender-affirming-care-policy-tracker/

53. American College of Physicians (ACP). Attacks on Gender-Affirming and Transgender Health Care. ACP. August 6, 2024. Accessed July 30, 2025.

https://www.acponline.org/advocacy/state-health-policy/attacks-on-gender-affirming-and-transgender-health-care

54. HRC Foundation. Map: Attacks on Gender Affirming Care by State. HRC. Accessed July 29, 2025. https://www.hrc.org/resources/attacks-on-gender-affirming-care-by-state-map

55. Resnick S. Abortion providers in shield law states say they are undeterred by legal threats. Arkansas Advocate. February 21, 2015. Accessed July 29, 2025. https://www.newsfromthestates.com/article/abortion-providers-shield-law-states-say-they-are-undeterred-legal-threats

56. Klibanoff E. Texas man sues California doctor in federal court, testing a new angle to crackdown on abortion pills. The Texas Tribune. July 23, 2025. Accessed July 29, 2025. https://www.texastribune.org/2025/07/23/texas-california-abortion-pill-shield-law-lawsuit/

57. Kashiwagi S. Blue states see ‘shield laws’ as bulwark against Republican efforts to restrict abortion and gender-affirming care | CNN Politics. CNN. July 13, 2023. Accessed July 29, 2025. https://www.cnn.com/2023/07/13/politics/shield-laws-abortion-gender-affirming-care

58. Restar AJ, Layland EK, Davis B, Thompson H, Streed C. The Public Health Crisis State of Transgender Health Care and Policy. *Am J Public Health*. 2024;114(2):161-163. doi:10.2105/AJPH.2023.307523

59. Meyer IH, Bouton LJA. Impact of Executive Orders on Access to Federal Data. Williams Institute. February 2025. Accessed July 30, 2025. https://williamsinstitute.law.ucla.edu/publications/access-federal-lgbt-data/

REPORT OF THE BOARD OF TRUSTEES

B of T Report 11-I-25

Subject: Supporting Diversity in Research

Presented by: David H. Aizuss, MD, Chair

Referred to: Reference Committee on Ethics and Bylaws

---

At the 2024 Interim Meeting, the House of Delegates (HOD) referred Resolution 007-I-24, "Supporting Diversity in Research," introduced by the Minority Affairs Section, which offered four resolves aimed at improving diversity in research:

> RESOLVED, that our American Medical Association support the use of language interpreters and translators in clinical and medical research participation to promote equitable data collection and outcomes (New HOD Policy); and be it further
>
> RESOLVED, that our AMA encourage all Institutional and Research Review Boards (IRBs) to develop and publish transparent guidelines for interpreter services to ensure appropriate enrollment and ongoing participation of medical and clinical research participants with Limited English Proficiency and Deaf or Hard of Hearing people (New HOD Policy); and be it further
>
> RESOLVED, that our AMA advocate for the Department of Health and Human Services and Office for Human Research Protections (OHRP) to update their guidance on "Informed Consent of Subjects Who Do Not Speak English (1995)" (Directive to Take Action); and be it further
>
> RESOLVED, that our AMA support the creation of a federal standard upon which individual Institutional Review Boards (IRBs) may base their recommendations. (New HOD Policy)

In response to Resolution 007, this report provides background, discussion, and recommendations.

## BACKGROUND

Ideally, the makeup of research participants (or human subjects) would closely resemble the demographic diversity of the general population or the prevalence of a specific disease.[1] Despite federal regulations aimed at promoting participant diversity in research, it is widely acknowledged that there is a need for greater diversity and inclusion in clinical trials and health research.[2,3] Improving diversity in clinical research would help strengthen the generalizability, external validity, and quality of research results.[4,5] Improving representation in clinical research would also reduce health disparities, potentially saving the U.S. billions of dollars, improve trust in science and medicine, and help promote public health and health equity.[4,6] Because improving research participant diversity promotes trust, fairness, justice, and health equity, achieving greater representation in clinical research is not only a scientific imperative but an ethical one as well.[4,7]

© 2025 American Medical Association. All rights reserved.

## DISCUSSION

Enrolling diverse research participant populations is crucial to ensure accurate and equitable outcomes, as disease prevalence and responses to treatments can vary significantly across different groups.[8] Underrepresentation of certain groups in research can lead to biased findings and ineffective interventions for those populations. Despite evidence of recent increases in participation by women and elderly individuals in clinical trials, research participants remain mostly white and male.[6] Groups that are frequently underrepresented in clinical research include, but are not limited to, non-white women, pregnant and lactating individuals, gender minorities, sexual minorities, racial and ethnic minorities, individuals with disabilities, individuals with mental illness, older adults, children, and individuals with limited English proficiency (LEP).[3,6,9] Because some subgroups of patients might respond differently to interventions due to genetic, social, and cultural factors, ensuring diversity within research study cohorts is crucial to ensure that research is generalizable, that the risks and benefits of research are fairly distributed, and that research does not perpetuate existing health inequities.[8] By including underrepresented and excluded groups, research may lead to more effective therapies that can help reduce health disparities.[4] Inclusive enrolment practices can also lead to increases in participation and greater public trust in science and medicine.[7]

### *Federal Regulations and Research Participant Diversity*

In the U.S., federal regulations require diversity in research participation, particularly in federally funded studies, to ensure that research findings are generalizable and equitable. The National Institutes of Health (NIH) Revitalization Act of 1993 mandates that NIH-funded clinical research include women and minorities as participants.[10] In 2019, the NIH instituted the Inclusion Across the Lifespan policy, mandating that NIH-funded research include individuals of all ages, including children and older adults, unless there exists scientifically or ethically justifiable reasons for exclusion.[11] The Common Rule (45 CFR 46), which outlines federal protections for human research participants, emphasizes equitable selection of participants; it also states that in obtaining informed consent, all information given to the research participant (or their legally authorized representative) must be in language understandable to them.[12] The U.S. Department of Health and Human Services' Office for Human Research Protections, in their guidance "Informed Consent of Subjects Who Do Not Speak English" published in 1995 and last reviewed in 2016, similarly states that when obtaining informed consent, information should be presented in language understandable to the participant.[13] However, despite these regulations, underrepresentation and exclusion of certain groups in research persists.

One challenge to improving representation in clinical research has been that data on population demographics across clinical trials has not been consistently reported. Demographic data of participants enrolled in clinical trials in the U.S. is most readily collected by ClinicalTrials.gov (a registry maintained by the National Library of Medicine at the NIH), but limitations on how often and how comprehensively data are collected and made available have made longitudinal institute-level data difficult to examine, and not all trials report their demographic characteristics.[6] It is therefore crucial that policies be developed to ensure that more complete incidence data across demographic groups and subgroups are captured and disseminated for more conditions in order to improve clinical research diversity.[14]

In addition, it has been argued that federal regulations and guidance are insufficient and overly vague on issues related to language diversity for informed consent and exclusion criteria for clinical trials, and that there exists considerable variation in IRB policies.[3,15] Recent executive orders, which have revoked previous orders directing federal agencies to address disparities,

including in research funding and participation, have further complicated attempts at addressing underrepresentation and exclusion of certain groups in clinical research.[16,17]

*Improving Enrollment Diversity*

Strategies to improve the representation of participants in clinical research requires the engagement of multiple stakeholders and must be embedded at every stage of the research process, from ideation, to study design, implementation, and approval and dissemination.[6,9] However, Collister et al. acknowledge, "Diversity in recruitment requires additional resources, time, and skills from trial teams, and this requirement for diversity needs to be balanced with the feasibility and generalizability of the trial."[5] They add that new systems-level approaches to increase participant diversity need to be developed for both industry and investigators.[5]

To facilitate the successful inclusion of underrepresented and excluded groups in research, several strategies have been developed. For example, in the National Academies report "Improving Representation in Clinical Trials and Research: Building Research Equity for Women and Underrepresented Groups," the authors note, "From goal setting to community partnering strategies, intentionality and planning are critical themes for overcoming the systemic barriers previously outlined […]. While planning and engagement with diverse communities is resource, time, and labor intensive, it is critical to advancing inclusion."[6] This highlights the fact that equitable representation in clinical research must be a goal from the onset. They add, "Setting a priori recruitment goals for the inclusion of underrepresented groups is essential to planning and can help research teams measure progress and develop more effective engagement strategies".[6]

Other strategies outlined include building and maintaining trust with research participants and their communities at large; anticipating and removing barriers to participation; identifying and reaching out to relevant community stakeholders to help develop more equitable study designs and drive recruitment and retention of diverse research participants; and educating researchers on strategies to increase the enrollment of diverse participants, including the use of broad eligibility criteria and avoiding sex-specific exclusion criteria.[6]

The FDA, in collaboration with the Clinical Trials Transformation Initiative, held a two-day virtual public workshop in 2024 focused on ways to increase the enrollment of historically underrepresented populations in clinical studies and promote greater representation in research. Panelists discussed barriers to clinical study diversity and "how strategies to improve diversity should consider the languages and varying levels of health and digital literacy, broadband access for digital tools, and accessibility among potential participants to enable inclusive and equitable participation."[9] Other strategies discussed included "targeted patient engagement plans, enhanced site selection and inclusive patient educational materials using decentralized trial tools, digital technologies, choosing sites that are located in diverse areas, protocol optimization with inclusive study design elements, and using patient concierges to help with scheduling and reimbursement for travel and transportation."[9]

With respect to individuals with limited English proficiency, Muthukmar et al write, "A meaningful percentage of U. S. interventional clinical trials for adults exclude individuals who cannot read, speak, and/or understand English, or are not native English speakers. To advance more inclusive and generalizable research, funders, sponsors, institutions, investigators, institutional review boards, and others should prioritize translating study materials and eliminate language requirements unless justified either scientifically or ethically."[18] In their analysis, they found that 18.98 percent of clinical trials required the ability to read, speak, and/or understand English, while only 2.71 percent specifically required accommodations for translation. They add that funders and

sponsors should include translation costs as a matter of course, that institutions with access to translation or interpreter services for clinical purposes could extend these services to researchers, and that IRBs should develop standardized guidelines for the implementation of translators, which currently do not exist.[18]

A common refrain when it comes to increasing participant diversity in research is the importance of building trust with local communities.[2,4,6,9] *JAMA* Editor-in-Chief Kirsten Bibbins-Domingo explains, "Building trust with local communities requires a sustained commitment and presence, with financial investment in research infrastructure and systems and technologies to reduce barriers to participation."[2] This requires adopting the collaborative mindset and long-term commitments central to community-based participatory research, which aims to bring equity into the center of research projects by collaborating with community members and other stakeholders throughout the research process to address community needs. Bibbins-Domingo notes, "This begins with community-centered engagement and prioritization across the research life cycle, from the substance and design of questions being asked, to culturally cognizant recruitment and retention of study participants, to analysis and reporting of results, and to monitoring and reporting across the research ecosystem to ensure that the goals of inclusion are met."[2] Of course, there is wide acknowledgement that strategies to increase participant diversity will require additional resources but that committing to doing so will help advance more inclusive and generalizable research.

In addition to strategies aimed at fostering trust and improving enrollment diversity, clinical researchers should also reconsider eligibility criteria for participation in research. A study by Plosky et al. found that 85 percent of protocols allowed broad investigator discretion in determining eligibility and often utilized phrasing so non-specific or expansive as to render entire groups ineligible.[3] They suggest that eligibility criteria be as inclusive as possible, that written justification be provided so that oversight bodies such as IRBs could review whether exclusion is justified, and that accommodations be considered, such as virtual visits, additional time for the informed consent process, communications assistance, American Sign Language interpreters, or transportation to study appointments.[3]

For LEP individuals, the provision of interpreters or translators could greatly reduce the underrepresentation of this group in clinical research. An interpreter is generally a person trained in the language of health care who conducts live interpretations between two people, while a translator is generally someone who translates text-based documents between the source language and the target language.[19] In thinking through the language support needed for a clinical trial, Willis et al. state, "it is important to distinguish trial contexts where language is required solely as part of the informed consent process (an ethical imperative for all research participants) and trial contexts where language is part of the intervention."[8] Generative AI models have recently been proposed as one means to meet the needs of LEP individuals and foster greater inclusion in clinical research. However, these technologies must be considered alongside issues of accuracy, safety, privacy, and other risks involved. For instance, due to differences in languages available for AI model training, translation performance in the US is significantly better for Spanish than for other languages with less diffusion, creating a higher risk for clinically significant errors for these linguistic populations.[20,21]

While digital health technologies, such as generative AI translators, may help support the inclusion of underrepresented and excluded populations, they should not be considered solutions on their own. Barriers such as a lack of broadband, digital literacy, and the potential for embedded biases should be carefully considered. It is also crucial not to dismiss the importance of building human connection with participants and communities, which is vital to building and sustaining trust.[9] To support enrollment diversity, all study protocols should include considerations for diverse linguistic

groups, including LEP, deaf, and hard of hearing individuals and should provide clear protections for these groups during the informed consent process. As Alhalel et al. state, "Fulfilling the ethical demands for inclusive clinical trials also requires research funders to prioritize language access by including expenses for language assistance resources in all clinical trial budgets."[22]

## RELEVANT AMA POLICY

AMA policies that support participant diversity in research include H-525.988, "Sex and Gender Differences in Medical Research," which affirms support for including "people of all sexes and gender identities and expressions in studies that involve the health of society at large".[23] H-460.881, "Increasing Diversity in Stem Cell Biobanks and Disease Models," encourages "participation by underrepresented populations" and the collection of "racially and ethnically diverse sample" to "better represent the population."[24]

Though not specific to research, H-160.924, "Use of Language Interpreters in the Context of the Patient-Physician Relationship," states that "patients should have access to documentation and communications in their preferred language" and that "physicians cannot be expected to provide and fund these translation services for their patients, as the Department of Health and Human Services' policy guidance currently requires".[25] And H-180.944, "Plan for Continued Progress Toward Health Equity," defines health equity as a goal of our AMA.[26]

The AMA *Code of Medical Ethics* also contains several relevant opinions. Opinion 7.1.1, "Physician Involvement in Research," states that research participants "must be able to make informed decisions about whether to participate or continue in a given protocol."[27] Opinion 7.1.2, "Informed Consent in Research," states that physicians must ensure that research participants have "given voluntary, informed consent before enrolling".[28] Opinion 8.5, "Disparities in Health Care," states that physicians should "Cultivate effective communication and trust by seeking to better understand factors that can influence patients' health care decisions, such as cultural traditions, health beliefs and health literacy, language or other barriers to communication and fears or misperceptions about the health care system" and support "the development of quality measures and resources to help reduce disparities."[29] And Opinion 11.2.7, "Responsibilities to Promote Equitable Care," states that physicians should "Identify institutional policies and practices that perpetuate or create barriers to equitable care" and "Participate in designing and supporting well-considered strategies for change to ensure equitable care for all."[30]

Viewed collectively, these policies reveal a commitment to supporting health equity, patient-centered care, and quality research, and provide a foundation for further policy development aimed at reducing the underrepresentation and exclusion of certain groups from clinical research.

## CONCLUSION

While Resolution 007-I-24, "Supporting Diversity in Research," focused specifically on the need to increase representation of LEP individuals and deaf and hard of hearing people in clinical research, this report has examined the importance of supporting diversity in research for all underrepresented and excluded populations. Lack of participant diversity in research is an urgent problem that needs to be addressed. It is critical, for example, that the clinical researchers examine how various populations are defined and how these definitions impact who is included or excluded.[6] It is important to note, however, that barriers and solutions will vary by topic or field of study, the population, intervention, and the trial setting, such that local approaches will likely be more successful than one-size-fits-all practices.[5] For example, eligibility criteria should only be as strict as is medically and ethically necessary, and categorical exclusions should be avoided in favor of

criteria that can be objectively assessed on an individual basis.[3] While strategies for promoting inclusion should not be overburdensome to the point of limiting the feasibility of carrying out research, improving diversity in clinical research is an ethical and scientific imperative that will lead to improved generalizability and health equity.[4,8]

Achieving greater representation in research will require a multifaced approach. Community engagement, decentralization of research sites, and use of digital tools can all enhance the accessibility of clinical research, and improving representation among investigators and clinical research staff may translate to improved recruitment and retention of underrepresented groups.[4] Gross et al. state, "It is imperative that industry sponsors and academic investigators embrace diversity in research and development to address the variability of individual patients treated"—highlighting the importance of centering representation at every stage of the research program.[14] True reform will require greater outreach to communities, targeted recruitment strategies, improved IRB and regulatory oversight, and stronger federal regulations and guidelines. As Hwang and Brawley acknowledge, "new diversity provisions [by the House of Representatives] do not fully resolve the underlying causes of a lack of representativeness in clinical trials, which include restrictive eligibility criteria, costs associated with participation, limited enrollment outreach in marginalized racial and ethnic communities and in safety-net facilities, implicit English-language requirements, and systemic inequities in access to care."[31] Addressing these systemic barriers will require a concerted effort and commitment by all stakeholders involved in clinical research.

RECOMMENDATIONS

The Board of Trustees recommends that the following be adopted in lieu of Resolution 007-I-24 and the remainder of this report be filed:

1. That our American Medical Association support the use of language interpreters and translators, at a cost not to be funded by the physician, in clinical trials and health research participation to promote equitable data collection and outcomes. (New HOD Policy)

2. That our AMA encourage Institutional and Research Review Boards (IRBs) to develop and publish standardized guidelines for interpreter services to ensure appropriate enrollment and ongoing participation of clinical research participants with Limited English Proficiency and Deaf or Hard of Hearing people. (New HOD Policy)

3. That our AMA encourage Institutional and Research Review Boards (IRBs) to develop and publish transparent guidelines for improving the diversity of research participants, including (1) that eligibility criteria be as inclusive as possible, (2) that written justification for exclusion be provided for review, and (3) that additional accommodations for potential enrollees be considered. (New HOD Policy)

4. That our AMA support greater inclusion in clinical trials and health research of all peoples and groups that are underrepresented or excluded from such research to promote greater study generalization, health equity, and justice. (New HOD Policy)

5. That our AMA support community-centered engagement before, during, and after clinical trials and health research to foster and sustain public trust in medicine and science. (New HOD Policy)

6. That our AMA encourage that all study protocols involving human research participants include appropriate funding to support the inclusion of underrepresented and excluded populations. (New HOD Policy)

Fiscal Note: Minimal – less than $500

REFERENCES


1. Shea L, Pesa J, Geonnotti G, Powell V, Kahn C, Peters W. Improving diversity in study participation: Patient perspectives on barriers, racial differences and the role of communities. *Health Expect*. 2022;25(4):1979-1987. doi:10.1111/hex.13554.
2. Bibbins-Domingo K, Helman A, Dzau VJ. The Imperative for Diversity and Inclusion in Clinical Trials and Health Research Participation. *JAMA*. 2022;327(23):2283. doi:10.1001/jama.2022.9083.
3. DeCormier Plosky W, Ne'eman A, Silverman BC, et al. Excluding People With Disabilities From Clinical Research: Eligibility Criteria Lack Clarity And Justification: Study examines factors and practices that exclude people with disabilities from clinical research. *Health Aff (Millwood)*. 2022;41(10):1423-1432. doi:10.1377/hlthaff.2022.00520.
4. Kelsey MD, Patrick-Lake B, Abdulai R, et al. Inclusion and diversity in clinical trials: Actionable steps to drive lasting change. *Contemp Clin Trials*. 2022;116:106740. doi:10.1016/j.cct.2022.106740.
5. Collister D, Song C, Ruzycki SM. Fostering diversity in clinical trials: need for evidence and implementation to improve representation. *BMJ Med*. 2024;3(1):e000984. doi:10.1136/bmjmed-2024-000984.
6. Committee on Improving the Representation of Women and Underrepresented Minorities in Clinical Trials and Research, Committee on Women in Science, Engineering, and Medicine, Policy and Global Affairs, National Academies of Sciences, Engineering, and Medicine. *Improving Representation in Clinical Trials and Research: Building Research Equity for Women and Underrepresented Groups*. (Bibbins-Domingo K, Helman A, eds.). National Academies Press; 2022:26479. doi:10.17226/26479.
7. Schwartz AL, Alsan M, Morris AA, Halpern SD. Why Diverse Clinical Trial Participation Matters. *N Engl J Med*. 2023;388(14):1252-1254. doi:10.1056/NEJMp2215609
8. Willis A, Isaacs T, Khunti K. Improving diversity in research and trial participation: the challenges of language. *Lancet Public Health*. 2021;6(7):e445-e446. doi:10.1016/S2468-2667(21)00100-6.
9. U.S. Food and Drug Administration. Enhancing Clinical Study Diversity Report. Published online 2024. https://ctti-clinicaltrials.org/wp-content/uploads/2024/06/FDORA-enhancing-clincal-study-diversity-workshop-report.pdf.
10. Sen. Kennedy EM [D M. S.1 - 103rd Congress (1993-1994): National Institutes of Health Revitalization Act of 1993. June 10, 1993. Accessed March 29, 2025. https://www.congress.gov/bill/103rd-congress/senate-bill/1.
11. NOT-OD-18-116: Revision: NIH Policy and Guidelines on the Inclusion of Individuals Across the Lifespan as Participants in Research Involving Human Subjects. Accessed March 29, 2025. https://grants.nih.gov/grants/guide/notice-files/NOT-OD-18-116.html.
12. 45 CFR 46.116 -- General requirements for informed consent. Accessed March 29, 2025. https://www.ecfr.gov/current/title-45/part-46/section-46.116.
13. Protections (OHRP) O for HR. Informed Consent of Subjects Who Do Not Speak English (1995). November 30, 2010. Accessed March 29, 2025. https://www.hhs.gov/ohrp/regulations-and-policy/guidance/obtaining-and-documenting-infomed-consent-non-english-speakers/index.html.
14. Gross AS, Harry AC, Clifton CS, Della Pasqua O. Clinical trial diversity: An opportunity for improved insight into the determinants of variability in drug response. *Br J Clin Pharmacol*. 2022;88(6):2700-2717. doi:10.1111/bcp.15242.
15. Jones CW, Resnik DB. Research Subjects with Limited English Proficiency: Ethical and Legal Issues. *Account Res*. 2006;13(2):157-177. doi:10.1080/08989620600654043.

16. Ending Radical And Wasteful Government DEI Programs And Preferencing. The White House. January 21, 2025. Accessed March 29, 2025. https://www.whitehouse.gov/presidential-actions/2025/01/ending-radical-and-wasteful-government-dei-programs-and-preferencing/.
17. Initial Rescissions Of Harmful Executive Orders And Actions. The White House. January 20, 2025. Accessed March 29, 2025. https://www.whitehouse.gov/presidential-actions/2025/01/initial-rescissions-of-harmful-executive-orders-and-actions/.
18. Muthukumar AV, Morrell W, Bierer BE. Evaluating the frequency of English language requirements in clinical trial eligibility criteria: A systematic analysis using ClinicalTrials.gov. Kruk ME, ed. *PLOS Med*. 2021;18(9):e1003758. doi:10.1371/journal.pmed.1003758.
19. Squires A, Sadarangani T, Jones S. Strategies for overcoming language barriers in research. *J Adv Nurs*. 2020;76(2):706-714. doi:10.1111/jan.14007.
20. Lion KC, Lin YH, Kim T. Artificial Intelligence for Language Translation: The Equity Is in the Details. *JAMA*. 2024;332(17):1427. doi:10.1001/jama.2024.15296.
21. Bakdash L, Abid A, Gourisankar A, Henry TL. Chatting Beyond ChatGPT: Advancing Equity Through AI-Driven Language Interpretation. *J Gen Intern Med*. 2024;39(3):492-495. doi:10.1007/s11606-023-08497-6.
22. How Should Representation of Subjects With LEP Become More Equitable in Clinical Trials? *AMA J Ethics*. 2022;24(4):E319-325. doi:10.1001/amajethics.2022.319.
23. H-525.988 Sex and Gender Differences in Medical Research | AMA. Accessed March 29, 2025. https://policysearch.ama-assn.org/policyfinder/detail/diversity%20in%20research?uri=%2FAMADoc%2FHOD.xml-0-4724.xml.
24. H-460.881 Increasing Diversity in Stem Cell Biobanks and Diseas | AMA. Accessed March 29, 2025. https://policysearch.ama-assn.org/policyfinder/detail/diversity?uri=%2FAMADoc%2FHOD.xml-H-460.881.xml.
25. H-160.924 Use of Language Interpreters in the Context of the Pa | AMA. Accessed March 29, 2025. https://policysearch.ama-assn.org/policyfinder/detail/limited%20english?uri=%2FAMADoc%2FHOD.xml-0-739.xml.
26. H-180.944 Plan for Continued Progress Toward Health Equity | AMA. Accessed March 29, 2025. https://policysearch.ama-assn.org/policyfinder/detail/diversity%20research?uri=%2FAMADoc%2FHOD.xml-H-180.944.xml.
27. Physician Involvement in Research | AMA-Code. Accessed March 29, 2025. https://code-medical-ethics.ama-assn.org/ethics-opinions/physician-involvement-research.
28. Informed Consent in Research | AMA-Code. Accessed March 29, 2025. https://code-medical-ethics.ama-assn.org/ethics-opinions/informed-consent-research.
29. Disparities in Health Care | AMA-Code. Accessed March 29, 2025. https://code-medical-ethics.ama-assn.org/ethics-opinions/disparities-health-care.
30. Responsibilities to Promote Equitable Care | AMA-Code. Accessed March 29, 2025. https://code-medical-ethics.ama-assn.org/ethics-opinions/responsibilities-promote-equitable-care.
31. Hwang TJ, Brawley OW. New Federal Incentives for Diversity in Clinical Trials. *N Engl J Med*. 2022;387(15):1347-1349. doi:10.1056/NEJMp2209043.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 19-I-25

Subject: Addressing the Historical Injustices of Anatomical Specimen Use

Presented by: David H. Aizuss, MD, Chair

Referred to: Reference Committee on Ethics and Bylaws

---

Resolution 017, "Addressing the Historical Injustices of Anatomical Specimen Use," was adopted at the 2024 Annual Meeting by the House of Delegates (HOD) and codified as H-140.820.[1] This report responds to a directive in section 6 of H-140.820 which asks our AMA to:

> Study and develop recommendations regarding regulations for ethical body donations including, but not limited to, guidelines for informed and presumed consent; care and use of cadavers, body parts, and tissue.

BACKGROUND

In the wake of the recent Harvard anatomical donation scandal, in which the school's former morgue manager was allegedly stealing and selling human body parts, concerns surrounding cadaveric donation policies have come under renewed scrutiny.[2,3] The history in the U.S. regarding procurement of bodies for dissection and educational purposes has included grave robbing,[4] the looting of native burial grounds,[5] and the use of bodies without consent.[6] Presently, several of America's most prestigious museums, including those at Harvard University, the University of California-Berkeley, and the Field Museum in Chicago, still claim stolen human remains, igniting fierce debate, criticism, and calls for their return.[6] Additionally, several U.S. states—including Ohio, Oregon, and Texas—allow medical education on "bodies without informed consent" that remain unclaimed and 12.4 percent of U.S. medical schools self-report using unclaimed bodies.[7] The use of bodies as anatomical specimens without informed consent raises questions about the ethics of body donation and anatomical specimen procurement and use.

DISCUSSION

Despite the historic injustices surrounding how bodies have been procured, there has not been any standardized policy guiding the ethical donation of human bodies and anatomical specimens. Due to the recent scrutiny related to a lack of ethical body and anatomical specimen donation policies, the American Association for Anatomy (AAA) assembled a task force of experts to determine best practices and develop standards for body donation.[8] The task force developed foundational and aspirational recommendations which they published as "Human body donation programs best practices and recommended standards: A task force report from the American Association for Anatomy".

The task force report grounds their best practices and foundational recommendations on informed consent as the fundamental ethical tenet underlying body donation.[8] Importantly, the report calls for body donation policies to include a mandatory standard for informed consent as a matter of justice and to not use the bodies of unclaimed individuals, despite what individual state laws may

© 2025 American Medical Association. All rights reserved.

allow. Additionally, the task force identified core operational practices to be implemented with mechanisms for oversight that are pertinent for ensuring an ethical body donation policy. Core operational practices include the following:

1. *Outreach*: This covers all communications with body donors and their families, beginning with the initial engagement to request donations. Ethical outreach is premised on transparency and accountability, free from any form of coercion or enticement.

2. *Registration*: A registration process is imperative for ensuring accurate and transparent informed consent during the body donation decision process. Pertinent information which should be conveyed during the registration process includes any disposition and distribution of bodies or body parts, including the locations, possible uses of the body or body parts (i.e. military, education, forensic, etc.), and financial aspects of body donation. Additionally, the registration process should outline the body donor eligibility and suitability criteria.

3. *Custody*: A transparent custody process is imperative for ensuring the ethical stewardship and management of the body entrusted to the end user (e.g. researchers, educators, clinicians).

4. *Tracking*: A tracking system should be put in place to ensure proper governance, oversight, and infrastructure (including registration and informed consent) during the use of donated bodies. Tracking systems should include a mechanism for monitoring body donation policies and procedures and a reporting mechanism for violations of these policies.

5. *Use*: Bodies should be used in a respectful, dignified, and ethical manner for education and research purposes.

6. *Disposition*: Final disposition of the body should be made in accordance with the wishes of the donor and their families.

7. *Memorialization*: A respectful memorial ceremony for the family in which the body donor is honored for their "altruism and commitment to education and research" should be held at the conclusion of the use of the body as well as governing oversight of the body donation policies.

To ensure that these core operational procedures are upheld, the task force calls for policy setting, dissemination, and training on the implementation of these guidelines. Additionally, the AAA conceives this guidance to be a "living document intended to be periodically modified and updated as the ethos and legislation of body donation evolve."[8] The AAA guidelines are intended to ensure transparency and accountability during every aspect of the body donation process from solicitation for use of bodies to the respectful disposition and memorial at the conclusion of use. The AAA guidelines were approved by the AAA's board of directors in 2024.

CONCLUSION

In response to the need for standardized policy guiding the ethical donation of human bodies and anatomical specimens the AAA recently published "Human body donation programs best practices and recommended standards: A task force report from the American Association for Anatomy". The AAA guidance is grounded in key ethical principles, including privacy, respect, justice, and

non-maleficence and is thoughtful, well-researched, and comprehensively addresses the issue by experts in the field.

RECOMMENDATIONS

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

1. Our AMA supports the guidelines set forth by the American Association for Anatomy's 2024 best practices and recommended standards for human body donation programs. (New HOD Policy)

2. That section 6 of H-140.820 be rescinded as having been accomplished by this report

Fiscal Note: Minimal – less than $500

REFERENCES


1. "H-140.820 Addressing the Historical Injustices of Anatomical Specimen Use | AMA," accessed June 18, 2025, https://policysearch.ama-assn.org/policyfinder/detail/h-140.820?uri=%2FAMADoc%2FHOD.xml-H-140.820.xml.
2. Li DK, Harvard morgue theft ring stole body parts, sold brains, turned human flesh into leather, officials say. *NBC News*. June 14, 2023. Available at:https://www.nbcnews.com/news/us-news/4-charged-stealing-selling-human-body-parts-harvard-medical-school-mor-rcna89357.
3. Stelloh T. Harvard human remains case highlights need for body donation regulations, experts say. *NBC News*. June 21, 2023. Available at: https://www.nbcnews.com/news/us-news/harvard-human-remains-case-highlights-need-body-donation-regulations-e-rcna90524
4. Comer A. The evolving ethics of anatomy: Dissecting an unethical past in order to prepare for a future of ethical anatomical practice. *Anat Rec*. 2022;305:818–826.
5. Meier AC. Grave Robbing, Black Cemeteries, and the American Medical School . *JSTOR Daily*. Published: August 24, 2018. Available at: https://daily.jstor.org/grave-robbing-black-cemeteries-and-the-american-medical-school/.
6. Jaffe, L., Hudetz, M., Ngu, A., & Brewer, G. L. America's biggest museums fail to return Native American human remains. ProPublica. Published: January 11, 2023. Available at: https://www.propublica.org/article/repatriation-nagpra-museums-human-remains.
7. AMA - Issue Brief. Ethics of unclaimed bodies in cadaveric dissection in medical education. *American Medical Association*. Published; May 2024. Available at: https://www.ama-assn.org/system/files/issue-brief-unclaimed-bodies-medical-education.pdf.
8. Balta J. Champney TH, et. al. Human body donation programs best practices and recommended standards: A task force report from the American Association for Anatomy. *Anat Sci Educ.* 2025;18:8–26.

REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 1-1-25

Subject: Bylaws Review Report

Presented by: Jerry P. Abraham, MD, MPH, Chair

Referred to: Reference Committee on Ethics and Bylaws

---

At the 2025 Annual Meeting, the House of Delegates referred CCB Report 1-A-25, Bylaws Review Report, back to the Council. CCB Report 1 proposed bylaw amendments related to inconsistent, incomplete or inaccurate bylaw provisions, most notably those associated with the filling of vacancies. Online and in-person reference committee testimony was supportive of changes other than those that focused on the Board's role vis-à-vis that of the Medical Student Section (MSS) when appointing student members to American Medical Association (AMA) Councils and in filling a vacancy in the Medical Student Trustee position.

The MSS testified that it was not opposed to language requiring its governing council to submit two or more nominees for each Council position as the section's practice was to submit multiple nominees for each position. However, the testimony opposed new language paralleling existing language governing the filling of the Medical Student Trustee vacancy which explicitly stated the Board could request additional nominations. Lastly, the MSS supported deletion of that long-existing language codifying the Board's prerogative to request additional nominations from the MSS Governing Council before appointing a Medical Student Trustee to fill the vacancy.

The Council committed to better understanding why existing bylaw language related to a student trustee vacancy and its proposed changes to the student councilor appointment process was problematic. In doing so, it looked at the history of the medical student trustee position as well as the current and historical processes used by the MSS and the Board to appoint student members of the AMA Councils. It also looked at the Board's Standing Rules, which provide specificity regarding the Board's processes in making all appointments.

BACKGROUND

The Medical Student Trustee position came into existence as a result of BOT Report W-A-83 in which the Board proposed to create a "slotted" seat for a medical student on the Board. This recommendation followed years of inviting a medical student to attend Board meetings as a guest, with a later policy of formally inviting the guest medical student to contribute to the Board deliberations. BOT Report W-A-83 noted that "students traditionally were afforded a separate participation status due to their limited time in a student membership category" and thus the Board proposed a mechanism comparable to how student members of the AMA Councils were then selected -- whereby the MSS provided two or more nominations to the Board, who would then select and confirm one of the candidates. [Earlier processes for student members of councils entailed House election of nonvoting medical student members of some but not all AMA Councils from among medical student candidates presented by the Board of Trustees from among nominations submitted by the MSS; however, by 1983, the House was no longer involved in selecting the medical student councilors]. The House adopted the Board proposal that the medical

© 2025 American Medical Association. All rights reserved.

student trustee position be created as a nonvoting position similar to student council positions whereby the Board vets the MSS-submitted student nominees.

As the creation of a student trustee position required a change to the AMA Constitution as well as Bylaws, the House acted on the bylaws via CCB-A-I-83. The Bylaw language addressed the appointment of the student trustee from among nominations submitted by the MSS Governing Council as well as filling a student trustee vacancy from among two or more nominations similarly submitted by the MSS. In both cases, the House adopted bylaw language that enabled the Board to request additional nominations.

Nearly a decade later, the MSS submitted a resolution proposing that the MSS directly elect the student trustee. BOT L-I-91, Medical Student Trustee Selection Process, addressed the referred resolution but also provided a historical background on the student nomination process. While the 1983 Bylaws specified two or more nominations from the MSS governing council, in practice student applicants were solicited from among the MSS membership. The MSS Assembly then elected three nominees, the Governing Council forwarded those three names to the Board, and then the Board selected a student for appointment. For the first five years, the MSS ranked the nominees, with the Board consistently selecting the first ranked student. Beginning in 1990 the Board requested that candidates be unranked and in 1991 recommended that the MSS directly elect the nonvoting student trustee. BOT Report L-I-91 also noted that "Since the House of Delegates does not elect the student trustee, it is important for the Board to continue to play a role in selection of the student trustee as it does in the selection of student representatives to most AMA Councils." In separate action in 1991, the student trustee was also given voting privileges on policy-making matters, and the House adopted the requisite constitutional and bylaws changes in 1992.

DISCUSSION

While CCB Report 1-A-25 came about as part of the Council's ongoing responsibility to ensure clear and consistent Bylaws, the Council learned that the Board itself had been looking at the current student appointment process with an eye toward making improvements to increase the candidate pool. In 2025, a Board-appointed subcommittee articulated its concern about how the MSS Governing Council often selected students who have already served in an MSS leadership role for additional leadership positions on AMA councils and committees. The Board then was compelled to vote for a specific candidate as most but not all ranked nominees were recommended for multiple positions due to the MSS application process that allowed students to rank their choice of three councils rather than apply for just one. In follow-up, the Board asked the MSS to implement changes such that student candidates would apply for a single position only to ensure that the Board would receive a greater variety of applicants. The goal was to have MSS provide at least two candidates per position with diverse candidates representing students in their early years of medical school, students from traditional four-year programs and students from programs of longer duration that often culminated in multiple degrees.

After the House referred CCB Report 1-A-25 back to the Council, the Council confirmed with the Board its support of the Council's recommendations to require two or more nominations for any student council positions. The Council also confirmed the Board's prerogative to request additional nominations for any appointed position should be referenced in the Bylaws with respect to student positions, as those student positions are the only positions referenced in the Bylaws where nominees come from a single source.

Throughout its discussions, the Council acknowledged that the student trustee and the student council members are managed differently than all other AMA leadership positions. Whereas the House elects every other trustee position, the MSS itself elects the medical student trustee with no House involvement. In electing the trustees for the other two Board seats that exist for special time-limited membership segments -- the Resident and Fellow Trustee and the Young Physician Trustee -- the House elects from among candidates that may be nominated by the Federation. In 2024, the House defeated a proposal that would have allowed the RFS to elect the Resident and Fellow Trustee in similar fashion to how the MSS elects the Medical Student Trustee. The Council also noted that while all three time-limited trustee positions were created to give voice to a specific time-limited membership segments, those trustees indeed represent all physicians and medical students.

In further reviewing the Board's Standing Rules, the Council examined the role of the Awards and Nominations Committee, the body that advises the Board on all awards and nominations. Awards and Nominations present a recommendation from the list of nominees for each vacancy, with the Board voting on the nominations. The Standing Rules state that when a single nominee remains after the nominations have been declared closed, the Board may accept or reject said nominee for appointment, and when rejecting a nominee, the Committee then is tasked with presenting additional nominees for the position. The Council concluded that since the Board confirms nominees for any vacancy that occurs with the Medical Student Trustee position, student positions on all councils and any ensuing vacancies, these positions are under the purview of the Awards and Nominations Committees, which manages these as appointed positions. The Council, in resubmitting its bylaw language to acknowledge the Board's prerogative of being able to request additional nominees, emphasizes this is not unique to MSS positions as it applies to any Board-appointed positions. However, while not unique, the Council believes the language should be included in the Bylaws as the Board's role with these positions is indeed unique as contrasted with all other positions cited in the AMA Bylaws. The hope is that the Board's suggestions to the MSS about ways to modify its application process and to expand the applicant pool will allow for more diverse candidates and culminate in a new process that obviates the need to ever ask the MSS to submit additional nominations.

RECOMMENDATIONS

The Council on Constitution and Bylaws recommends that the following amendments (highlighted in RED) to the Bylaws be adopted, and that the remainder of the report be filed. Adoption requires the affirmative vote of two-thirds of the members of the House of Delegates present and voting following a one-day layover.

**3--Officers**

***

**3.6 Vacancies.**

**3.6.1 Appointment.** The Board of Trustees may, by appointment, fill any vacancy in the office of Speaker, Vice Speaker or Trustee, except the public trustee, to serve until the next meeting of the House of Delegates. A vacancy in the office of medical student trustee ~~shall~~ may be filled by appointment by the Board of Trustees from a minimum of two ~~2 or more nominations~~ nominees submitted ~~provided~~ by the Medical Student Section Governing Council. The Board of Trustees may request additional nominations from the Medical Student Section Governing Council before making the appointment.

## 6--Councils

***

**6.6 Council on Long Range Planning and Development.**

**6.6.2 Membership.**

**6.6.2.1** Ten active members of the AMA. Five members shall be appointed by the Speaker of the House of Delegates as follows: Two members shall be appointed from the membership of the House of Delegates, ~~2~~ two members shall be appointed from the membership of the House of Delegates or from the AMA membership at-large, and one member appointed shall be a resident/fellow physician. Four members shall be appointed by the Board of Trustees from the membership of the House of Delegates or from the AMA membership at-large. One member ~~appointed~~ shall be a medical student member appointed by the Board of Trustees from a minimum of two nominees submitted by the Medical Student Section Governing Council ~~of the Medical Student Section with the concurrence of the Board of Trustees~~. The Board of Trustees may request additional nominations from the Medical Student Section Governing Council before making the appointment.

**6.6.5 Vacancies.**

**6.6.5.1 Members Other than the Resident/Fellow Physician and Medical Student Member.** Any vacancy among the members of the Council other than the resident/fellow physician member and the medical student member shall be filled by appointment by either the Speaker of the House of Delegates or by the Board of Trustees as provided in Bylaw 6.6.2. The new member shall be appointed for a 4four-year term.

**6.6.5.2 Resident/Fellow Physician Member.** If the resident/fellow physician member of the Council ceases to complete the term for which appointed, the remainder of the term shall be deemed to have expired. The successor shall be appointed by the Speaker of the House of Delegates for a ~~2~~two-year term.

**6.6.5.3 Medical Student Member.** If the medical student member of the Council ceases to complete the term for which appointed, the Board of Trustees may appoint a successor to fill the remainder of the unexpired term from a minimum of two nominees submitted by the Medical Student Section Governing Council. The Board of Trustees may request additional nominations from the Medical Student Section Governing Council before making the appointment.

**6.7 Council on Legislation.**

**6.7.2 Membership.**

**6.7.2.1** Twelve active members of the AMA, one of whom shall be a resident/fellow physician, and one of whom shall be a medical student.

These members of the Council shall be appointed by the Board of Trustees. The medical student member shall be appointed by the Board of Trustees from a minimum of two nominees ~~nominations~~ submitted by the Medical Student Section Governing Council. The Board of Trustees may request additional nominations from the Medical Student Section Governing Council before making the appointment.

**6.7.3 Term.**

**6.7.3.1** Members of the Council on Legislation shall be appointed for terms of one year, beginning at the conclusion of the Annual Meeting. Except as provided in Bylaw 6.11, if the resident/fellow physician member ceases to be a resident/fellow physician at any time prior to the expiration of the term for which appointed, the service of such resident/fellow physician member on the Council shall thereupon terminate, and the position shall be declared vacant. Except as provided in Bylaw 6.11, if the medical student member ceases to be enrolled in an educational program the service of such medical student member on the Council shall thereupon terminate, and the position shall be declared vacant.

***

**6.7.5** Vacancies. Any vacancy, with the exception of a vacancy in the medical student position, occurring on the Council ~~shall~~ may be filled for the remainder of the unexpired term at the next meeting of the Board of Trustees. Completion of an unexpired term shall not count toward maximum tenure on the Council.

6.7.5.1 Medical Student Member. If the medical student member ceases to complete the term for which appointed, the Board may appoint a medical student member from a minimum of two nominees submitted by the Medical Student Section Governing Council to fill the remainder of the one-year term. The Board of Trustees may request additional nominations from the Medical Student Section Governing Council before making the appointment.

**6.8 Election - Council on Constitution and Bylaws, Council on Medical Education, Council on Medical Service, and Council on Science and Public Health.**

**6.8.1 Nomination and Election.** Members of these Councils, except the medical student member, shall be elected by the House of Delegates. The Chair of the Board of Trustees will present announced candidates, who shall be entered into nomination by the Speaker at the opening session of the meeting at which elections take place. Nominations may also be made from the floor by a member of the House of Delegates at the opening session of the meeting at which elections take place.

**6.8.2 Medical Student Member.** Medical student members of these Councils shall be appointed by the Board of Trustees from a minimum of two nominees submitted by the Medical Student Section Governing Council ~~of the Medical Student Section with the concurrence of the Board of Trustees~~. The Board of Trustees may request additional nominations from the Medical Student Section Governing Council before making the appointments.

**6.9 Term and Tenure - Council on Constitution and Bylaws, Council on Medical Education, Council on Medical Service, and Council on Science and Public Health.**

**6.9.1 Term.**

**6.9.1.3 Medical Student Member.** The medical student member of these Councils shall be appointed for a term of one year. Except as provided in Bylaw 6.11, if the medical student member ceases to be enrolled in an educational program at any time prior to the expiration of the term for which elected, the service of such medical student member on the Council shall thereupon terminate, and the position shall be declared vacant.

**6.9.2 Tenure.** Members of these Councils may serve no more than ~~8~~eight years. The limitation on tenure shall take priority over a term length for which the member was elected. Medical student members who are appointed shall assume office at the close of the Annual Meeting with the exception of a medical student who is appointed to fill a vacancy.

**6.9.3 Vacancies.**

**6.9.3.1 Members other than the Resident/Fellow Physician and Medical Student Member.** Any vacancy among the members of these Councils other than the resident/fellow physician and medical student member shall be filled at the next Annual Meeting of the House of Delegates. The successor shall be elected by the House of Delegates for a 4four-year term.

**6.9.3.2 Resident/Fellow Physician Member.** If the resident/fellow physician member of these Councils cease~~s~~ to complete the term for which elected, the remainder of the term shall be deemed to have expired. The successor shall be elected by the House of Delegates for a ~~2~~two-year term.

**6.9.3.3 Medical Student Member.** If the medical student member of these Councils ceases to complete the term for which appointed, the Board may appoint a medical student member from a minimum of two nominees submitted by the Medical Student Section Governing Council to fill the remainder of the one-year term. The Board of Trustees may request additional nominations from the Medical Student Section Governing Council before making the appointment.

**6.11 Term of Resident/Fellow Physician or Medical Student Member.** A resident/fellow physician member of a Council who completes residency or fellowship within 90 days prior to an Annual Meeting shall be permitted to serve on the Council until the completion of the Annual Meeting. A medical student member of a Council who graduates from an educational program during their term shall be permitted to serve on the Council for up to 200 days after graduation but not extending past the completion of the Annual Meeting following graduation. Service on a Council as a resident/fellow physician and/or medical student member shall not be counted in determining maximum Council tenure.

(Modify Bylaws)

REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 2-I-25

Subject: Bylaws Clarifications Subsequent to A-25 House of Delegates Meeting

Presented by: Jerry P. Abraham, MD, MPH, Chair

Referred to: Reference Committee on Ethics and Bylaws

---

At the 2025 Annual Meeting, the House of Delegates adopted CCB Report 3, Clarifying Bylaw Language, which recommended changes to the American Medical Association (AMA) Bylaws that streamlined AMA's membership categories to be: Active Members, Honorary Members, International Members and Affiliate Members. Previously, Active Membership included two distinct categories -- Active Constituent Members (those who paid their dues through their constituent association) and Active Direct Members (those who remitted their dues directly to the AMA). It was brought to the Council's attention that the definition of Active Member should more clearly reflect that the AMA Active Member category was open only to international medical graduates who worked or lived in the United States.

Also, at the 2025 Annual Meeting, several HOD members sought a bylaw interpretation from the Council on Ethical and Judicial Affairs (CEJA) with respect to Bylaw 5.3.9, and questioned whether the HOD had the authority to constitute an advisory committee, or whether that was a privilege of the Board. CEJA's interpretation opined that based on other bylaw language about the fiduciary role and authority of the Board in implementing HOD policy as well as historical precedence associated with other advisory committees that it was the Board's responsibility to not only appoint members to these committees (as detailed in Bylaw 5.3.9) but also to constitute them. The Council and CEJA agreed that the existing Bylaw language should be clarified.

The Council has proposed bylaw amendments to ensure clarity and accuracy.

RECOMMENDATIONS

The Council on Constitution and Bylaws recommends that the following amendments (highlighted in RED) to the Bylaws be adopted, and that the remainder of the report be filed. Adoption requires the affirmative vote of two-thirds of the members of the House of Delegates present and voting following a one-day layover.

**1--Membership**

**1.1 Categories.**

Categories of membership in the American Medical Association (AMA) are: Active Members, Affiliate Members, Honorary Members, and International Members.

© 2025 American Medical Association. All rights reserved.

**1.1.1 Active Members.**

**1.1.1.1** Active Members. Active members must meet one of the following requirements:

a. Possess the United States degree of doctor of medicine (MD) or doctor of osteopathic medicine (DO)~~, or a recognized international equivalent~~;

b. Work or reside in the United States and possess a recognized international medical degree equivalent to the United States MD or DO; or

~~b~~. c. Are medical students in educational programs provided by a college of medicine or osteopathic medicine accredited by the Liaison Committee on Medical Education or the Commission on Osteopathic College Accreditation leading to the MD or DO degree. This includes those students who are on an approved sabbatical, provided that the student will be in good standing upon returning from the sabbatical.

**1.1.4 International Members.**

Physicians who have graduated from medical schools located outside the United States and its territories and are ineligible to be Active Members and who can fulfill and document the following requirements:

a. Graduation from a medical school listed in the World Health Organization Directory.

b. Possession of a valid license in good standing in the country of graduation or practice location documented by one of the following:

(i) verification that the applicant is an international member of a national medical specialty society seated in the House of Delegates that has a procedure to verify the applicant's educational credentials;

(ii) certification from the national medical association in the country of practice attesting to the applicant's valid authorization to practice medicine without limitation; or

(iii) certification from the registry or licensing authority of the country of practice attesting to the applicant's valid license in good standing.

**5—Board of Trustees**

***

**5.3 Duties and Privileges.** In addition to the rights and duties conferred or imposed upon the Board of Trustees by law and custom and elsewhere in the Constitution and Bylaws, the Board of Trustees shall:

**5.3.1 Management.** Manage or direct the management of the property and conduct the affairs, work and activities of the AMA consistent with the policy actions and directives adopted by the House of Delegates, except as may be otherwise provided in the Constitution or these Bylaws.

**5.3.1.1** The Board is the principal governing body of the AMA and it exercises broad oversight and guidance for the AMA with respect to the management systems and risk management program of the AMA through its oversight of the AMA's Executive Vice President.

**5.3.1.2** Board of Trustees actions should be based on policies and directives approved by the House of Delegates. In the absence of specifically applicable House policies or directives and to the extent feasible, the Board shall determine AMA positions based on the tenor of past policy and other actions that may be related in subject matter.

***

**5.3.3 Fulfillment of House of Delegates Charge.** Review all resolutions and recommendations adopted by the House of Delegates to determine how to fulfill the charge from the House. Resolutions and recommendations pertaining to the expenditure of funds also shall be reviewed. If it is decided that the expenditure is inadvisable, the Board shall report, at its earliest convenience, to the House the reasons for its decisions.

**5.3.3.1** In determining expenditure advisability, the Board will consider the scope of the proposed expenditure and whether it is consistent with the AMA's vision, goals, and priorities. Where the Board recommends that a proposed expenditure is not prudent and is inadvisable, the Board will present alternative actions, if feasible, in its report to the House.

***

**5.3.9 Establishment and Appointment of Committees.** Establish ~~Appoint such~~ committees ~~as~~ necessary to carry out the purposes of the AMA and appoint committee membership.

**5.3.9.1** An advisory committee will be constituted for purposes of education and advocacy.

/

**5.3.9.1.1** It will have a governing council and a direct reporting relationship to the Board.

**5.3.9.1.2** An advisory committee will not have representation in the House of Delegates.

**5.3.9.1.3** An advisory committee will operate under a charter that will be subject to review and renewal by the Board at least every four years.

**5.3.9.2** An ad hoc committee will be constituted as a special committee, workgroup or taskforce.

**5.3.9.2.1** It will operate for a specific purpose and for a prescribed period of time.

REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 3-I-25

Subject: Credentialing of Temporary Delegates and Alternate Delegates

Presented by: Jerry P. Abraham, MD, MPH, Chair

Referred to: Reference Committee on Ethics and Bylaws

---

Over the years, the Office of the House of Delegates Affairs, the Speakers and members of the House of Delegates (HOD) have been confused about several existing Bylaws that focus on the credentialing of delegates and alternate delegates, especially when a temporary replacement is needed when the original credentialed delegate or alternate is unable to attend a meeting in whole or in part. Specifically, the Speakers recently noted that they as well as delegations experienced difficulties at A-25 trying to follow existing Bylaws 2.10.4 and 2.10.4.1 and expressed strong support for a single designation to identify those delegates and alternate delegates who were taking the place of a previously credentialed delegate or alternate delegate for all or the remainder of the meeting.

The Council, whose members include the Speakers, looked at the Bylaws and agreed that the terms temporary delegate or temporary alternate delegate were better terms to characterize individuals who were taking the place of another individual who had been credentialed by their society at least 45-days in advance of a HOD meeting. For credentialing purposes, all individuals whose names and contact information were submitted by the 45-day deadline in advance of a meeting, even those delegates or alternate delegates who are filling vacancies for their societies, are not designated as a substitute delegate or alternate delegate and thus receive the privileges of their position.

The Council, however, in looking at these and other provisions that govern the credentialing of delegates found several outmoded and/or unnecessary provisions. Specifically, the term of a delegate or alternate delegate representing a federation entity, while currently referenced in AMA Bylaws, is established by the entity that the individual represents and not the AMA. Also, the language related to certification is outmoded when specifying how delegates and alternate delegates are credentialed. Language regarding some delegate and alternate delegate vacancies was similarly problematic. Additionally, earlier this year, the Speakers, the Council and the Resident and Fellow Section (RFS) noted a discrepancy with respect to the RFS sectional delegates and alternate delegates. Existing Bylaw 2.4.6 provided that a delegate selected to fill a vacancy shall assume office immediately after selection and serve for the remainder of the term, yet Bylaw 2.4.3 stated that delegates and alternate delegates shall be elected (not selected) by the RFS in accordance with procedures adopted by the Section.

Lastly, in keeping with the criteria by which AMA's Emergency Assistance Program funds are allocated, it is essential that the Bylaws are accurate when referencing the process by which duly credentialed members of the House are identified for each meeting as well as the process by which a vacancy is filled.

© 2025 American Medical Association. All rights reserved.

RECOMMENDATIONS

The Council on Constitution and Bylaws recommends that the following Bylaws amendments and deletions (highlighted in RED) be adopted, and that the remainder of the report be filed. Adoption requires the affirmative vote of two-thirds of the members of the House of Delegates present and voting following a one-day layover.

**2—House of Delegates**

**2.0.1 Composition and Representation**….

**2.0.1.1 Qualification of Members of the House of Delegates.** Members of the House of Delegates must be active members of the AMA and of the entity they represent.

**2.0.1.2 Rights and Privileges.** Delegates have the privilege of the floor of the House of Delegates which includes the ability to submit resolutions, discuss and make motions on items of business and vote in elections.

**2.0.1.3 Representation….**

**[subsequent sections will be renumbered accordingly]**

**2.1 Constituent Associations….**

***

**2.1.3 ~~Certification~~ Credentialing.** The president or chief executive officer of each constituent association, or ~~the president's~~ their designee, shall provide ~~certify to~~ the AMA with the names and contact information of their delegates and alternate delegates ~~from their respective associations. Certification must occur~~ at least 45 days prior to each ~~the Annual or Interim M~~meeting of the House of Delegates. These appropriately identified individuals shall be duly credentialed for that meeting only.

**2.1.4 ~~Term.~~** ~~Delegates from constituent associations shall be selected for 2-year terms and assume office on the date set by the constituent association, provided that such seats are authorized pursuant to these Bylaws. Constituent associations entitled to more than one delegate shall select them so that half the number, as near as may be, are selected each year. One-year terms may be provided but only to the extent and for such time as is necessary to accomplish this proportion.~~

**~~2.1.5 Vacancies.~~** ~~The delegate selected to fill a vacancy shall assume office immediately after selection and serve for the remainder of that term.~~

**~~2.1.6 Resident/Fellow Physician and Medical Student Delegates.~~** ~~A constituent association may designate one or more of its delegate and alternate delegate seats to be filled by a resident/fellow physician member or a medical student member.~~

**~~2.1.6.1 Term.~~** ~~Such resident/fellow physician or medical student delegate or alternate delegate shall serve for a one-year term beginning as of the~~

~~date of certification of the delegate or alternate delegate by the constituent association to the AMA.~~

~~**2.1.6.2 No Restriction on Selection.** Nothing in this bylaw shall preclude a resident/fellow physician or medical student member from being selected to fill a full 2-year term as a delegate or alternate delegate from a constituent association as provided in Bylaw 2.1.4.~~

**2.2 National Medical Specialty Societies….**

***

**2.2.3 ~~Certification~~ Credentialing.** The president or chief executive officer of each specialty society, or ~~the president's~~ their designee, shall provide ~~certify to~~ the AMA with the names and contact information of their delegates and alternate delegates ~~from their respective societies~~. ~~Certification must occur~~ at least 45 days prior to each ~~the Annual or Interim M~~meeting of the House of Delegates. These appropriately identified individuals shall be duly credentialed for that meeting only.

~~**2.2.4 Term.** Delegates from specialty societies shall be selected for 2-year terms, and shall assume office on the date set by the specialty society provided that such seats are authorized pursuant to these Bylaws. Specialty societies entitled to more than one delegate shall select them so that half the number, as near as may be, are selected each year. One-year terms may be provided but only to the extent and for such time as is necessary to accomplish this proportion.~~

~~**2.2.5 Vacancies.** The delegate selected to fill a vacancy shall assume office immediately after selection and serve for the remainder of that term.~~

**2.3 Medical Student Regional Delegates.** In addition to the delegate and alternate delegate representing the Medical Student Section, medical student regional delegates and regional alternate delegates shall be apportioned and elected as provided in this bylaw.

**2.3.1 Qualifications.** Medical student regional delegates and alternate delegates must be active medical student members of the AMA. In addition, medical student regional delegates and alternate delegates must be members of and have received written endorsement from their ~~endorsing~~ constituent association where their educational program is located. The region in which the endorsing society is located determines the student's region, and a medical student may only serve as a regional delegate, alternate delegate or a~~ny~~ temporary delegate or alternate delegate ~~form of substitute~~ (pursuant to Bylaws 2.8.5 or 2.10.4) ~~only~~ for that region.

**2.3.2 Apportionment.** The total number of ~~M~~medical ~~S~~student r~~R~~egional delegates and alternate delegates is based on one delegate and one alternate delegate for each 2,000 active medical student members of the AMA, as recorded by the AMA on December 31 of each year. Each Medical Student Region, as ~~defined by~~ delineated in the rules of the Medical Student Section, is entitled to one delegate and one alternate delegate for each 2,000 active medical student members of the AMA in an educational program located within the jurisdiction of the Medical Student Region. Any remaining ~~M~~medical ~~S~~student ~~Section~~ r~~R~~egional delegates

and alternate delegates shall be apportioned one delegate and one alternate delegate per region(s) with the greatest number of active AMA medical student members in excess of a multiple of 2,000. If two regions have the same number of active AMA medical student members, ties will be broken by lottery by the ~~MSS~~ Medical Student Section Governing Council.

**2.3.2.1 Effective Date.** In January of each year the AMA shall notify the Medical Student Section ~~Governing Council~~ Director of the number of seats in the House of Delegates to which each Medical Student Region is entitled. Such apportionment shall take effect on January 1 of the following year and shall remain effective for one year.

**2.3.3 Election.** Medical student regional delegates and alternates shall be elected by the Medical Student Section in accordance with procedures adopted by the Medical Student Section and approved by the Board of Trustees. ~~Each elected delegate and alternate delegate must receive written endorsement from their constituent association in accordance with procedures adopted by the Medical Student Section and approved by the Board of Trustees.~~ Regional d~~D~~elegates and alternate delegates shall be elected in conjunction with ~~at~~ the Business Meeting of the Medical Student Section associated with ~~prior to~~ the Interim Meeting of the House of Delegates. Regional d~~D~~elegates and alternate delegates shall assume their office ~~be seated~~ at the next Annual Meeting of the House of Delegates.

**2.3.4 ~~Certification~~ Credentialing.** The ~~Chair~~ Director of the Medical Student Section ~~Governing Council, or the Chair's designee,~~ shall provide ~~certify to~~ the ~~AMA~~ Office of House of Delegates Affairs with the names and contact information of the delegates and alternate delegates for each Medical Student Region elected in accordance with 2.3.3 by December 5 of each year. These appropriately identified individuals shall be duly credentialed for each House of Delegates meeting occurring within their term as defined in 2.3.5. ~~Certification of delegates and alternate delegates must occur at least 45 days prior to the Annual Meeting of the House of Delegates.~~

**2.3.5 Term.** Medical s~~S~~tudent r~~R~~egional delegates and alternate delegates shall be elected for one-year terms ~~and shall assume office on the date set by the Medical Student Section Governing Council~~.

**2.3.6 Vacancies.** A student who fills a vacancy for a regional medical student delegate must have been elected from the same medical student region as the vacating student and credentialed as a regional alternate delegate or a temporary delegate in accordance with Bylaws 2.3.3, 2.8.2, and 2.10.4. ~~The delegate selected to fill a vacancy shall assume office immediately after selection and serve for the remainder of that term.~~

**2.4 ~~Delegates from the~~ Resident and Fellow Sectional Delegates.** In addition to the delegate and alternate delegate representing the Resident and Fellow Section, resident and fellow ~~physician~~ sectional delegates and alternate delegates shall be apportioned and elected in a manner as provided in this bylaw.

**2.4.1 Qualifications.** Resident and fellow sectional ~~D~~delegates and alternate delegates ~~from the Resident and Fellow Section~~ must be active members of the Resident and

Fellow Section of the AMA. In addition, resident and fellow sectional ~~physician~~ delegates and alternate delegates must be members of and have written endorsement from a ~~their endorsing~~ society or organization currently seated in the HOD, in a capacity appropriate to their level of training.

**2.4.2 Apportionment.** The apportionment of resident and fellow sectional delegates ~~from the Resident and Fellow Section~~ is one delegate for each 2,000 active resident and fellow physician members of the AMA, as recorded by the AMA on December 31 of each year.

**2.4.2.1 Effective Date.** In January of each year, the AMA shall notify the Resident and Fellow Section ~~Governing Council~~ Director of the number of seats in the House of Delegates to which the Resident and Fellow Section is entitled. Such apportionment shall take effect on January 1 of the following year and shall remain effective for one year.

**2.4.3 Election.** Resident and fellow sectional ~~D~~delegates and alternate delegates shall be elected by the Resident and Fellow Section in accordance with procedures adopted by the Section and approved by the Board of Trustees. Resident and fellow sectional delegates and alternate delegates shall be elected at the Business Meeting of the Resident and Fellow Section prior to the Interim Meeting of the House of Delegates. Elected resident and fellow sectional delegates and alternate delegates shall assume their office at the next Annual Meeting of the House of Delegates. ~~Each delegate and alternate delegate must receive written endorsement from a society or organization currently seated in the House of Delegates and in accordance with procedures adopted by the Resident and Fellow Section and approved by the Board of Trustees.~~

**2.4.4 ~~Certification~~ Credentialing.** The ~~Chair~~ Director of the Resident and Fellow Section ~~Governing Council or the Chair's designee~~ shall provide ~~certify to~~ the ~~AMA~~ Office of House of Delegates Affairs the names and contact information of the resident and fellow sectional delegates and alternate delegates elected in accordance with 2.4.3 by December 5 of each year ~~for the Resident and Fellow Section~~. These appropriately identified individuals shall be duly credentialed for each House of Delegates meeting within their term as defined in 2.4.5. ~~Certification of delegates and alternate delegates must occur at least 45 days prior to the Annual Meeting of the House of Delegates.~~

**2.4.5 Term.** Resident and fellow sectional ~~D~~delegates and alternate delegates ~~from the Resident and Fellow Section~~ shall be elected for one-year terms ~~and shall assume office on the date set by the Resident and Fellow Section Governing Council~~.

**2.4.6 Vacancies.** A resident or fellow who fills a vacancy for a resident and fellow sectional delegate must have been elected by the Resident and Fellow Section and credentialed as a temporary delegate in accordance with Bylaws 2.4.3, 2.8.2 and 2.10.4. ~~The delegate selected to fill a vacancy shall assume office immediately after selection and serve for the remainder of the term.~~

***

**2.6 Other Delegates.** Each of the following is entitled to a delegate: AMA Sections; the Surgeons General of the United States Army, United States Navy, United States Air Force, and United States Public Health Service; the Chief Medical Director of the Department of Veterans Affairs; the National Medical Association; the American Medical Women's Association; the American Osteopathic Association; and professional interest medical associations granted representation in the House of Delegates.

**2.6.1 ~~Certification~~ Credentialing.** The president, chief executive officer, or other authorized individual of each entity shall provide ~~certify to~~ the AMA with the names and contact information of their respective delegate and alternate delegate at least~~. Certification must occur~~ 45 days prior to each ~~the Annual or Interim M~~meeting of the House of Delegates.

~~**2.6.2 Term.** Delegates from these entities shall be selected for 2-year terms, and shall assume office on the date set by the entity. Certification of delegates and alternate delegates must occur at least 45 days prior to the Annual or Interim Meeting of the House of Delegates.~~

~~**2.6.3 Vacancies.** The delegate selected to fill a vacancy shall assume office immediately after selection and serve for the remainder of that term.~~

***

**2.8 Alternate Delegates.** Each organization represented in the House of Delegates may select an alternate delegate for each of its delegates entitled to be seated in the House of Delegates.

**2.8.1 Qualifications.** Alternate delegates must be active members of the AMA and of the entity they represent.

**2.8.2 ~~Certification~~ Credentialing.** Alternate delegates shall be ~~certified~~ credentialed ~~to the AMA~~ in the same manner as delegates at least 45 days prior to each meeting of the House of Delegates.

~~**2.8.3 Term.** Alternate delegates shall be selected for a 2-year term, and shall assume office on the date set by the organization, unless otherwise provided in these Bylaws.~~

~~**2.8.4 Vacancies.** Alternate delegates selected to fill a vacancy shall assume office immediately after selection and shall serve for the remainder of that term.~~

~~**2.8.5**~~ **Rights and Privileges.** At the request of their corresponding delegate, ~~**a**A~~n alternate delegate may temporarily be seated for them ~~substitute for a delegate,~~ on the floor of the House of Delegates~~, at the request of the delegate by complying with the procedures established by the Committee on Rules and Credentials~~. The alternate delegate must display their corresponding delegate's temporary credential and may then assume their privilege of the floor. ~~While substituting for a delegate, the alternate delegate may speak and debate on the floor of the House, offer an amendment to a pending matter, make motions, and vote.~~

2.8.4

~~2.8.6~~ **Status.** The alternate delegate is not a "member of the House of Delegates" as that term is used in these Bylaws. Accordingly, an alternate delegate may not introduce resolutions into the House of Delegates~~, n~~or vote in any election conducted by the House of Delegates. An alternate delegate is not eligible for nomination or election as Speaker or Vice Speaker of the House of Delegates. The alternate delegate must immediately relinquish their position on the floor of the House of Delegates upon the request of their corresponding delegate for whom they are ~~alternate delegate is substituting~~ temporarily seated.

`

**2.10 Registration and Seating of Delegates.**

**2.10.1 Notification.** In January of each year, the AMA shall notify each organization of the number of seats in the House of Delegates to which it is entitled during the current year.

**2.10.2** ~~**Credentials.** A delegate or alternate delegate may only be seated if there is certification on file stating that the delegate or alternate delegate has been properly selected to serve in the House of Delegates.~~

~~**2.10.3 Lack of Credentials.** A delegate or alternate delegate may be seated without the certificate defined in Bylaw 2.10.2 provided proper identification as the delegate or alternate delegate selected by the respective entity is established, and so certified to the AMA.~~

~~**2.10.4 Substitute**~~ **Temporary Delegate.** When a credentialed delegate or alternate delegate is unable to attend a meeting of the House of Delegates, or a portion thereof, the president~~, the president's designee~~ or the chief executive officer ~~other authorized individual~~ of the entity the vacating delegate represents, or their designee, may ~~appoint~~ credential a temporary ~~substitute~~ delegate or temporary ~~substitute~~ alternate delegate, who shall be eligible to serve as ~~such~~ a temporary delegate or temporary alternate delegate in the House of Delegates at that meeting only.

~~**2.10.4.1 Temporary Substitute Delegate.** A delegate whose credentials have been accepted by the Committee on Rules and Credentials and whose name has been placed on the roll of the House of Delegates shall remain a delegate until final adjournment of that meeting of the House of Delegates. However, if the delegate is not able to remain in attendance, that delegate's place may be taken during the period of absence by an alternate delegate, or a substitute alternate delegate selected in accordance with Bylaw 2.10.4 if an alternate delegate is not available. The person who takes the place of the delegate must have certification on file and shall be known as a temporary substitute delegate. Such temporary substitute delegate shall have all of the rights and privileges of a delegate while serving as a temporary substitute delegate, including the right to vote in the House of Delegates and to vote in any election conducted by the House of Delegates. The temporary substitute delegate shall not be eligible for nomination or election as Speaker or Vice Speaker of the House of Delegates.~~

[Subsequent bylaw provisions will be renumbered]

****

**2.10.6**
~~**2.10.8**~~ **Medical Student Seating.** Each medical student regional delegate shall be seated with the student's endorsing constituent association. Alternate or temporary ~~substitute~~ medical student regional delegates shall be assigned to the original regional delegate's seat location during the time they are seated for the original delegate.

**2.10.7**
~~**2.10.9**~~ **Resident and Fellow Seating.** Each ~~delegate from the~~ ~~R~~resident and ~~F~~fellow ~~Section~~ sectional delegate shall be seated with ~~the physician's~~ their endorsing society or organization. ~~In the case where a delegate has been endorsed by multiple entities, the delegate must choose, prior to the election, with which delegation the delegate wishes to be seated.~~ Alternate or temporary ~~substitute~~ resident and fellow sectional delegates shall be assigned to the original delegate's seat location during the time they are seated for the original delegate.

(Modify Bylaws)

REPORT 01 OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS (I-25)
Amendment to Opinion 1.1.1 “Patient-Physician Relationships”

## EXECUTIVE SUMMARY

The Council on Ethical and Judicial Affairs (CEJA) believes that the AMA *Code of Medical Ethics* and the profession would be well served by amending guidance to provide a more robust discussion of the nature of patient-physician relationships and physicians’ associated ethical obligations. Indeed, the practice of medicine has changed in ways that demand a thorough review and potential reconceptualization of the obligations of both individual physicians and the profession as a whole. Ultimately, Opinion 1.1.1 “Patient-Physician Relationships” must move beyond the current language that focuses on when a patient-physician relationship begins in order to more fully address how to ethically and justly sustain the relationship. Furthermore, knowing that the practice of medicine will continue to change and that as a result, so too will patient-physician relationships, the *Code* needs to clearly acknowledge that patient-physician relationships are inherently dynamic, contextual, and will continue to evolve. In light of these considerations, CEJA recommends amending Opinion 1.1.1.

© 2025 American Medical Association. All rights reserved.

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

CEJA Report 01-I-25*

Subject: Amendment to Opinion 1.1.1 "Patient-Physician Relationships"

Presented by: Rebecca Brendel, MD, Chair

Referred to: Reference Committee on Ethics and Bylaws

---

The Council on Ethical and Judicial Affairs (CEJA) believes that the AMA *Code of Medical Ethics* and the profession would be well served by amending guidance to provide a more robust discussion of the nature of patient-physician relationships and physicians' associated ethical obligations. Indeed, the practice of medicine has changed in ways that demand a thorough review and potential reconceptualization of the obligations of both individual physicians and the profession as a whole.

At the 2025 Annual Meeting, testimony was heard that CEJA Report 06-A-25, "Amendment to Opinion 1.1.1 'Patient-Physician Relationships'," does not address "political and administrative influence" on the patient-physician relationship, and the report was referred back to CEJA.

In light of these considerations, CEJA has amended the body of the report and the recommendations to better reflect the reality of these external influences. As the first opinion of the *Code*, Opinion 1.1.1 is the foundation that supports all other *Code* opinions, many of which also address the important issues raised by the House. As the foundational opinion, Opinion 1.1.1 ought not be exhaustive and is not designed to address all of the important issues in the opinions that ultimately rely upon it.

BACKGROUND

*Relevant House Policies*

Several House policies reference the importance of the patient-physician relationship. Though not an exhaustive list, the following policies capture the spirit of the patient-physician relationship expressed within AMA House policy: H-165.837 "Protecting the Patient-Physician Relationship", H-225.950 "AMA Principles for Physician Employment", and H-275.937 "Patient/Physician Relationship and Medical Licensing Boards".[1–3] The patient-physician relationship as expressed by these policies is understood to be fundamental and paramount to the practice of medicine. This relationship is understood to carry certain obligations for physicians, including the duty to be patient advocates, to prioritize patient care, and be transparent regarding cost-sharing arrangements. Other considerations, including personal financial concerns, are to be secondary to the relationship. Furthermore, this relationship is not perceived as purely contractual, as termination of employment does not necessarily end the relationship between a physician and persons under their care (H-225.950).

* Reports of the Council on Ethical and Judicial Affairs are assigned to the Reference Committee on Ethics and Bylaws. They may be adopted, not adopted, or referred. A report may not be amended, except to clarify the meaning of the report and only with the concurrence of the Council.

© 2025 American Medical Association. All rights reserved.

*Relevant Code Provisions*

Within the AMA *Code of Medical Ethics*, the patient-physician relationship is understood as: "fundamentally a moral activity that arises from the imperative to care for patients and to alleviate suffering[… that is] based on trust" (Opinion 1.1.1).[4] This relationship is primarily represented as emerging from a physician's fiduciary duty to patients, in which both parties enter into this fiduciary relationship via a consensual agreement. Though not an exhaustive list, the following opinions capture the spirit of the patient-physician relationship expressed within the *Code*: Opinion 1.1.1 "Patient-Physician Relationships", Opinion 1.1.3 "Patient Rights", Opinion 1.1.5 "Terminating a Patient-Physician Relationship", Opinion 1.1.6 "Quality", Opinion 1.1.7 "Physician Exercise of Conscience", Opinion 8.6 "Promoting Patient Safety".[4–9] These opinions demonstrate that the patient-physician relationship entails fiduciary responsibility, mutual respect, support for the continuity of care, open communication, quality care, and trust.

In addition, the *Code* offers several opinions that highlight the importance of minimizing outside influence on the patient-physician relationship, such as political or administrative pressures that might negatively impact the relationship. Opinion 3.1.1 "Privacy in Health Care"[10] and Opinion 3.2.1 "Confidentiality"[11] underscore the importance of respecting patients' privacy and confidentiality in all clinical settings and the fundamental importance of doing so to maintain trust in the patient-physician relationship. Similarly, Opinion 11.1.1 "Defining Basic Health Care" states that physicians, both individually and collectively, share an obligation to "advocate for fair, informed decision making about basic health care that[…] [c]onsiders best available scientific data […] [and] seeks to improve health outcomes to the greatest extent possible"—focusing on the importance of science-based medicine and equity-focused policies regardless of political or administrative pressures to the contrary[12].

Opinion 11.2.1 "Professionalism in Health Care Systems" notes that models for financing and organizing the delivery of health care services can "pose ethical challenges for physicians that could undermine the trust essential to patient-physician relationships" and acknowledges, "[f]ormularies, clinical practice guidelines, decision support tools […], and other mechanisms intended to influence decision making, may impinge on physicians' exercise of professional judgment and ability to advocate effectively for their patients, depending on how they are designed and implemented."[13] To support physicians in upholding their ethical obligations, the Opinion states that all such tools should be designed in keeping with science-based medical practices and implemented fairly. This focus on equity is also supported by Opinion 11.2.7 "Responsibilities to Promote Equitable Care".[14] Lastly, Opinion 11.2.2 "Conflicts of Interest in Patient Care" states, "[t]he primary objective of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration. Under no circumstances may physicians place their own financial interests above the welfare of their patients."[15] The Opinion concludes, "[w]here the economic interests of the hospital, health care organization, or other entity are in conflict with patient welfare, patient welfare takes priority."[15] These opinions emphasize the importance that physicians be allowed to practice science-based medicine grounded in medical ethics without undue pressure from outside influences, including political or administrative pressures that might in any way prevent physicians from upholding their professional and ethical commitments. Regardless of external influences, and often in spite of them, physicians have an ethical duty to support the patient-physician relationship to the best of their ability.

ETHICAL ISSUE

Current guidance in Opinion 1.1.1 "Patient-Physician Relationships" focuses heavily on legal considerations about when a relationship is established and has little purchase on the ethical

concerns raised by extensive changes to the practice of medicine that have recently occurred. Among these changes are the continuing development of technology (such as augmented intelligence), the use of team-based care, the rising number of employed physicians (as contrasted with those in private practice), interference in the patient-physician relationship by third parties (such as health care administrators, insurers or government), and the recognition that physicians have an obligation to advocate for changes to institutions, policies, and practices in order to improve patient care and promote health care justice.

A major change to the patient-physician relationship over the past few decades has been an increased recognition of the importance of patient autonomy. Ironically, however, this move away from paternalism towards patient autonomy in the setting of the patient-physician relationship has taken place while medicine has come to be dominated by large institutions, financial concerns such as cost-containment, changes in financing designed to influence patient and physician behavior, commercialization, an increasing reliance on markets, and other pressures that have had a de-professionalizing effect on physicians. These changes have led in turn to a loss of autonomy for both physicians and patients. Even as the discretionary space of physicians has shrunk, their responsibilities have expanded. Physicians are now called to engage in cultural competency and humility, trauma-informed approaches to care, and to recognize past harms and historical contexts of patient populations. They are called upon to be the mechanism by which medical inflation will be controlled. They are called upon to advocate not just only for their own individual patients within systems of care but to advocate for changes in the social systems that determine health care needs and distribute illness, injury, and disability unjustly.

Recognizing that each patient brings different experiences to the relationship is now seen as a crucial part of establishing trust within a patient-physician relationship. The question that arises, however, is how is that trust to be earned within systems that often appear untrustworthy and designed to frustrate the commitment of physicians to act for the good of their patients?

## ETHICAL ANALYSIS

The patient-physician relationship is foundational for medical ethics. It is characterized by the nature of illness, the need for healing, and a commitment to help, culminating in a decision to take action directed toward healing and the alleviation of suffering caused by disease, injury, or disability. This relationship is inherently unequal. The patient is unavoidably in a position of vulnerability and dependency, while the physician holds the knowledge and the resources that the patient needs.[16] The sick, injured, and disabled therefore have little choice but to trust that their physicians will use the power of medicine for their good as individual patients. That trust is established by the physician's act of profession—the commitment, generally undertaken through an oath, to be worthy of patients' trust—and the patent's agreement to cooperative collaboration.

The heart of professionalism is thus the public commitment of physicians to use their medical knowledge, skills, and judgment for the good of their patients. Moreover, since patients are first and foremost persons, true healing can only take place when the uniqueness and personhood of patients are taken into account, incorporating their biological particularities, beliefs, relationships, emotions, values, and goals into medical decisions. This requires a mutually respectful, trusting collaboration aimed at serving the patient's good. For patients, this entails an obligation to seek care and be as candid as possible with their physicians.

All medical actions are oriented towards the ethical centrality of the patient-physician relationship. While the paradigmatic instance of this dynamic is serious illness, or injury, the care of patients with chronic conditions also requires a sustained, trusting relationship. Palliation, too, aims at the

relief of medical suffering and provides healing in a holistic sense even when cure is not possible. Prevention is also oriented towards the good of individual patients and requires trust that interventions are appropriate for that aim. Public health efforts provide the common resources necessary to promote healing and prevent illness, injury, and disability, and thus unite societal commitments to justice and prevention of harm with physicians' duties of beneficence, nonmaleficence, and respect for persons.

This understanding of the patient-physician relationship makes medicine an inherently moral enterprise, qualitatively different from the commercial transactions of providers and consumers. The patient-physician relationship itself is part of the healing process and not a commodity or product. Even economists recognize that the demand for health care is substantially inelastic and nonfungible, placing it outside the assumptions of normative market economics. Medical knowledge is not property that physicians own. It is a social good built up by the work of generations of physicians, scientists, and researchers and made possible by the generosity of generations of patients who have contributed to the advancement of medical progress (and who, it is acknowledged, have not always consented to such participation).

Medicine does not exist in a vacuum. Natural, historical, socioeconomic, and political circumstances always condition the patient-physician relationship. Physicians, for instance, do not always live up to the ideals of the profession. Structural social inequities result in unequal access to health care. While the patient-physician relationship itself is not a market commodity, markets provide many of the goods and services that physicians rely on to care for patients. Unfortunately, this also means that these goods and services are subject to the vicissitudes and inequities inherent to market systems, sexism, racism, and other unjust forms of discrimination.

Political decisions, for good or for ill, can also have a tremendous impact on care, affecting the distribution of physicians, the services they can provide for patients, the conditions under which physicians work, and the tenor of the patient-physician relationship. Therefore, if the good of the patient is the central moral focus of medicine, a commitment to justice will be required to ensure the integrity of the patient-physician relationship and to make the services of physicians available to all who stand in need of their care. In a pluralistic, liberal democracy, this requires, in turn, that professions be granted a relatively independent status outside other social institutions such as the market and the government. Too much encroachment by the market or the government into the legitimate authority of the medical profession ultimately undermines the central moral focus of medicine: the patient-physician relationship. Likewise, without the proper degree of self-regulation and respect for other social institutions, the medical profession itself can lose track of its own moral center. The good of the patient ought never to be made subservient to the political or financial ends of physicians, governments, or markets. Determining what the good of the patient is requires that physicians have the freedom and flexibility to adopt a patient-centered approach to care that allows for patients to feel heard and respected.

As the profession of medicine continues to change, there are concerns about how these changes impact patient-physician relationships and thus the relevance of the patient-physician relationship itself. However, despite the evolving landscape of the medical profession, the patient-physician relationship remains vital to the practice of medicine and to medical ethics. Regardless of changes to their roles that physicians face, clinical encounters will always be subject to the professional and ethical obligations that emerge from patient-physician relationships.

When we examine the patient-physician relationship, what we are really after is the source of the obligations that ground medical ethics. While medicine has always been practiced under non-ideal circumstances that can make it difficult to carry out these obligations to a maximal extent, we

recognize that current circumstances are making it more difficult than ever. Moreover, we recognize that a patient-physician relationship may arise in a variety of contexts, and that these may not always be geared towards benefiting the patient, the physician, or both. The goal of this report, however, is to outline the core aspects of ethical and just patient-physician relationships and articulate gaps in the current *Code* Opinion 1.1.1. in order to better support patients and physicians as the medical profession and health care ecosystems continue to evolve.

*Trust and the Patient-Physician Relationship*

The pressures of increasing de-professionalization and de-personalization in the healthcare environment have sometimes obscured or even seemed to denigrate the value of the patient-physician relationship. New ethical questions have arisen as systems of care have changed in ways that have made it more difficult for physicians to fulfil their duties that arise from a recognition that this relationship is central to the meaning and value of the profession. While the patient-physician relationship has responded and evolved in light of these challenges and in the face of other technological, economic, and sociocultural changes, there can be no doubt that patients' trust in medicine has declined. Nonetheless, there is also a renewed interest in the relational aspect of the patient-physician relationship and new attempts to build the trust that sustains it.

Trust is in many ways the cornerstone of any interpersonal relationship. Social psychologists who study trust have noted that the development of dyadic trust is a process that involves commitment, cooperation, and the building of confidence in benevolent values, motives, goals, and intentions.[17] Trust—and distrust—may be enacted in the immediate but is also built over time. Interpersonal trust is also impacted by (and in turn impacts) social trust, as social trust influences the development of interpersonal trust which then also impacts trust in the institutions in which interpersonal interactions take place.[18]

To protect the patient-physician relationship, then, a central goal of the medical profession should be to foster trust in health care, which has been in sharp decline for the past half century.[19] One of the primary means to engender trust is through good communication. Research has shown that aspects of physician communication can impact patient outcomes (such as medication compliance) and patient satisfaction (which is associated with greater continuity of care), and that patient-centered approaches to care, which consider the patient's perspective on equal ground with the physician's clinical diagnosis, enhance communication and the patient-physician relationship.[20]

*Fostering Trust to Support the Patient-Physician Relationship*

Research on physician communication practices have found at least five broad communication categories including: information giving, information seeking (questioning), partnership building, rapport-building behaviors (both verbal and nonverbal behaviors that explicitly convey emotional content), and socioemotional behaviors.[21] How patients and physicians view these aspects of communication, and the patient-physician relationship in general, are not always the same, however. In one study comparing physician and patient evaluations of the relationship, researchers found that while physicians identified their technical expertise and knowledge as vital for establishing trust in the relationship, emphasizing the importance of competence, devotion, serviceability, and reliability, patients stressed the importance of interpersonal skills as more important, such as caring, appreciation, and empathy.[22] Recognizing this difference in perceptions is crucial for understanding how trust can be gained or lost, especially considering that researchers found trust to make the largest contribution to patient-physician perceived satisfaction.[22]

Patient satisfaction is strongly associated with positive physician communication behaviors. Because physicians' communication behaviors vary widely, however, there is significant room here for improving patient-physician relationships. One study found that only 33% of physicians were rated "excellent" on all four communication behaviors analyzed, while 12% were rated either "fair" or "poor" on all four behaviors.[23] Patient-physician communication is one of the strongest factors that impact patient satisfaction and is fundamental to facilitating shared responsibility and trust.[24]

Communication is not the only value that engenders and supports trust. Research has found that clinicians whose patients expressed trust in them worked in environments that placed an emphasis on quality, communication, clinical cohesion, and alignment of values between clinicians and organizational leaders.[25] Like communication, physician empathy has also been regarded as central to patient-centered care, and research has found that empathy correlates with patient satisfaction, adherence, outcomes, and enablement.[26] Other models of trust establish foundational factors that include competency, motive, and transparency.[19]

*The Future of Patient-Physician Relationships*

When considering the source of the ideal patient-physician relationship, its emergence is simultaneously contractual, dependent on virtues, and relational. All three of these conceptual models rely on trust, and trust in turn is supported by additional values. Interpersonal trust is reliant upon collaboration, respect, empathy, and reciprocity. Contractual trust is reliant upon competency, transparency, aligned motives, and continuity. These values in many ways become ideal virtues within health care that help create trust in the institution of medicine over time, which is crucial for initial clinical encounters as well as for individuals who lack capacity. Regardless of external influences, such as political or administrative pressures, physicians have a responsibility first and foremost to their patients and to supporting the patient-physician relationship. When these influences create conflicting priorities, physicians should ensure that their actions align with their professional and ethical obligations.

Physicians have an ethical duty to support the patient-physician relationship by upholding the virtues of the profession. This ethical duty is grounded in medical professionalism and the commitment to serve as healers. The relationship that patients and physicians enter into is sustained by trust—in both the profession as whole, as well as in both the patient and the physician who agree to participate in a cooperative and collaborative partnership. This trust gives rise to physicians' ethical responsibility to place patients' welfare above the physician's own self-interest. This partnership is unique in that it is inherently unequal in terms of vulnerability, yet equal in importance with respect to both individuals' contributions to the relationship; similarly, the relationship is not a commodity product, yet it involves interacting with market economics. The patient-physician relationship is contextual—biological, historical, socioeconomic, and political elements will always be relevant—but it is also fundamentally a moral activity.

Honavar writes, "[the p]atient–physician relationship is a complex psychosocial interplay of vulnerability, trust, and authority in a professional setting".[27] Currently, the *Code* primarily speaks to the importance of trust within the patient-physician relationship without acknowledging that the reason trust is crucial is because of the unequal vulnerabilities and authorities at play. The power dynamics of every patient-physician relationship will be different, of course, but it is crucial that the *Code* address such concepts as patient vulnerability, the importance of respect, communication, and competency in establishing trust. Ultimately, Opinion 1.1.1 must move beyond the current language that focuses on when a patient-physician relationship begins in order to more fully address how to ethically and justly sustain the relationship. Furthermore, knowing that the practice of medicine will continue to change and that as a result, so too will patient-physician relationships,

the *Code* needs to clearly acknowledge that patient-physician relationships are inherently dynamic, contextual, and will continue to evolve.

RECOMMENDATION

Your Council on Ethical and Judicial Affairs recommends that Opinion 1.1.1, "Patient Physician Relationships" be amended by addition and deletion and the remainder of this report be filed.

The practice of medicine, and its embodiment in the clinical encounter between a patient and a physician, is fundamentally a moral activity that arises from the imperative to care for patients and to alleviate suffering. ~~The relationship between a patient and a physician is based on trust, which gives rise to~~ The relationship that emerges between a patient and a physician must be based on trust. The physician's obligation to be trustworthy entails additional ethical duties such as a commitment to act for the good of patients; to uphold respect for patients as persons; to develop good communication skills; and to be professionally competent. This trust is fostered by physicians' ethical responsibilit~~y~~ies to place patients' welfare above the physician's own self-interest or obligations to others, to use sound medical judgment on patients' behalf, and to advocate for their patients' welfare. When external influences negatively impact this trust, or the patient-physician relationship directly, physicians individually and collectively should advocate for changes to ameliorate the situation and promote a more hospitable environment in which patient-physician relationships may flourish.

A patient-physician relationship ~~exists~~ commences when a physician begins to serve a patient's medical needs. ~~Generally, the relationship is entered into by mutual consent between physician and patient (or surrogate). However, in certain circumstances a limited patient-physician relationship may be created without the patient's (or surrogate's) explicit agreement. Such circumstances include:~~ The contexts that may lead to a patient-physician relationship vary: they generally occur as a response to a request by a patient or a patient's surrogate, but can also include certain contractual, legally mandated, or emergency settings without the explicit request or consent of the patient.

While the patient-physician relationship may involve one patient and one physician in today's complex health care system, such relationships often involve multiple members of a care team, patient family members and surrogates. The core values of the patient-physician relationship, however, remain unchanged. How these values are implemented will depend on many factors, including the setting, the needs of the patient, the duration of the relationship, and the training, expertise, and experience of the physician, and will necessarily reflect the myriad ways that patients and physicians interact. While every patient-physician relationship will be different and will change over time, the fundamental importance of establishing and sustaining trust through respect for persons, good communication, and professional competency will always be crucial at every layer, node, and time of the relationship. It is the duty of physicians, therefore, to uphold these values and support patients and the primacy of the patient-physician relationship to the best of their ability in all practice settings and at all times.

~~(a) When a physician provides emergency care or provides care at the request of the patient's treating physician. In these circumstances, the patient's (or surrogate's) agreement to the relationship is implicit.~~

~~(b) When a physician provides medically appropriate care for a prisoner under court order, in keeping with ethics guidance on court-initiated treatment.~~

(c) ~~When a physician examines a patient in the context of an independent medical examination, in keeping with ethics guidance. In such situations, a limited patient-physician relationship exists.~~

(Modify HOD/CEJA Policy)

Fiscal Note: Minimal

REFERENCES

1. American Medical Association. H-165.837 Protecting the Patient-Physician Relationship. Accessed August 15, 2025. https://policysearch.ama-assn.org/policyfinder/detail/h-165.837?uri=%2FAMADoc%2FHOD.xml-0-823.xml
2. American Medical Association. H-225.950 AMA Principles for Physician Employment. Accessed August 15, 2025. https://policysearch.ama-assn.org/policyfinder/detail/H-225.950?uri=%2FAMADoc%2FHOD.xml-0-1535.xml
3. American Medical Association. H-275.937 Patient/Physician Relationship and Medical Licensing. Accessed August 15, 2025. https://policysearch.ama-assn.org/policyfinder/detail/H-275.937?uri=%2FAMADoc%2FHOD.xml-0-1915.xml
4. American Medical Association. Code of Medical Ethics, Opinion 1.1.1, Patient-Physician Relationships. Accessed August 8, 2025. https://code-medical-ethics.ama-assn.org/ethics-opinions/patient-physician-relationships
5. American Medical Association. Cde of Medical Ethics, Opinion 8.6, Promoting Patient Safety. Accessed January 7, 2025. https://code-medical-ethics.ama-assn.org/ethics-opinions/promoting-patient-safety
6. American Medical Association. Code of Medical Ethics, Opinion 1.1.7, Physician Exercise of Conscience. Accessed August 9, 2024. https://code-medical-ethics.ama-assn.org/ethics-opinions/euthanasia
7. American Medical Association. Code of Medical Ethics, Opinion 1.1.6, Quality. Accessed August 8, 2025. https://code-medical-ethics.ama-assn.org/ethics-opinions/quality
8. American Medical Association. Code of Medical Ethics, Opinion 1.1.5, Terminating a Patient-Physician Relationship. Accessed August 8, 2025. https://code-medical-ethics.ama-assn.org/ethics-opinions/terminating-patient-physician-relationship
9. American Medical Association. Code of Medical Ethics, Opinion 1.1.3, Patient Rights. Accessed September 6, 2024. https://code-medical-ethics.ama-assn.org/index.php/ethics-opinions/patient-rights
10. American Medical Association. Code of Medical Ethics, Opinion 3.1.1, Privacy in Health Care. Accessed August 15, 2025. https://code-medical-ethics.ama-assn.org/ethics-opinions/privacy-health-care
11. American Medical Association. Code of Medical Ethics, Opinion 3.2.1, Confidentiality. Accessed August 15, 2025. https://code-medical-ethics.ama-assn.org/ethics-opinions/confidentiality
12. American Medical Association. Code of Medical Ethics, Opinion 11.1.1, Defining Basic Health Care. Accessed August 15, 2025. https://code-medical-ethics.ama-assn.org/ethics-opinions/defining-basic-health-care
13. American Medical Association. Code of Medical Ethics, Opinion 11.2.1, Professionalism in Health Care Systems. Accessed August 15, 2025. https://code-medical-ethics.ama-assn.org/ethics-opinions/professionalism-health-care-systems
14. American Medical Association. Code of Medical Ethics, Opinion 11.2.7, Responsibilities to Promote Equitable Care. Accessed August 15, 2025. https://code-medical-ethics.ama-assn.org/ethics-opinions/responsibilities-promote-equitable-care
15. American Medical Association. Code of Medical Ethics, Opinion 11.2.2, Conflicts of Interest in Patient Care. Accessed August 15, 2025. https://code-medical-ethics.ama-assn.org/ethics-opinions/conflicts-interest-patient-care
16. Pellegrino ED. Toward a reconstruction of medical morality. Am J Bioeth AJOB. 2006;6(2):65-71. doi:10.1080/15265160500508601
17. Simpson JA. Foundations of interpersonal trust. In: Social Psychology: Handbook of Basic Principles, 2nd Ed. The Guilford Press; 2007:587-607.

18. Pellegrini CA. Trust: The Keystone of the Patient-Physician Relationship. J Am Coll Surg. 2017;224(2):95. doi:10.1016/j.jamcollsurg.2016.10.032
19. Sandy LG, Pham HH, Levine S. Building Trust Between Physicians, Hospitals, and Payers: A Renewed Opportunity for Transforming US Health Care. JAMA. 2019;321(10):933-934. doi:10.1001/jama.2018.19357
20. Dugdale DC, Epstein R, Pantilat SZ. Time and the patient-physician relationship. J Gen Intern Med. 1999;14 Suppl 1(Suppl 1):S34-40. doi:10.1046/j.1525-1497.1999.00263.x
21. Roter D. The enduring and evolving nature of the patient-physician relationship. Patient Educ Couns. 2000;39(1):5-15. doi:10.1016/s0738-3991(99)00086-5
22. Berger R, Bulmash B, Drori N, Ben-Assuli O, Herstein R. The patient-physician relationship: an account of the physician's perspective. Isr J Health Policy Res. 2020;9(1):33. doi:10.1186/s13584-020-00375-4
23. Clever SL, Jin L, Levinson W, Meltzer DO. Does doctor-patient communication affect patient satisfaction with hospital care? Results of an analysis with a novel instrumental variable. Health Serv Res. 2008;43(5 Pt 1):1505-1519. doi:10.1111/j.1475-6773.2008.00849.x
24. Shirley ED, Sanders JO. Patient satisfaction: Implications and predictors of success. J Bone Joint Surg Am. 2013;95(10):e69. doi:10.2106/JBJS.L.01048
25. Linzer M, Neprash H, Brown R, et al. Where Trust Flourishes: Perceptions of Clinicians Who Trust Their Organizations and Are Trusted by Their Patients. Ann Fam Med. 2021;19(6):521-526. doi:10.1370/afm.2732
26. Zhang X, Li L, Zhang Q, Le LH, Wu Y. Physician Empathy in Doctor-Patient Communication: A Systematic Review. Health Commun. 2024;39(5):1027-1037. doi:10.1080/10410236.2023.2201735
27. Honavar SG. Patient–physician relationship – Communication is the key. Indian J Ophthalmol. 2018;66(11):1527-1528. doi:10.4103/ijo.IJO_1760_18

REPORT 02 OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS (I-25)
Supporting Efforts to Strengthen Medical Staffs Through Collective Actions and/or Unionization

## EXECUTIVE SUMMARY

In adopting Policy H-405.946, "Supporting Efforts to Strengthen Medical Staffs Through Collective Actions and/or Unionization," the House of Delegates requested that the Council on Ethical and Judicial Affairs (CEJA) "review the advisory restricting collective action in section 1.2.10 of its *Code of Medical Ethics* to allow for more flexibility on the part of physicians who have exhausted other non-disruptive methods for reform."

Although not all collective actions by physicians may impact clinical practice, the practical issue for consideration is whether disruptive collection actions by physicians, such as but not limited to strikes, may be permissible. The ethical dilemma is whether physicians can prioritize patient welfare over their own self-interest while engaging in tactics that have the potential to harm patients in the short term, even if the ultimate goal of the action is proposed to be long-term patient benefit. To respond to these issues, CEJA recommends amending Opinion 1.2.10, "Political Action by Physicians," to more clearly articulate that disruptive collective actions that would likely harm patients are to be avoided; however, this does not mean that all forms of disruptive collective action must be avoided. Disruptive actions should, though, only be undertaken as a last resort when good faith negotiations have broken down and the aim of the action is to improve patient care.

© 2025 American Medical Association. All rights reserved.

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 02-I-25

Subject: Supporting Efforts to Strengthen Medical Staffs Through Collective Actions and/or Unionization

Presented by: Rebecca Brendel, MD, Chair

Referred to: Reference Committee on Ethics and Bylaws

---

Council on Ethical and Judicial Affairs (CEJA) Report 8, "Supporting Efforts to Strengthen Medical Staffs Through Collective Actions and/or Unionization," was introduced by CEJA at the 2025 Annual Meeting and was referred. CEJA Report 08-A-25 responded to Policy H-405.946, "Supporting Efforts to Strengthen Medical Staffs Through Collective Actions and/or Unionization," which was adopted at the 2023 Annual Meeting and asks the following:

1. Our American Medical Association will reevaluate the various efforts to achieve collective actions and/or unionization for physicians nationally.

2. Our AMA will request CEJA to review the advisory restricting collective action in section 1.2.10 of its Code of Medical Ethics to allow for more flexibility on the part of physicians who have exhausted other non-disruptive methods for reform.

The House testified against the word "could" in recommendation (c) of CEJA Report 8-A-25, noting that its use is too broad, nonspecific, and might restrict physicians' ability to take collective action. CEJA appreciates that the use of "could" created an insurmountable bar, and so as a result, in recognition of physicians' fiduciary duties and the need for physician advocacy, CEJA has reached a balance by changing "could" to "would likely" in recommendation (c) for greater clarity.

BACKGROUND

The consolidation of hospitals and physician practices in recent years has led to a shift in the practice of medicine away from the independent practice model to one in which physicians increasingly find themselves working as employees. In 2012, only 5.6 percent of physicians were directly employed by hospitals, with 23.4 percent of physician-owned practices having some hospital ownership; however, by 2022, a total of 74 percent of practicing physicians were employed, including 52.1 percent of physicians employed by hospitals or health systems and 21.8 percent employed by other corporate entities.[1] Paralleling this increase in corporate intrusion into medicine has been the rise of unionization within the profession. While the number of physicians who are members of a union is relatively small, and mostly among house officers, their ranks saw an approximately 26 percent increase in just five years from 2014–2019.[2] As of 2021, an estimated 5.9 percent of practicing physicians were union members, with union contracts covering 8.1

* Reports of the Council on Ethical and Judicial Affairs are assigned to the Reference Committee on Ethics and Bylaws. They may be adopted, not adopted, or referred. A report may not be amended, except to clarify the meaning of the report and only with the concurrence of the Council.

© 2025 American Medical Association. All rights reserved.

percent of practicing physicians.[1] Currently, two of the main physician unions are the Federation of Physicians and Dentists and the Union of American Physicians and Dentists.

As the financing, organization, and leadership of the health care system change, the practice environment increasingly makes it challenging for physicians to provide the kind of care patients want and deserve. Physicians are now increasingly held to strict performance metrics that many feel are more about meeting corporate financial goals than they are about providing quality patient care. As a recent New York Times article puts it, "longer-term consolidation of health care companies has left workers feeling powerless in big bureaucracies. They say the trend has left them with little room to exercise their professional judgment."[3] There is a growing sense among physicians that current working conditions are increasingly compromising the patient–physician relationship, physicians' health, and medical professionalism, driving burnout, moral injury, and retirement from medicine.

Unions are seen by some as a mechanism for physicians to exert influence on corporate health systems where physicians have less autonomy than in private practices.[4] Unions' power for collective bargaining comes from their ability to organize members to take collective action. Unionization, however, is not the only means by which physicians can organize and take collective action. Hospitals' organized medical staff has been a means by which physicians have exercised authority over decision making and culture, but the authority and scope of responsibility of the organized medical staff has been limited.[5] While employed physicians in large systems have not typically explored re-invigorating the organized medial staff, this remains an alternative means by which physicians can reclaim lost authority and exercise collective action.[5]

Physicians may undertake many forms of collective action, both in the public arena and within health care institutions. Public actions include, but are not limited to, public advocacy, media campaigns, lobbying, negotiation, and litigation. Collective actions in the clinical setting increasingly are being considered as additional forms of collective action, particularly to effect change in specific clinical environments. Some of these are not disruptive, such as negotiation with administrators. Disruptive actions are also being considered, such as picketing, refusal to comply with corporate directives deemed unethical, withholding billing, work slowdowns, or striking. A primary concern surrounding the use of these disruptive collective actions by physicians in the clinical setting is that some of these actions may impact patient care and thus be in direct conflict with physicians' professional and ethical duties to not abandon patients and to prioritize patient care above self-interest.[6]

*Relevant Laws*

In 1935, Congress passed the National Labor Relations Act (NLRA), amended in 1947 through the Taft-Hartley Act, which guarantees private sector employees the right to unionize, engage in collective bargaining, and take collective actions such as strikes.[1] The NLRA covers most private sector employees but does not cover independent contractors, supervisors, or managers. Part-time physicians working as independent contractors, physicians in private practice, and physicians considered to serve a supervisory role, such as medical directors or tenured medical faculty, are currently excluded.[2]

When Congress passed the 1974 amendments to the NLRA, which extended coverage to nonprofit hospitals, it added Section 8(g), requiring health care employee unions to give at least a ten-day notice before engaging in any strike or picketing to ensure that hospitals have sufficient time to make appropriate arrangements for the continuity of patient care in the event of a work stoppage.[2]

Laws prohibiting the corporate practice of medicine are an under-appreciated mechanism for physicians to use in reclaiming clinical authority. Most states have had laws dating to the 1880s that prohibit the corporate practice of medicine, but little attention has been paid to the potential use of such laws to prevent health care institutions from infringing upon the clinical decision-making authority that properly belongs to physicians.[7]

*Relevant AMA Policy Provisions*

In 2019, the AMA modified two relevant policies: H-385.973 "Collective Negotiations" and H-385.976 "Physician Collective Bargaining."[8,9] Both support the right of physicians to engage in collective bargaining and express the AMA's commitment to work for the expansion of which physicians are eligible for that right under federal law. This includes supporting efforts to narrow the definition of supervisors such that more physicians are protected under the NLRA.
Though not policy, the AMA's Advocacy Resource Center has also issued a recent Issue Brief: "Collective bargaining for physicians and physicians in training" that outlines AMA policy on physician unions and collective bargaining, including the interpretation that the AMA's position is that "physicians should refrain from the use of the strike as a bargaining tactic, although in rare circumstances, individual or grassroots actions, such as brief limitations of personal availability, may be appropriate as a means of calling attention to needed changes in patient care."[2]

*Relevant* Code *Provisions*

The AMA *Code of Medical Ethics* Opinion 1.1.1, "Patient-Physician Relationships," states that the core tenets of the clinical encounter for the physician are "to place patients' welfare above the physician's own self-interest or obligations to others, to use sound medical judgment on patients' behalf, and to advocate for their patients' welfare." This foundational opinion emphasizes the primary ethical duties of physicians to prioritize patient care and regard their responsibility to the patient as paramount. The Principles enumerated in the Code also indicate that such duties extend beyond the bedside and that physicians have a responsibility to seek changes to laws that are contrary to the best interests of the patient.

Opinion 1.2.10, "Political Action by Physicians," currently states that not only *can* physicians seek to change policies or laws that they find contrary to the best interest of patients but they in fact *have* an ethical duty to do so, though they also "have a responsibility to do so in ways that are not disruptive to patient care."[10] While the opinion states that "[s]trikes and other collective actions […] should not be used as a bargaining tactic", it also adds that "[i]n rare circumstances, briefly limiting personal availability may be appropriate as a means of calling attention to the need for changes in patient care."[10] However, this permissibility must be balanced by the opinion's first directive that physicians participating in advocacy activities should "[e]nsure that the health of patients is not jeopardized and that patient care is not compromised."[10]

This is in line with Opinion 1.1.6, "Quality," which states that "[a]s professionals dedicated to promoting the well-being of patients, physicians individually and collectively share the obligation to ensure that the care patients receive is safe, effective, patient centered, timely, efficient, and equitable."[11] Taken together, by stating that "physicians have an ethical responsibility to seek change" at times (Opinion 1.2.10) and that they also have an "obligation to ensure" quality care (Opinion 1.1.6), these opinions highlight the fact that certain conditions may arise that actually demand action be taken by physicians to improve patient care.

Opinion 9.3.1, "Physician Health & Wellness," similarly outlines that physicians have a responsibility to take action when their own health or wellness is compromised.[12] The opinion

stipulates that physicians have a responsibility both individually and collectively to ensure and promote health and wellness among physicians, and that when their health or wellness is compromised, individual physicians should fulfill this responsibility by "taking measures to mitigate the problem."[12] Physician health and wellness is necessary for effective healing and the provision of quality care, and collective action may be an appropriate means of securing institutional conditions that are conducive to patient health and well-being.

*Additional Relevant Policy*

The World Medical Association recommends that physicians adopt the following guidelines regarding collective action:

1. Physicians who take part in collective action are not exempt from their ethical or professional obligations to patients.
2. Even when the action taken is not organized by or associated with the Constituent Member, the Constituent Member should ensure that the individual physician is aware of and abides by their ethical obligations.
3. Whenever possible, physicians should press for reforms through non-violent public demonstrations, lobbying and publicity or informational campaigns, and/or through negotiation or mediation.
4. If involved in collective action, Constituent Members should act to minimize the harm to the public and ensure that essential and emergency health services, and the continuity of care, are provided throughout a strike. Further, Constituent Members should advocate for measures to review exceptional cases. If involved in collective action, Constituent Members should provide continuous and up-to-date information to their patients and the general public with regard to the demands of the conflict and the actions being undertaken. The general public must be kept informed in a timely manner about any strike actions and the restrictions they may have on health care.[13]

## ETHICAL ISSUE

What are the ethical considerations regarding participation in collective labor action by physicians? Since certain collective actions can be disruptive, they present a potential risk to patient care and thus create a dilemma for physicians, particularly when collective actions may create immediate risks to patients, even if intended as a means to improve patient care in the long term. What collective actions by physicians are ethically permissible must be examined to ensure that the primacy and quality of patient care are protected. The core ethical issue is whether physicians who embrace tactics used by organized labor will also still be able to embrace their role as professionals.

## REVIEW OF RELEVANT LITERATURE

While not all collective actions by physicians may impact clinical practice, disruptive actions such as strikes result in practical challenges to clinical care. This report defines a disruptive collective action by physicians as any collective action that disrupts the day-to-day workflow of physicians within the health care systems in which they practice. Some of these actions may have the potential to decrease quality of care and cause patient harm.

The normative ethics literature on the use of collective actions by physicians is generally cautious about collective actions that present a risk to patients, such as striking. A common stance is that, provided adequate precautions are taken to minimize the risk to patients, the primary goal of the

collective action is to improve patient care, and the disruptive action is considered only as a last resort after all other means have been exhausted, physician strikes may be ethically justifiable.[6,13,18,19,20] However, strikes and other disruptive collective actions become ethically problematic when they are done for any reason other than for improving patient care, such as for increasing physicians' income.[6,18]

One line of argument in favor of permitting disruptive collective actions that might harm patients, such as strikes, is to suggest that physicians are, and have always been, workers like any other set of workers, and that claims of professionalism that would place physicians in a special position of privilege in recognition of a higher set of ethical standards have always been a mere pretense. On this view, there is nothing intrinsically "special" about medicine as opposed to any other form of work. There are some limits on what forms of collective action may be undertaken that are due to the critical nature of the service physicians provide, but there is no reason to maintain the fiction that they cannot engage in strikes or job actions because they are professionals called to put patient interest ahead of self-interest. The ethical question thus becomes how to draw limits on the scope of permissible collective action that recognizes physicians as laborers with all the rights of laborers, while drawing limits that protect the public from harm.

A second line of argument is a variation on this first line of argument—asserting that while medicine is ideally construed as a profession with intrinsically special rights and obligations, one must now, however reluctantly, accept the de-professionalization of physicians as a socioeconomic and historical fact. On this view, physicians have been forced out of their professional status by changes in the financing and organization of health care and the only available means of asserting power now is through unionization and the means of negotiation that have been used for the last two centuries by other workers in resolving disputes with their employers. Again, the operative ethical question becomes one of setting limits on these actions in accord with the vital nature of the service physicians provide.

A third line of argument attempts to reconcile a conception of physicians as professionals, obligated to place patient interest above self-interest, with an understanding that, under certain circumstances (such as those experienced by house officers and, increasingly, physicians employed in large health care systems), there is a *de facto* imbalance in power between the administrators and the employed physicians. They argue on consequentialist grounds that if impediments to good patient care are sufficiently serious, and the goal of a disruptive collective action (such as a strike) is to improve patient care in the long run, then if potential harm to patients in the short-run is minimized, the action is undertaken only as a last resort, and the goal of improving patient care through the action is foreseeably achievable, such an action could be justified.[6,19] These commentators reject the idea that a disruptive collective action with the potential to harm patients could be ethically and justifiably undertaken solely to advance the welfare of physicians. However, they generally recognize that the motives for such actions will often be mixed, and admit that the argument that physician welfare could be sought as the primary (or even secondary) goal of a strike but justified as a necessary means for achieving patient welfare in the long run might either be self-deceived, or, at least, difficult for the public to believe.[6,19,21]

Others have held that strikes by physicians are almost never justifiable.[22-24] Strikes by physicians raise serious questions at the heart of what it means to be a physician. As Pellegrino has written:

> Whatever justification they may have, strikes or "slow downs" by segments of the profession have seriously damaged the image of medicine as a profession dedicated to service above its own interests. One of the distinguishing features of the medical profession has thus been compromised by physicians themselves. Those who choose to

> pursue self-interest, as union members may, cannot at the same time demand a superior moral position in society.[22]

Contrary to the arguments favoring physicians strikes, opponents have appealed to the principle that the duty to promote the good of the patient is always paramount, and that strikes will always harm patients, at least to a modest degree. In fact, they argue, this is the point of the strike—to disrupt care, inconvenience, or possibly harm patients, even if minimally, in order to pressure administrators into acceding to the demands of the striking physicians. Even granting that the ultimate aim of the strike is to improve patient care in the long run, patients will be harmed in the short run, and this conflicts with the profession's ancient duty to protect patients from harm.

Moreover, opponents take issue with the consequentialist argument that some patients could justifiably be exposed to potential harms now for the sure benefit of others in the future. They argue that a primary principle of ethics is that persons should always be treated as ends in themselves and never as means only. Physician strikes, by their nature, instrumentalize some patients, using their potential harm as means of achieving physicians' ends, even if those ends are justifiable and good.

Additionally, the effect of strikes on public trust in the profession must be considered. Trust is the glue that holds the patient-physician relationship together. The sense that one's own health as a patient could in any way be jeopardized or used as a bargaining tool might lead to public distrust in the profession.

While there is not a substantive body of empirical research on the effects of physician strikes on patient outcomes, there are some data. Although the majority of available empirical evidence shows that strikes have minimal impact on patient care,[25-28] much of the data are of relatively poor quality, are at risk of bias, and suffer from a lack of generalizability.[26,27] Furthermore, most studies examine patient mortality as the primary outcome of interest, which has limitations as an indicator of deleterious change in patient health outcomes.[25] Importantly, a 2019 study found a slight increase in 30-day readmission rates for Black patients on strike days in the UK, suggesting that the ways in which strikes impact staffing are unlikely to affect all patient groups equally, with minority groups more likely to experience worse care when hospital systems are under strain[28] This observation has critical importance in determining care for vulnerable populations when considering collective actions. Additionally, there is a lack of crucial research on how collective actions by physicians impact patient perceptions of and trust in both the medical profession and health care institutions. Reports of strongly negative public perceptions during a recent physicians' strike in Korea, while not systematic, suggest a note of caution.[29]

## ETHICAL ANALYSIS

In its review of Opinion 1.2.10, "Political Action by Physicians," CEJA has examined the ethics of collective actions by physicians. While the practical issue for consideration is whether disruptive collection actions by physicians, such as but not limited to strikes, may be permissible, the ethical dilemma is whether physicians can, in fact, fully understand themselves as professionals called to prioritize patient welfare over their own self-interest while engaging in tactics that have the potential to harm patients in the short term, even if the ultimate goal of the action is proposed to be long-term patient benefit.

Historically, physicians retained strong independence in clinical practice, and self-regulation permitted this professionalism to flourish. However, the growth of the health care sector has seen an increase in the complexity of health care systems, the transition to a majority physician

employment structure, and as a result, a loss of physician independence and control in clinical practice. This bureaucratization has led physicians to seek other non-physicians to run the administrative aspects of their practices, and decreasing margins has led physicians to seek capital infusions and buyouts from private equity firms and venture capitalists, further driving the financialization of medicine and the employment of physicians.

The result is a general loss of control over practice conditions that have driven dissatisfaction, burnout, and early retirement from the profession. However, the issue is not necessarily employment itself, but the associated loss of independence of clinical practice and control over the clinical environment, which many today see as the de-professionalization of medicine.

For those seeking to maintain and restore physician authority and independence, the primary avenue has been to pursue legal and political actions, such as lobbying (either independently or through medical associations). However, with the change towards physician employment, physicians are now considering the use of tools that laborers have historically relied on for negotiating, such as legally permissible collective actions, in their attempts to improve patient care. This acceptance of the tools of organized labor, however, is in tension with medicine's self-understanding and public representation of itself as a profession with distinct privileges granted by society in recognition of its commitment to a distinctive set of ethical duties. Certainly, some forms of collective action are not likely to violate the norms of medical professionalism.[30]. Disruptive collective actions, however, which have the potential to disrupt the day-to-day workflow of physicians, decrease quality of care, and cause harm to patients, seem prima facie to violate the medical profession's fundamental duty to do no harm and care for patients. Any disruptive collective action that causes harm to patients is inherently inconsistent with the responsibilities and duties of physicians.

Disruptive collective actions that create the potential for harm to patients, even minimally, and even if undertaken for the purpose of improving the care of other patients in the future, are therefore to be avoided. This does not mean, however, that all forms of disruptive collective action must be avoided. Certain forms of disruptive action, such as collective refusal to comply with administrative directives that are understood as antithetical to good patient care or otherwise incompatible with the norms of professional ethics, may be ethically justified. Other forms of disruptive action that are aimed at disrupting administrative processes such as billing but do not disrupt service to patients, might also be justified. Disruptive actions should only be undertaken, however, as a last resort when good faith negotiations have broken down and the aim of the action is to improve patient care.

## CONCLUSION

Physicians must uphold their central ethical and professional responsibilities to patients when considering collective actions. When considering disruptive collective actions, physicians should take into account that the care of current patients must be continued and not compromised; urgent, emergent and otherwise needed medical care must still be provided; and all other non-disruptive actions that do not negatively impact patients must first be exhausted. Additionally, the primary goal of the action must be to improve patient care and not solely physician self-interest. To protect the integrity of the profession, patients and the public should also be informed well in advance and be continuously updated with respect to the demands being made and the actions being undertaken, with the terms for resolving disruptive actions made public and open to scrutiny and discussion. Whether all these conditions can ever be met in a physician strike or work slowdown remains an open question.

Physicians thinking about participating in disruptive collective actions therefore must first consider their professional responsibilities and obligations.

RECOMMENDATIONS

The Council on Ethical and Judicial Affairs recommends that the following recommendations be adopted and the remainder of the report be filed:

1. That Opinion 1.2.10 be amended by addition and deletion with a change in title as follows:

   Advocacy and Collective Actions by Physicians ~~Political Action by Physicians~~

   Like all Americans, physicians enjoy the right to advocate for change in law and policy, in the public arena, and within their institutions. Indeed, physicians have an ethical responsibility to seek change when they believe the requirements of law, ~~or~~ policy, or practice are contrary to the best interests of patients. However, advocacy actions should not put the wellbeing of patients in jeopardy.

   Collective action is one means by which physicians can advocate for patients, the health of communities, the profession, and their own health. Physicians have a responsibility to avoid disruption to patient care when engaging in any collective action. When considering collective actions that have the potential to be disruptive, whether aimed at changing the policies of government, the private sector, or their own institutions, there are additional considerations that should be addressed. These include avoiding harm to patients, minimizing the impact of actions on patient access to care, maintaining trust in the patient-physician relationship, fulfilling the responsibility to improve patient care, avoiding mental and physical harms to physicians, promoting physician wellbeing, upholding the values and integrity of the profession, and considering alternative measures that could reasonably be expected to achieve similar results with less potential effect on patient and physician wellbeing.

   When considering participation ~~Physicians who participate~~ in advocacy activities, including collective actions:

   (a) ~~Ensure that the health of patients is not jeopardized, and that patient care is not compromised.~~ Physicians should recognize that, in pursuing their primary commitment to patients, physicians can, and at times may have an obligation to, engage in collective political action to advocate for changes in law and institutional policy aimed at promoting patient care and wellbeing.

   (b) ~~Avoid using disruptive means to press for reform. Strikes and other collective actions may reduce access to care, eliminate or delay needed care, and interfere with continuity of care and should not be used as a bargaining tactic. In rare circumstances, briefly limiting personal availability may be appropriate as a means of calling attention to the need for changes in patient care. Physicians should be aware that some actions may put them or their organizations at risk of violating antitrust laws or laws pertaining to medical licensure or malpractice.~~ Physicians may also engage in collective action to advocate for changes within their institutions, including changes in patient care practices, physician work

conditions, health and wellbeing, and/or institutional culture that negatively affect patient care.

(c) Physicians should refrain from collective action that would likely jeopardize the health of patients or compromise patient care.

(d) Physicians may consider engaging in disruptive forms of collective action that do not compromise patient care only as a last resort, with the primary objective to improve patient care and outcomes by calling attention to and/or making needed changes in practices, protocols, incentives, expectations, structures, and/or institutional culture.

(e) Disruptive actions, including strikes, that could directly compromise patient care should be avoided and should not be used solely for physician self-interest.

(f) Physicians should avoid forming workplace or other alliances, such as unions, with ~~workers~~ colleagues and others who do not share physicians' primary and overriding commitment to patients.

(g) Physicians should refrain from using ~~undue influence or pressure colleagues~~ punitive or coercive means to force others to participate in advocacy activities or collective actions, or to penalize others ~~and should not punish colleagues, overtly or covertly,~~ for deciding not to participate in such activities.

2. That Policy H-405.946(2) be rescinded as having been accomplished by this report. (Rescind AMA Policy)

Fiscal Note: Minimal

REFERENCES


1. Bowling D, Richman BD, Schulman KA. The rise and potential of physician unions. *JAMA*. 2022;328(7):617-8.
2. AMA. Issue brief: Collective bargaining for physicians and physicians-in-training. *AMA Advocacy Resource Center*. 2023. https://www.ama-assn.org/system/files/advocacy-issue-brief-physician-unions.pdf.
3. Scheiber N. Why Doctors and Pharmacists Are in Revolt. *NY Times.* 3 December 2023. https://www.nytimes.com/2023/12/03/business/economy/doctors-pharmacists-labor-unions.html?unlocked_article_code=1.DE0.ct8T.5mKAmg0HXEfX&hpgrp=ar-abar&smid=url-share.
4. Richman BD, Schulman KA. Restoring Physician Authority in an Era of Hospital Dominance. *JAMA*. 2022;328(24):2400-1.
5. Burroughs J. Re-design the Medical Staff Model. Chicago: American College of Healthcare Executives, 2015: 1-22; Gosfield AG. The organized medical staff: should anyone care anymore? *J Med Pract Manage*. 2005 Jan-Feb;20(4):210-6.
6. Thompson SL, Salmon JW. Strikes by physicians: a historical perspective toward an ethical evaluation. *Int J of Health Serv*. 2006;36(2):331-54.
7. Zhu JM, Rooke-Ley H, Fuse Brown E. A Doctrine in Name Only - Strengthening Prohibitions against the Corporate Practice of Medicine. *N Engl J Med*. 2023 Sep 14;389(11):965-968.
8. American Medical Association. H-385.973 Collective Negotiations. Accessed May 13, 2024. https://policysearch.ama-assn.org/policyfinder/detail/H-385.973?uri=%2FAMADoc%2FHOD.xml-0-3292.xml.
9. American Medical Association. H-385.976 Physician Collective Bargaining. Accessed May 13, 2024 https://policysearch.ama-assn.org/policyfinder/detail/H-385.976?uri=%2FAMADoc%2FHOD.xml-0-3294.xml
10. American Medical Association. Opinion 1.1.3 Patient Rights. *AMA Code of Medical Ethics*. Accessed May 8, 2024. https://code-medical-ethics.ama-assn.org/ethics-opinions/patient-rights.
11. American Medical Association. Opinion 1.1.6 Quality. *AMA Code of Medical Ethics*. Accessed May 8, 2024. https://code-medical-ethics.ama-assn.org/ethics-opinions/patient-rights.
12. American Medical Association. Opinion 9.3.1 Physician Health and Wellness. *AMA Code of Medical Ethics*. Accessed May 8, 2024. https://code-medical-ethics.ama-assn.org/ethics-opinions/physician-health-wellness.
13. WMA statement on the ethical implications of collective actions by physicians. WMA 2022. https://www.wma.net/policies-post/wma-statement-on-the-ethical-implications-of-collective-action-by-physicians/#:~:text=The%20World%20Medical%20Association%20recommends,or%20professional%20obligations%20to%20patients.
14. Zwolinski M, Ferguson B, Wertheimer A. Exploitation. The Stanford Ency of Phil, Edward N. Zalta & Uri Nodelman, eds. 2022;Winter. https://plato.stanford.edu/archives/win2022/entries/exploitation/.
15. Vesoulis A. 'I'm mentally and physically exhausted.' Healthcare workers battling coronavirus are running out of protective gear. *Time*. Published March 24, 2020. https://time.com/5808992/healthcare-workers-lack-ppe/

16. Working overtime, not seeing family members for days, doctors recount struggle during covid fight. *The Economic Times*. Published July 1, 2021. https://economictimes.indiatimes.com/industry/healthcare/biotech/healthcare/working-overtime-not-seeing-family-members-for-days-doctors-recount-struggle-during-covid-fight/articleshow/84037386.cms?from=mdr
17. Iacobucci G. Covid-19: Doctors feel under pressure to work extra shifts unpaid, survey shows. *BMJ*. 2021;373:n1189. doi:10.1136/bmj.n1189.
18. Howard D. What should physicians consider prior to unionizing? *AMA JoE*. 2020;22(3):193-200.
19. Thompson SL, Salmon JW. Physician strikes. *Chest*. 2014;146(5):1369-1374. doi:10.1378/chest.13-2024.
20. Jackson RL. Physician strikes and trust. *Cambridge Quarterly of Healthcare Ethics*. 2000;9(4):504-12.
21. West CP, Dyrbye LN, Shanafelt TD. Physician burnout: contributors, consequences and solutions. *J of Int Med*. 2018;283(6):516-29.
22. Pellegrino ED, Relman AS. Professional medical associations: ethical and practical guidelines. JAMA 1999;282:984; Pellegrino ED Humanism and the Physician. Knoxville: *University of Tennessee Press*. 1979:122.
23. Cohen JJ. White coats should not have union labels. *N Engl J Med*. 2000 Feb 10;342(6):431-4. doi: 10.1056/NEJM200002103420614.
24. Bion J. Are doctors justified in taking industrial action in defense of their pensions? No. BMJ 2012;344:e3175; Glick SM. Health workers' strikes: a further rejoinder. *J Med Ethics*. 1986;12:43-44.
25. Cunningham SA, Mitchell K, Narayan KV, Yusuf S. Doctors' strikes and mortality: a review. *Soc Sci & Med*. 2008;67(11):1784-8.
26. Essex R, Milligan W, Williams G, Weldon SM. The impact of strike action on patient morbidity: A systematic literature review. T*he Int J of Health Plan and Manag*. 2022;37(3):1311-26.
27. Essex R, Weldon SM, Thompson T, Kalocsányiová E, McCrone P, Deb S. The impact of health care strikes on patient mortality: A systematic review and meta-analysis of observational studies. *Health Serv Res*. 2022;57(6):1218-34.
28. Stoye G, Warner M. The effects of doctor strikes on patient outcomes: Evidence from the English NHS. *J of Econ Behav & Org*. 2023;212:689-707.
29. Young JY. More doctors walk off the job in Korea. New York Times. June 18, 2024: https://www.nytimes.com/2024/06/18/world/asia/south-korea-doctor-strike.html.
30. Goold SD. Collective action by physicians: beyond strikes. *Camb Q Healthc Ethics*. 2000 Fall;9(4):498-503. doi: 10.1017/s0963180100904079.

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 03-I-25

Subject: Ethical Impetus for Research in Pregnant and Lactating Individuals

Presented by: Rebecca Brendel, MD, Chair

Referred to: Reference Committee on Ethics and Bylaws

---

Policy D-140.949, "Ethical Impetus for Research in Pregnant and Lactating Individuals," was adopted at the 2024 Annual Meeting and asks "that our Council on Ethical and Judicial Affairs (CEJA) consider updating its ethical guidance on research in pregnant and lactating individuals."

## BACKGROUND

More than four million individuals give birth in the United States every year[1] and 70 percent of these individuals will require at least one prescription medication while pregnant.[2] Despite the widespread use of medications during pregnancy, most information about the efficacy and safety of medication used during pregnancy comes from the post-marketing setting and is not derived from clinical research trials.[3]

Only a dozen medications have been approved by the United States Food and Drug Administration (FDA) for use during pregnancy, and those medications are for gestation- or birth-related medical issues.[4] Therefore, any medications utilized to treat chronic health conditions in pregnancy are used without FDA approval ("off label"). Only 2.4 percent of those commonly used medications for chronic health conditions have included pregnant individuals in controlled human clinical trials. The lack of clinical trial data is a result of the historical exclusion of pregnant and lactating individuals from clinical trials. Exclusion of pregnant and lactating individuals from clinical trials has often occurred due to the fear of harming the fetus or newborn, as well as concern that physiologic changes in pregnancy or during lactation will impact the results of pharmacologic trials.[3,5] The effect of this exclusion is that physicians and patients are forced to make decisions about whether to utilize medications during pregnancy without adequate fetal and maternal safety data.[6]

## ETHICAL ISSUE

Pregnant and lactating individuals have been systematically excluded from clinical trials for decades out of concern for negative effects on fetuses and nursing infants. This exclusion has resulted in a paucity of evidence regarding safe and effective medication use in these groups of individuals. Due to the existing knowledge gaps surrounding the use of medications during pregnancy and breastfeeding, physicians and patients are faced with making treatment decisions without appropriately understanding the potential benefits and risks to both the pregnant individual and their fetuses or nursing infant. Additionally, these knowledge gaps prevent physicians from

* Reports of the Council on Ethical and Judicial Affairs are assigned to the Reference Committee on Ethics and Bylaws. They may be adopted, not adopted, or referred. A report may not be amended, except to clarify the meaning of the report and only with the concurrence of the Council.

© 2025 American Medical Association. All rights reserved.

being able to appropriately counsel pregnant patients regarding the risks, benefits, and alternatives of treatments. At issue is how to balance respect for pregnant and lactating individuals with the potential benefits and harms of research.

## REVIEW OF RELEVANT LITERATURE

Pregnant and lactating individuals have historically been considered "vulnerable" and subjected to additional research protections and exclusion from research.[7] This problem is known as the "protection-inclusion dilemma", whereby groups deemed "vulnerable" are "over-protected" and excluded from research, leading to justice issues including a "lack of relevant health data for under-represented populations."[8] The consequence of the protection-inclusion dilemma is that most of the medications pregnant individuals are prescribed are not FDA approved for pregnancy. This is problematic because while "there are significant physiologic changes in pregnancy, including near doubling of maternal blood volume and alterations in binding proteins, the pharmacokinetics [PK] and efficacy of drugs in pregnancy are, by and large, unknown."[7] This uncertainty for prescribers results in dosages labelled for use in nonpregnant individuals being used for pregnant individuals, "with little consideration for the PK changes that occur during pregnancy."[9]

Although the negative effects of excluding pregnant and lactating individuals in clinical trials have been noted for years, little has been done in that time to address the significant knowledge gaps in research that remain. For example, many Institutional Review Boards (IRB) "continue to regard pregnancy as a near-automatic cause for exclusion, regardless of the costs of exclusion or the magnitude or likelihood of the risks of participation," and the lack of research data leads to persistent disparities for chronic disease management among pregnant individuals.[5]

### *Relevant Laws*

The FDA has several relevant regulations. 45 CFR 46, Subpart B "Additional Protections for Pregnant Women, Human Fetuses and Neonates Involved in Research", provides regulations regarding research involving pregnant individuals. 45 CFR §46.204 – "Research involving pregnant women or fetuses" states that:

> Pregnant women or fetuses may be involved in research if all of the following conditions are met:
>
> (b) The risk to the fetus is caused solely by interventions or procedures that hold out the prospect of direct benefit for the woman or the fetus; or, if there is no such prospect of benefit, the risk to the fetus is not greater than minimal and the purpose of the research is the development of important biomedical knowledge which cannot be obtained by any other means.[10]

Additionally, as of January 21, 2019, the Common Rule no longer labels pregnant individuals as "vulnerable" with regards to IRBs. This is because while pregnant individuals have historically been deemed vulnerable, it has since been recognized that while some individuals who are pregnant may be vulnerable, being pregnant in and of itself does not automatically denote vulnerability. [11,12] The 2024 updated version of the World Medical Association's Declaration of Helsinki reinforces this point, stating that "[w]hen such individuals, groups, and communities have distinctive health needs, their exclusion from medical research can potentially perpetuate or exacerbate their disparities. Therefore, the harms of exclusion must be considered and weighed against the harms of inclusion."[11]

*Relevant Code Provision(s)*

The *Code of Medical Ethics* encourages the inclusion of pregnant individuals in clinical trials, when appropriate, so long as the research "balance[s] the health and safety of the woman who participates and the well-being of the fetus with the desire to develop new and innovative therapies" (Opinion 7.3.4). However, the *Code* also places constraints on physicians involved in maternal-fetal research, advising that they should "[e]nroll a pregnant woman in maternal-fetal research only when there is no simpler, safer intervention available to promote the well-being of the woman or fetus" (Opinion 7.3.4).

## ETHICAL ANALYSIS

A multitude of historical, legal, scientific, and societal factors have resulted in the exclusion of pregnant and lactating individuals from clinical trials for decades. However, the ethical principle of justice necessitates that the benefits and burdens of research participation be fairly distributed across all groups, including pregnant and lactating individuals, because failure to do so produces disparities that impact both safety and quality of care for pregnant and lactating individuals, fetuses, and nursing infants.

Concerns for fetal safety have served as the primary justification for the exclusion of pregnant individuals from clinical trials for decades, but this exclusion has paradoxically resulted in substantial maternal and fetal harm. Because information about toxicity and dosing for pregnant and lactating individuals has not been determined through smaller scale and well-controlled clinical trials for most medications, far more pregnant and lactating individuals who require medications for chronic medical conditions are being exposed to potentially harmful medications via "off label" uses.

Examples of this harm can be seen in the historical use of thalidomide and diethylstilbestrol in pregnant individuals. While the tragic consequences of their use have been cited as reasons to exclude pregnant individuals from clinical trials, it was actually the lack of controlled data from clinical trials that caused such widespread detrimental effects due to the teratogenic effects of these drugs not being examined until post-marketing surveillance data was available. Had smaller scale and better controlled clinical trials been conducted, mass marketing and exposure to these medications for pregnant individuals may have been avoided because the teratogenic effects would have been discovered during trials.[13]. Another example is that of ACE inhibitors, which were used in pregnant individuals for three decades prior to the 1996 discovery that its use in the first trimester can cause congenital anomalies.[5]. Had it been studied more rigorously through smaller scale clinical trials with individuals consenting to the risks of participating in research, this discovery may have been made much sooner and far fewer individuals would have been exposed to this drug in the first trimester without knowing the risks of doing so.

Historically, concern for pregnant individuals and fetuses has centered on defining this population as "vulnerable", thus needing broad shielding from risks, such as medical research. Such an approach to research practices has been deemed "overly paternalistic, disempowering, or coercive."[14] Pregnant and lactating individuals are not automatically vulnerable, and this approach does not respect their autonomy to assess the benefits and risks of participation for themselves and their fetuses or newborns.[15] Pregnant and lactating individuals should always be provided the opportunity to decide whether research participation is in their best interest through informed consent. If pregnant or lactating individuals are unable to be included in research, alternative ways to rectify any gap in knowledge should be developed. For example, pregnant and lactating

individuals should be instructed on how to participate in research registries and adverse event reporting programs.

## CONCLUSION

The historical exclusion of pregnant and lactating individuals from clinical trials has resulted in a lack of data about the appropriate safety, dosage, and efficacy of most medications in this group. This knowledge gap has created an ethical imperative to include more pregnant and lactating individuals in clinical trials. While consideration of maternal, fetal, and nursing infant well-being should be important criteria included in guidelines for research, wholesale exclusion of pregnant and lactating individuals from clinical trials comes with its own risk to fetal and maternal safety. Theoretical risks for fetal harm should not automatically be assumed to outweigh potential risks of ongoing nonparticipation. Currently, the *Code* does not reference this disparity. Nor does it refer to lactating individuals. It also does not contain gender neutral language, i.e., it references women and not individuals.

## RECOMMENDATION

The Council on Ethical and Judicial Affairs recommends that following being adopted and the remainder of the report be filed:

1. Research involving pregnant and lactating individuals, including but not limited to, research regarding interventions intended to benefit pregnant or lactating individuals and/or their fetuses or nursing infants, must balance the health and safety of individuals who participate and the well-being of their fetuses or nursing infant against the desire to develop new and innovative therapies. Although it is important to carefully consider potential fetal risks involved when pregnant and lactating individuals participate in research, it is critical to realize that large scale exclusion from participation by these individuals has also precluded potential benefits and in some cases resulted in harm for this group. The paucity of data on safe and effective medical treatment during pregnancy and breastfeeding has resulted in physicians and patients choosing between pursuing medical interventions with uncertain risks to themselves and their fetuses or nursing infants, or foregoing the interventions altogether, which might itself cause harm due to undertreatment of medical conditions.

   Understanding both the potential risks of participation and of non-participation, physicians conducting research must obtain the informed, voluntary consent of pregnant or lactating individuals, and adhere to general principles for ethical conduct of research as in all human participant's research. In addition, physicians conducting research should:

   (a) Include pregnant and lactating individuals in research for which they would otherwise be eligible in order to establish a greater knowledge base, produce relevant data, and promote respect for individuals.

   (b) Consider excluding pregnant and lactating individuals only when a study poses a substantial risk of significant harm to them or their fetuses or nursing infants, and:

      i. specify why the research excludes pregnant and lactating individuals;

      ii. seek alternative research methodologies to rectify gaps in knowledge.

(c) Where scientifically appropriate and available, base studies that include pregnant and lactating individuals on well-designed, ethically sound, existing research with nonhuman animals or nongravid human participants to better assess potential risks.

(d) Minimize risks to the fetus or nursing infant to the greatest extent possible, especially when the research is not conducted primarily to investigate potential benefit for fetuses or nursing infants, but rather for the development of important biomedical knowledge that cannot be obtained by any other means. (New HOD/CEJA Policy)

2. AMA Policy D-140.949 be rescinded as having been accomplished by this report. (Rescind AMA Policy)

Fiscal Note: Minimal

REFERENCES


1. Martin JA, Hamilton BE, et al. Births: Final Data for 2007. *National Vital Statistics Reports*. 2010;58(24):1-85.
2. Wesley BD, Sewell CA, et al. Prescription medications for use in pregnancy-perspective from the US Food and Drug Administration. *AJOG.* 2021;225(1):21-32.
3. Center for Drug Evaluation Research and Center for Biologics Evaluation and Research. Pregnant Women: Scientific and Ethical Considerations for Inclusion in Clinical Trials: Guidance for Industry. *Food and Drug Administration*. Published: April 2018. Available at: https://www.fda.gov/media/112195/download?attachment
4. Haire D. FDA Approved Obstetric Drugs: Their Effects on Mother and Baby. New York: American Foundation for Maternal and Child Health, 2001 Available at: https://asanfranciscodoula.com/resources/Preview%20of%20"FDA%20Approved%20Obstetric%20Drugs-%20Their%20Effects%20on%20Mother%20and%20Baby".pdf
5. Lyerly A., Little M, Faden R. The Second Wave: Toward Ethical Inclusion of Pregnant Women in Clinical Research. *International Journal of Feminist Approaches to Bioethics* . 2008; 1(2):5–22.
6. Wilson 2007. SOGC clinical practice guideline #199: Principles of teratology. *Journal of Obstetrics and Gynaecology Canada*. 2007;21(11): 911–917
7. Blehar MC, Spong C, Grady C, Goldkind SF, Sahin L, Clayton JA. Enrolling pregnant women: issues in clinical research. *Womens Health Issues.* 2013 Jan;23(1):e39-45.
8. Friesen P, Gelinas L, Kirby A, Strauss DH, Bierer BE. IRBs and the Protection-Inclusion Dilemma: Finding a Balance. *The American Journal of Bioethics*. 2022;23(6):75–88.
9. Illamola SM, Bucci-Rechtweg C, et al. Inclusion of pregnant and breastfeeding women in research – efforts and initiative. *Br J Clin Pharmacol*. 2018;8:215–222.
10. 45 CFR 46, Subpart B - Additional Protections for Pregnant Women, Human Fetuses and Neonates Involved in Research https://www.hhs.gov/ohrp/regulations-and-policy/regulations/45-cfr-46/common-rule-subpart-b/index.html#46.204
11. World Medical Association. World Medical Association Declaration of Helsinki: ethical principles for medical research involving human participants. *JAMA*. 2025;333(1):71-4.
12. A Point in Time eCFR System, 45 CFR § 46.107, *National Archives*. 2018. Available at: https://ecfr.gov/compare/2018-07-19/to/2018-07-18/title-45/subtitle-A/subchapter-A/part-46/subpart-A/section-46.107
13. International Ethical Guidelines for Health-related Research Involving Humans. *Council for International Organizations of Medical Sciences (CIOMS)*. Published: 2016. Available at: https://cioms.ch/wp-content/uploads/2017/01/WEB-CIOMS-EthicalGuidelines.pdf
14. Roest J, Nkosi B, et al. Respecting relational agency in the context of vulnerability: What can research ethics learn from the social sciences? *Bioethics.* 2023;37:379-388.
15. Shields KE, Lyerly AD. Exclusion of pregnant women from industry-sponsored clinical trials. *Obstet Gynecol*. 2013:122(5):1077-1081

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 001
(I-25)

Introduced by: New England Delegation

Subject: Clarifying Conscientious Objection

Referred to: Reference Committee on Ethics and Bylaws

---

Whereas, recent high-profile cases of conscientious objection have involved physicians refusing care to patients based upon their identity characteristics, including a child who was refused care because their parents' sexuality and a mother who was refused prenatal care because they were unmarried; [1-2] and

Whereas, present AMA policy, by limiting conscientious objection only where it constitutes discrimination against or an undue burden on patients, tacitly permits the use of conscientious objection in the aforementioned cases; and

Whereas, in spite of AMA policy asking physicians to "take care that their actions do not discriminate against…individual patients," conscientious objection has long been invoked to refuse care to patients based upon protected characteristics, including gender identity and sexuality; [3-5] and

Whereas, in spite of the fact that AMA policy clear places limits on conscientious objection, such limits are frequently not reflected in state or federal law or policy; [6-8] and

Whereas, by limiting conscientious objection where it constitutes discrimination, present AMA policy is dependent on the legal definition of discrimination, and a change in the legal definition of discrimination would thereby change where conscientious objection is permissible; and

Whereas, the revocation of federal protections for LGBTQ+, gender-diverse, or disabled populations would thereby render it permissible, per present AMA policy, for physicians to conscientiously object to providing care to patients in these populations; and

Whereas, the ethical principles which underlie medical practice are beholden to no law; and

Whereas, the use of conscientious objection to refuse care to patients based upon their membership in particular groups, rather than an ethical objection to providing a particular type of care, is widely regarded as unethical by philosophers of medicine; [9-11] therefore be it

RESOLVED, that our American Medical Association study the use of conscientious objection to refuse care to patients based upon their membership in particular groups, including when such refusal does not meet the legal standard of invidious discrimination, and return recommendations strengthening present policy against this practice (Directive to Take Action); and be it further

RESOLVED, that our AMA ask the Council on Ethical and Judicial Affairs to consider amending the AMA Code of Medical Ethics--including, but not limited to, its relevant Principles--to ensure

that a physician's right to choose their patients is appropriately limited by their duty to provide equitable access to care (Directive to Take Action); and be it further

RESOLVED, that our AMA (i) support efforts to include protections for patients, as they are delineated in the AMA Code of Medical Ethics, in state- and federal-level policies codifying conscientious objection and (ii) oppose policies protecting conscientious objection which do not also provide these protections to patients. (New HOD Policy)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/18/25

**REFERENCES**

1. https://www.washingtonpost.com/news/morning-mix/wp/2015/02/19/pediatrician-refuses-to-treat-baby-with-lesbian-parents-and-theres-nothing-illegal-about-it/
2. https://nashvillebanner.com/2025/07/20/doctor-denies-pregnant-woman-care/
3. https://www.motherjones.com/politics/2006/07/breeder-reaction/
4. https://www.nbcnews.com/politics/supreme-court/supreme-court-won-t-take-catholic-hospital-appeal-over-surgery-n1282851
5. Brummett A, Campo-Engelstein L. Conscientious objection and LGBTQ discrimination in the United States. J Public Health Policy. 2021 Jun;42(2):322-330. doi: 10.1057/s41271-021-00281-2. Epub 2021 Apr 27. PMID: 33907303.
6. https://www.legislature.mi.gov/documents/2003-2004/billengrossed/house/htm/2003-HEBH-5006.htm
7. https://www.capitol.tn.gov/Bills/114/Bill/SB0955.pdf
8. https://www.govinfo.gov/content/pkg/FR-2024-01-11/pdf/2024-00091.pdf
9. https://journalofethics.ama-assn.org/article/limits-conscientious-refusal-duty-ensure-access/2013-03
10. https://bioethics.pitt.edu/sites/default/files/Physicians%2C%20Not%20Conscripts.pdf
11. https://academic.oup.com/jmp/article/46/1/37/6054702#226657373

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 002
(I-25)

Introduced by: Women Physicians Section

Subject: Ensuring Ethical Use of Wearable Recording Devices in Clinical Encounters

Referred to: Reference Committee on Ethics and Bylaws

---

Whereas, wearable smart devices with discreet recording capabilities, such as Ray-Ban Meta glasses and other similar technologies, are increasingly accessible to physicians and patients alike; and

Whereas, these devices may have always-on or easily activated photo, audio, or video recording functionality that can be difficult to detect, potentially enabling covert documentation of clinical encounters; and

Whereas, existing healthcare technology companies report an interest in integrating popular artificial intelligence scribes with wearable smart devices[1]; and

Whereas, AMA Ethics Opinion 3.1.3, "Audio or Visual Recording Patients for Education in Health Care," outlines necessary consent and privacy protections for educational recordings, but does not explicitly address personal, wearable, or commercial recording devices used by individual clinicians or patients in routine care; and

Whereas, patients have a reasonable expectation of privacy in the clinical setting, and undisclosed recording—whether by the clinician or patient—risks undermining trust in the physician-patient relationship, violates ethical norms, and may conflict with state or federal law; and

Whereas, sensitive physical examinations, including breast, pelvic, genital, and rectal exams, require heightened attention to patient dignity and privacy, and the presence of wearable recording devices during such exams—even if not actively recording—may compromise patient trust and comfort; and

Whereas, there is currently no clear AMA policy guiding the ethical and privacy considerations for physician-worn recording devices outside of institutional educational or telehealth settings; therefore be it

RESOLVED, that our American Medical Association consider developing new ethical guidance to address the use of personal or wearable recording devices—including eyeglass-mounted cameras—by physicians and patients in clinical encounters, including provisions that:

a. Require informed patient consent prior to any recording,
b. Prohibit covert or undisclosed use of such devices in clinical care,
c. Recommend that such non-clinical visual recording devices not be worn during physical examinations of the breast, pelvic, genital, or rectal areas, regardless of recording status.

(Directive to take Action); and be it further

RESOLVED, that our AMA work with appropriate entities and organizations to develop model institutional policies on the ethical use, disclosure, and documentation of wearable and ambient personal recording technologies in health care settings. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/25/25

**REFERENCES**

1. https://getvim.com/blog/ambient-scribe/

## RELEVANT AMA POLICY

### 3.1.3 Audio or Visual Recording Patients for Education in Health Care

Audio or visual recording of patients can be a valuable tool for educating health care professionals, but physicians must balance educational goals with patient privacy and confidentiality. The intended audience is bound by professional standards of respect for patient autonomy, privacy, and confidentiality, but physicians also have an obligation to ensure that content is accurate and complete and that the process and product of recording uphold standards of professional conduct.

To safeguard patient interests in the context of recording for purposes of educating health care professionals, physicians should:

a. Ensure that all nonclinical personnel present during recording understand and agree to adhere to medical standards of privacy and confidentiality.
b. Restrict participation to patients who have decision-making capacity. Recording should not be permitted when the patient lacks decision-making capacity except in rare circumstances and with the consent of the parent, legal guardian, or authorized decision maker.
c. Inform the patient (or authorized decision maker, in the rare circumstances when recording is authorized for minors or patients who lack decision-making capacity):
    i. about the purpose of recording, the intended audience(s), and the expected distribution;
    ii. about the potential benefits and harms (such as breach of privacy or confidentiality) of participating;
    iii. that participation is voluntary and that a decision not to participate (or to withdraw) will not affect the patient's care;
    iv. that the patient may withdraw consent at any time and if so, what will be done with the recording;
    v. that use of the recording will be limited to those involved in health care education, unless the patient specifically permits use by others.
d. Ensure that the patient has had opportunity to discuss concerns before and after recording.
e. Obtain consent from a patient (or the authorized decision maker):
    i. prior to recording whenever possible;
    ii. before use for educational purposes when consent could not be obtained prior to recording.
f. Respect the decision of a patient to withdraw consent.
g. Seek assent from the patient for participation in addition to consent by the patient's parent or guardian when participation by a minor patient is unavoidable.
h. Be aware that the act of recording may affect patient behavior during a clinical encounter and thereby affect the film's educational content and value.
i. Be aware that the information contained in educational recordings should be held to the same protections as any other record of patient information. Recordings should be securely stored and properly destroyed, in keeping with ethics guidance for managing medical records.
j. Be aware that recording creates a permanent record of personal patient information and may be considered part of the medical record and subject to laws governing medical records. [Issued: 2016]

**3.1.4 Audio or Visual Recording of Patients for Public Education**

Audio and/or visual recording of patient care for public broadcast is one way to help educate the public about health care. However, no matter what medium is used, such recording poses challenges for protecting patient autonomy, privacy, and confidentiality. Filming cannot benefit a patient medically and may cause harm. As advocates for their patients, physicians have an obligation to protect patient interests and ensure that professional standards are upheld. Physicians also have a responsibility to ensure that information conveyed to the public is complete and accurate (including the risks, benefits, and alternatives of treatments).

Physicians involved in recording patients for public broadcast should:

(a) Participate in institutional review of requests to record patient interactions.
(b) Require that persons present for recording purposes who are not members of the health care team:
    (i) minimize third-party exposure to the patient's care; and
    (ii) adhere to medical standards of privacy and confidentiality.
(c) Encourage recording personnel to engage medical specialty societies or other sources of independent expert review in assessing the accuracy of the product.
(d) Refuse to participate in programs that foster misperceptions or are otherwise misleading.
(e) Restrict participation to patients who have decision-making capacity. Recording should not be permitted when the patient lacks decision-making capacity except in rare circumstances and with the consent of the parent, legal guardian, or authorized decision maker.
(f) Inform a patient (or authorized decision maker) who is to be recorded:
    (i) about the purpose for which patient encounters with physicians or other health care professionals will be recorded;
    (ii) about the intended audience(s);
    (iii) that the patient may withdraw consent at any time prior to recording and up to an agreed on time before the completed recording is publicly broadcast, and if so, what will be done with the recording;
    (iv) that at any time the patient has the right to have recording stopped and recording personnel removed from the area;
    (v) whether the patient will be allowed to review the recording before broadcast and the degree to which the patient may edit the final product; and
    (vi) whether the physician was compensated for his participation and the terms of that compensation.
(g) Ensure that the patient has had the opportunity to address concerns before and after recording.
(h) Ensure that the patient's consent is obtained by a disinterested third party not involved with the production team to avoid potential conflict of interest.
(i) Request that recording be stopped and recording personnel removed if the physician (or other person involved in the patient's care) perceives that recording may jeopardize patient care.
(j) Ensure that the care they provide and the advice they give to patients regarding participation in recording is not influenced by potential financial gain or promotional benefit to themselves, their patients, or the health care institution.
(k) Remind patients and colleagues that recording creates a permanent record and may in some instances be considered part of the medical record. [Issued: 2016]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 003
(I-25)

Introduced by: Women Physicians Section

Subject: Report on Gender-Based Pay Equity in Medicine

Referred to: Reference Committee on Ethics and Bylaws

---

Whereas, the American Medical Association (AMA) has established several policies aimed at addressing gender-based pay equity within the medical profession, reflecting a commitment to ensuring fair and equitable compensation for all physicians, regardless of gender; and

Whereas, the AMA's policies emphasize the importance of pay equity, transparency in compensation, support for research and data collection, education and advocacy, workplace policies, and support for female physicians (AMA Policy D-65.989, H-65.961, and E-9.5.5); and

Whereas, multiple studies have demonstrated persistent gender-based pay disparities in medicine, with female physicians earning approximately $2 million less than their male counterparts over a 40-year career, even after adjusting for specialty, hours worked, and experience; and

Whereas, these disparities negatively impact the morale, retention, and advancement of female physicians, and contribute to broader issues of equity and diversity within the profession; and

Whereas, transparency and accountability are essential for identifying and rectifying pay disparities, as supported by AMA policies and recommendations from national organizations such as the National Academy of Medicine; therefore be it

RESOLVED, that our American Medical Association study and report at HOD 2026 the current pay structures and existing disparities between male and female physicians, and review policies to ensure equitable compensation for all physicians. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/25/25

**REFERENCES**


1. Jena AB, Khullar D, Ho O, Olenski AR, Blumenthal DM. Sex Differences in Physician Salary in US Public Medical Schools. JAMA Intern Med. 2016;176(9):1294-1304. doi:10.1001/jamainternmed.2016.3284
2. American Medical Association. Policy D-65.989, H-65.961, E-9.5.5.
3. National Academy of Medicine. Taking Action Against Clinician Burnout: A Systems Approach to Professional Well-Being. 2019

**RELEVANT AMA POLICY**

**D-65.989 Advancing Gender Equity in Medicine**

1. Our American Medical Association will:
    a. advocate for institutional, departmental and practice policies that promote transparency in defining the criteria for initial and subsequent physician compensation.
    b. advocate for pay structures based on objective, gender-neutral criteria.
    c. encourage a specified approach, sufficient to identify gender disparity, to oversight of compensation models, metrics, and actual total compensation for all employed physicians.
    d. advocate for training to identify and mitigate implicit bias in compensation determination for those in positions to determine salary and bonuses, with a focus on how subtle differences in the further evaluation of physicians of different genders may impede compensation and career advancement.
2. Our AMA will recommend as immediate actions to reduce gender bias:
    a. Elimination of the question of prior salary information from job applications for physician recruitment in academic and private practice.
    b. Create an awareness campaign to inform physicians about their rights under the Lilly Ledbetter Fair Pay Act and Equal Pay Act.
    c. Establish educational programs to help empower all genders to negotiate equitable compensation.
    d. Work with relevant stakeholders to host a workshop on the role of medical societies in advancing women in medicine, with co-development and broad dissemination of a report based on workshop findings.
    e. Create guidance for medical schools and health care facilities for institutional transparency of compensation, and regular gender-based pay audits.
3. Our AMA will collect and analyze comprehensive demographic data and produce a study on the inclusion of women members including, but not limited to, membership, representation in the House of Delegates, reference committee makeup, and leadership positions within our AMA, including the Board of Trustees, Councils and Section governance, plenary speaker invitations, recognition awards, and grant funding, and disseminate such findings in regular reports to the House of Delegates and making recommendations to support gender equity.
4. Our AMA will commit to pay equity across the organization by asking our Board of Trustees to undertake routine assessments of salaries within and across the organization, while making the necessary adjustments to ensure equal pay for equal work.
5. Our AMA will:
    a. require all members elected and appointed to national and regional AMA leadership positions to complete AMA Code of Conduct and anti-harassment training, with continued evaluation of the training for effectiveness in reducing harassment within the AMA.
    b. work with the Women Physicians Section, American Medical Women's Association, GLMA: Health Professionals Advancing LGBTQ Equality, and other stakeholders to identify an appropriate, evidence-based anti-harassment and sexual harassment prevention training to administer to leadership. [Res. 010, A-18; Modified BOT Rep. 27, A-19; Appended: Res. 615, A-22]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 004
(I-25)

Introduced by: Connecticut

Subject: Patient Options to Restrict Secondary Use of Their Healthcare Data

Referred to: Reference Committee on Ethics and Bylaws

Whereas, health data and protected health information (PHI) that are de-identified per Department of Health and Human Services (HHS) guidelines are no longer protected under the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule and may be lawfully aggregated and shared for secondary use[1,2]; and

Whereas, large de-identified patient datasets are critical for studies of rare diseases, health disparities, and population-wide trends, and their availability enables augmented intelligence innovation, expands access to precision medicine, enhances interoperability, and advances equitable patient-centered healthcare[3-11]; and

Whereas, de-identified data is typically controlled by the entity that performs the de-identification, reinforcing institutional control over de-identified derivatives and decreasing autonomy in patients' control over their own data and its secondary use[12-14]; and

Whereas, HHS acknowledges that data de-identified via by its guidelines still retains a non-zero risk of re-identification, which has been subsequently proven in medical literature, running the risk for potential submission of fraudulent medical claims, leakage of PHI, and loss of trust in healthcare organizations[15-20].; and

Whereas, entities that control de-identified data may freely sell this data for-profit to external organizations without patient consent, a multi-billion dollar industry and practice that is detrimental to patients by placing them at risk of re-identification without allowing for autonomous control over secondary use of their own data[21-23]; and

Whereas, data privacy practices acknowledging that all data collected on an individual can present risks, and establishes that individuals control access to their own health data (access, use, sharing) have been implemented successfully under the EU's General Data Protection Regulation (GDPR)[24-29]; and

Whereas, these practices allow patients' right to control their data to coexist with large-scale research infrastructures that preserve privacy like OpenSAFELY, which has supported numerous peer-reviewed studies using secure and auditable access to EHRs while allowing individuals to request that organizations delete personal data on the basis of withdrawing consent, thereby restricting secondary data use[25-30]; and

Whereas, it is logically and ethically reasonable to argue for the continued use of appropriately de-identified data for research, as the potential benefits (robust research, equitable innovation, precision care) justify the privacy hazards; and

Whereas, preserving patients' autonomy to restrict secondary use of their data from use in these efforts is an implementable solution that address the non-zero re-identification risk of de-identified data and advances patient-directed healthcare; therefore be it

RESOLVED, that our American Medical Association support healthcare data privacy practices that provide patients with options to withdraw or restrict secondary uses of their data, including the ability to retroactively withdraw their data from de-identified data sets. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 9/25/25

**REFERENCES**

1. (OCR) OfCR. Guidance Regarding Methods for De-identification of Protected Health Information in Accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule. U.S. Department of Health and Human Services. 2025. https://www.hhs.gov/hipaa/for-professionals/special-topics/de-identification/index.html
2. Archives N. Code of Federal Regulations. 452025.
3. Collins FS, Varmus H. A new initiative on precision medicine. *N Engl J Med*. Feb 26 2015;372(9):793-5. doi:10.1056/NEJMp1500523
4. Khan S, Khan HU, Nazir S. Systematic analysis of healthcare big data analytics for efficient care and disease diagnosing. *Sci Rep*. Dec 26 2022;12(1):22377. doi:10.1038/s41598-022-26090-5
5. *Sharing Clinical Trial Data: Maximizing Benefits, Minimizing Risk*. 2015.
6. Chustecki M. Benefits and Risks of AI in Health Care: Narrative Review. *Interact J Med Res*. Nov 18 2024;13:e53616. doi:10.2196/53616
7. Office USGA. Artificial Intelligence in Health Care: Benefits and Challenges of Machine Learning Technologies for Medical Diagnostics. U.S. Government Accountability Office. 2025. https://www.gao.gov/products/gao-22-104629
8. Alowais SA, Alghamdi SS, Alsuhebany N, et al. Revolutionizing healthcare: the role of artificial intelligence in clinical practice. *BMC Med Educ*. Sep 22 2023;23(1):689. doi:10.1186/s12909-023-04698-z
9. Delpierre C, Lefevre T. Precision and personalized medicine: What their current definition says and silences about the model of health they promote. Implication for the development of personalized health. *Front Sociol*. 2023;8:1112159. doi:10.3389/fsoc.2023.1112159
10. Johnson KB, Wei WQ, Weeraratne D, et al. Precision Medicine, AI, and the Future of Personalized Health Care. *Clin Transl Sci*. Jan 2021;14(1):86-93. doi:10.1111/cts.12884
11. Administration USFD. Precision Medicine. U.S. Food & Drug Administration. 2025. https://www.fda.gov/medical-devices/in-vitro-diagnostics/precision-medicine
12. Kahn SD, Terry SF. Who owns (or controls) health data? *Sci Data*. Feb 1 2024;11(1):156. doi:10.1038/s41597-024-02982-1
13. Services USDoHaH. How Can Covered Entities Use and Disclose Protected Health Information for Research and Comply with the Privacy Rule? National Institutes of Health. 2025. https://privacyruleandresearch.nih.gov/pr_08.asp
14. Journal TH. De-identification of Protected Health Information: How to Anonymize PHI. 2025. https://www.hipaajournal.com/de-identification-protected-health-information/
15. (OCR) OfCR. Guidance Regarding Methods for De-identification of Protected Health Information in Accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule. U.S. Department of Health and Human Services. 2025. https://www.hhs.gov/hipaa/for-professionals/special-topics/de-identification/index.html
16. Janmey V, Elkin PL. Re-Identification Risk in HIPAA De-Identified Datasets: The MVA Attack. *AMIA Annu Symp Proc*. 2018;2018:1329-1337.
17. Elizabeth Ford SP, Robert Stewart, Kerina Jones, Angus Roberts, Arlene Casey, Katie Goddard, Goran Nenadic What is the patient re-identification risk from using de-identified clinical free text data for health research? *AI and Ethics*. 2025;doi:https://doi.org/10.1007/s43681-025-00681-0
18. Sarkar AR, Chuang YS, Mohammed N, Jiang X. De-identification is not enough: a comparison between de-identified and synthetic clinical notes. *Sci Rep*. Nov 29 2024;14(1):29669. doi:10.1038/s41598-024-81170-y
19. Simon GE, Shortreed SM, Coley RY, et al. Assessing and Minimizing Re-identification Risk in Research Data Derived from Health Care Records. *EGEMS (Wash DC)*. Mar 29 2019;7(1):6. doi:10.5334/egems.270
20. Wetsman N. Hospitals are selling treasure troves of medical data — what could go wrong? The Verge; 2021. 06/23/2021. Accessed 2025. https://www.theverge.com/2021/6/23/22547397/medical-records-health-data-hospitals-research
21. Mandl KD, Perakslis ED. HIPAA and the Leak of "Deidentified" EHR Data. *N Engl J Med*. Jun 10 2021;384(23):2171-2173. doi:10.1056/NEJMp2102616
22. Palmer K. 'Some very noble, some less than noble': The growing health data marketplace sparks privacy concerns. STAT; 2021. 6/19/2021. Accessed 2025. https://www.statnews.com/2021/06/09/datavant-ciox-health-data-hipaa/
23. Intelligence SUH-CA. De-Identifying Medical Patient Data Doesn't Protect Our Privacy. Stanford University Human-Centered Artificial Intelligence; 2021. 7/19/2021. Accessed 2025. https://hai.stanford.edu/news/de-identifying-medical-patient-data-doesnt-protect-our-privacy
24. Kahn SD, Terry SF. Who owns (or controls) health data? *Sci Data*. Feb 1 2024;11(1):156. doi:10.1038/s41597-024-02982-1
25. Consulting I. Rights of the data subject. Intersoft Consulting. 2025. https://gdpr-info.eu/chapter-3/

26. Nab L, Schaffer AL, Hulme W, et al. OpenSAFELY: A platform for analysing electronic health records designed for reproducible research. *Pharmacoepidemiol Drug Saf*. Jun 2024;33(6):e5815. doi:10.1002/pds.5815
27. Santhakumaran S, Fisher L, Zheng B, et al. Identification of patients undergoing chronic kidney replacement therapy in primary and secondary care data: validation study based on OpenSAFELY and UK Renal Registry. *BMJ Med*. 2024;3(1):e000807. doi:10.1136/bmjmed-2023-000807
28. Open SC, Wood C, Speed V, et al. The impact of COVID-19 on medication reviews in English primary care. An OpenSAFELY-TPP analysis of 20 million adult electronic health records. *Br J Clin Pharmacol*. Jul 2024;90(7):1600-1614. doi:10.1111/bcp.16030
29. Regulation GDP. Article 20 GDPR. Right to data portability. In: Regulation GDP, editor.
30. Consulting I. Art. 17 GDPR Right to erasure ('right to be forgotten'). Chapter 3 (Art 12-23): Intersoft Consulting.

## RELEVANT AMA POLICY

### D-478.996 Information Technology Standards and Costs

1. Our American Medical Association will:
    a. encourage the setting of standards for health care information technology whereby the different products will be interoperable and able to retrieve and share data for the identified important functions while allowing the software companies to develop competitive systems.
    b. work with Congress and insurance companies to appropriately align incentives as part of the development of a National Health Information Infrastructure (NHII), so that the financial burden on physicians is not disproportionate when they implement these technologies in their offices.
    c. review the following issues when participating in or commenting on initiatives to create a NHII:
        i. cost to physicians at the office-based level;
        ii. security of electronic records; and
        iii. the standardization of electronic systems;
    d. continue to advocate for and support initiatives that minimize the financial burden to physician practices of adopting and maintaining electronic medical records.
    e. continue its active involvement in efforts to define and promote standards that will facilitate the interoperability of health information technology systems.
2. Our AMA advocates that physicians:
    a. are offered flexibility related to the adoption and use of new certified Electronic Health Records (EHRs) versions or editions when there is not a sufficient choice of EHR products that meet the specified certification standards.
    b. not be financially penalized for certified EHR technology not meeting current standards.

[Res. 717, A-04; Reaffirmation, A-05; Appended: Sub. Res. 707, A-06; Reaffirmation A-07; Reaffirmed in lieu of Res. 818, I-07; Reaffirmed in lieu of Res. 726, A-08; Reaffirmation I-08; Reaffirmation I-09; Reaffirmation A-10; Reaffirmation I-10; Reaffirmed: Res. 205, A-11; Reaffirmed in lieu of Res. 714, A-12; Reaffirmed in lieu of Res. 715, A-12; Reaffirmed in lieu of Res. 724, A-13; Reaffirmation I-13; Reaffirmation A-14; Reaffirmed: BOT Rep. 03, I-16; Reaffirmed: BOT Rep. 05, I-16; Appended: Res. 204, I-17; Reaffirmation: I-17; Reaffirmed: BOT Rep. 45, A-18; Reaffirmed: BOT Rep. 19, A-18; Reaffirmation: A-19; Reaffirmed: CMS Rep. 7, I-20; Reaffirmation: A-22; Reaffirmed: A-23]

### D-478.995 National Health Information Technology

1. Our American Medical Association will closely coordinate with the newly formed Office of the National Health Information Technology Coordinator all efforts necessary to expedite the implementation of an interoperable health information technology infrastructure,

while minimizing the financial burden to the physician and maintaining the art of medicine without compromising patient care.

2. Our AMA:
    a. Advocates for standardization of key elements of electronic health record (EHR) and computerized physician order entry (CPOE) user interface design during the ongoing development of this technology.
    b. Advocates that medical facilities and health systems work toward standardized login procedures and parameters to reduce user login fatigue.
    c. Advocates for continued research and physician education on EHR and CPOE user interface design specifically concerning key design principles and features that can improve the quality, safety, and efficiency of health care.
    d. Advocates for continued research on EHR, CPOE and clinical decision support systems and vendor accountability for the efficacy, effectiveness, and safety of these systems.
3. Our AMA will request that the Centers for Medicare & Medicaid Services:
    a. Support an external, independent evaluation of the effect of Electronic Medical Record (EMR) implementation on patient safety and on the productivity and financial solvency of hospitals and physicians' practices.
    b. Develop, with physician input, minimum standards to be applied to outcome-based initiatives measured during this rapid implementation phase of EMRs.
4. Our AMA will
    a. seek legislation or regulation to require all EHR vendors to utilize standard and interoperable software technology components to enable cost efficient use of electronic health records across all health care delivery systems including institutional and community based settings of care delivery.
    b. work with CMS to incentivize hospitals and health systems to achieve interconnectivity and interoperability of electronic health records systems with independent physician practices to enable the efficient and cost effective use and sharing of electronic health records across all settings of care delivery.
5. Our AMA will seek to incorporate incremental steps to achieve electronic health record (EHR) data portability as part of the Office of the National Coordinator for Health Information Technology's (ONC) certification process.
6. Our AMA will collaborate with EHR vendors and other stakeholders to enhance transparency and establish processes to achieve data portability.
7. Our AMA will directly engage the EHR vendor community to promote improvements in EHR usability.
8. Our AMA will advocate for appropriate, effective, and less burdensome documentation requirements in the use of electronic health records.
9. Our AMA will urge EHR vendors to adopt social determinants of health templates, created with input from our AMA, medical specialty societies, and other stakeholders with expertise in social determinants of health metrics and development, without adding further cost or documentation burden for physicians.

[Res. 730, I-04; Reaffirmed in lieu of Res. 818, I-07; Reaffirmed in lieu of Res. 726, A-08; Reaffirmation A-10; Reaffirmed: BOT Rep. 16, A-11; Modified: BOT Rep. 16, A-11; Modified: BOT Rep. 17, A-12; Reaffirmed in lieu of Res. 714, A-12; Reaffirmed in lieu of Res. 715, A-12; Reaffirmed: BOT Rep. 24, A-13; Reaffirmed in lieu of Res. 724, A-13; Appended: Res. 720, A-13; Appended: Sub. Res. 721, A-13; Reaffirmed: CMS Rep. 4, I-13; Reaffirmation I-13; Appended: BOT Rep. 18, A-14; Appended: BOT Rep. 20, A-14; Reaffirmation A-14; Reaffirmed: BOT Rep. 17, A-15; Reaffirmed in lieu of Res. 208, A-15; Reaffirmed in lieu of Res. 223, A-15; Reaffirmation I-15; Reaffirmed: CMS Rep. 07, I-16; Reaffirmed: BOT Rep. 05, I-16; Appended: Res. 227, A-17; Reaffirmed in lieu of: Res. 243, A-17; Modified: BOT Rep. 39, A-18; Reaffirmed:

BOT Rep. 45, A-18; Reaffirmed: BOT Rep. 19, A-18; Reaffirmation: A-19; Reaffirmed: CMS Rep. 3, I-19; Reaffirmed: CMS Rep. 2, A-22; Reaffirmation: Res. 715, A-24; Reaffirmed: Res. 802, I-24]

**H-315.962 Research Handling of De-Identified Patient Information**
Our American Medical Association supports efforts to promote transparency in the use of de-identified patient data and to protect patient privacy by developing methods of, and technologies for, de-identification of patient information that reduce the risk of re-identification of such information. [BOT Rep. 16, I-21; Reaffirmation: A-22; Reaffirmed: CMS Rep. 07, A-24]

**H-480.931 Assessing the Intersection Between AI and Health Care**
Augmented Intelligence Development, Deployment, and Use in Health Care

1. General Governance
    a. Health care AI must be designed, developed, and deployed in a manner which is ethical, equitable, responsible, accurate, transparent, and evidence-based.
    b. Use of AI in health care delivery requires clear national governance policies to regulate its adoption and utilization, ensuring patient safety, and mitigating inequities. Development of national governance policies should include interdepartmental and interagency collaboration.
    c. Compliance with national governance policies is necessary to develop AI in an ethical and responsible manner to ensure patient safety, quality, and continued access to care. Voluntary agreements or voluntary compliance is not sufficient.
    d. AI systems should be developed and evaluated with a specific focus on mitigating bias and promoting health equity, ensuring that the deployment of these technologies does not exacerbate existing disparities in health care access, treatment, or outcomes.
    e. Health care AI requires a risk-based approach where the level of scrutiny, validation, and oversight should be proportionate to the overall potential of disparate harm and consequences the AI system might introduc [See also Augmented Intelligence in Health Care H-480.939 at (1)]
    f. AI risk management should minimize potential negative impacts of health care AI systems while providing opportunities to maximize positive impacts.
    g. Clinical decisions influenced by AI must be made with specified qualified human intervention points during the decision-making process. A qualified human is defined as a licensed physician with the necessary qualifications and training to independently provide the same medical service without the aid of AI. As the potential for patient harm increases, the point in time when a physician should utilize their clinical judgment to interpret or act on an AI recommendation should occur earlier in the care plan. With few exceptions, there generally should be a qualified human in the loop when it comes to medical decision making capable of intervening or overriding the output of an AI model.
    h. Health care practices and institutions should not utilize AI systems or technologies that introduce overall or disparate risk that is beyond their capabilities to mitigate. Implementation and utilization of AI should avoid exacerbating clinician burden and should be designed and deployed in harmony with the clinical workflow and, in institutional settings, consistent with AMA Policy H-225.940 - Augmented Intelligence and Organized Medical Staff.
    i. Medical specialty societies, clinical experts, and informaticists are best positioned and should identify the most appropriate uses of AI-enabled technologies relevant to their clinical expertise and set the standards for AI use in their specific domain. [See Augmented Intelligence in Health Care H-480.940 at (2)]

2. When to Disclose: Transparency in Use of Augmented Intelligence-Enabled Systems and Technologies That Impact Medical Decision Making at the Point of Care
    a. Decisions regarding transparency and disclosure of the use of AI should be based upon a risk- and impact-based approach that considers the unique circumstance of AI and its use case. The need for transparency and disclosure is greater where the performance of an AI-enabled technology has a greater risk of causing harm to a patient.
        i. AI disclosure should align and meet ethical standards or norms.
        ii. Transparency requirements should be designed to meet the needs of the end users. Documentation and disclosure should enhance patient and physician knowledge without increasing administrative burden.
        iii. When AI is used in a manner which impacts access to care or impacts medical decision making at the point of care, that use of AI should be disclosed and documented to both physicians and/or patients in a culturally and linguistically appropriate manner. The opportunity for a patient or their caregiver to request additional review from a licensed clinician should be made available upon request.
        iv. When AI is used in a manner which directly impacts patient care, access to care, medical decision making, or the medical record, that use of AI should be documented in the medical record.
    b. AI tools or systems cannot augment, create, or otherwise generate records, communications, or other content on behalf of a physician without that physician's consent and final review.
    c. When AI or other algorithmic-based systems or programs are utilized in ways that impact patient access to care, such as by payors to make claims determinations or set coverage limitations, use of those systems or programs must be disclosed to impacted parties.
    d. The use of AI-enabled technologies by hospitals, health systems, physician practices, or other entities, where patients engage directly with AI, should be clearly disclosed to patients at the beginning of the encounter or interaction with the AI-enabled technology. Where patient-facing content is generated by AI, the use of AI in generating that content should be disclosed or otherwise noted within the content.
3. What to Disclose: Required Disclosures by Health Care Augmented Intelligence-Enabled Systems and Technologies
    a. When AI-enabled systems and technologies are utilized in health care, the following information should be disclosed by the AI developer to allow the purchaser and/or user (physician) to appropriately evaluate the system or technology prior to purchase or utilization:
        i. Regulatory approval status.
        ii. Applicable consensus standards and clinical guidelines utilized in design, development, deployment, and continued use of the technology.
        iii. Clear description of problem formulation and intended use accompanied by clear and detailed instructions for use.
        iv. Intended population and intended practice setting.
        v. Clear description of any limitations or risks for use, including possible disparate impact.
        vi. Description of how impacted populations were engaged during the AI lifecycle.
        vii. Detailed information regarding data used to train the model:
            1. Data provenance.

2. Data size and completeness.
3. Data timeframes.
4. Data diversity.
5. Data labeling accuracy.

viii. Validation Data/Information and evidence of:
1. Clinical expert validation in intended population and practice setting and intended clinical outcomes.
2. Constraint to evidence-based outcomes and mitigation of "hallucination"/"confabulation" or other output error.
3. Algorithmic validation.
4. External validation processes for ongoing evaluation of the model performance, e.g., accounting for AI model drift and degradation.
5. Comprehensiveness of data and steps taken to mitigate biased outcomes.
6. Other relevant performance characteristics, including but not limited to performance characteristics at peer institutions/similar practice settings.
7. Post-market surveillance activities aimed at ensuring continued safety, performance, and equity.

ix. Data Use Policy:
1. Privacy.
2. Security.
3. Special considerations for protected populations or groups put at increased risk.

x. Information regarding maintenance of the algorithm, including any use of active patient data for ongoing training.

xi. Disclosures regarding the composition of design and development team, including diversity and conflicts of interest, and points of physician involvement and review.

b. Purchasers and/or users (physicians) should carefully consider whether or not to engage with AI-enabled health care technologies if this information is not disclosed by the developer. As the risk of AI being incorrect increases risks to patients (such as with clinical applications of AI that impact medical decision making), disclosure of this information becomes increasingly important. [See also Augmented Intelligence in Health Care H-480.939]

4. Generative Augmented Intelligence
a. Generative AI should: (a) only be used where appropriate policies are in place within the practice or other health care organization to govern its use and help mitigate associated risks; and (b) follow applicable state and federal laws and regulations (e.g., HIPAA-compliant Business Associate Agreement).
b. Appropriate governance policies should be developed by health care organizations and account for and mitigate risks of:
i. Incorrect or falsified responses; lack of ability to readily verify the accuracy of responses or the sources used to generate the response.
ii. Training data set limitations that could result in responses that are out of date or otherwise incomplete or inaccurate for all patients or specific populations.
iii. Lack of regulatory or clinical oversight to ensure performance of the tool.
iv. Bias, discrimination, promotion of stereotypes, and disparate impacts on access or outcomes.
v. Data privacy.

vi. Cybersecurity.
vii. Physician liability associated with the use of generative AI tools.

c. Health care organizations should work with their AI and other health information technology (health IT) system developers to implement rigorous data validation and verification protocols to ensure that only accurate, comprehensive, and bias managed datasets inform generative AI models, thereby safeguarding equitable patient care and medical outcomes. [See Augmented Intelligence in Health Care H-480.940 at (3)(d)]
d. Use of generative AI should incorporate physician and staff education about the appropriate use, risks, and benefits of engaging with generative AI. Additionally, physicians and healthcare organizations should engage with generative AI tools only when adequate information regarding the product is provided to physicians and other users by the developers of those tools.
e. Clinicians should be aware of the risks of patients engaging with generative AI products that produce inaccurate or harmful medical information (g., patients asking chatbots about symptoms) and should be prepared to counsel patients on the limitations of AI-driven medical advice.
f. Data and prompts contributed by users should primarily be used by developers to improve the user experience and AI tool quality and not simply increase the AI tool's market value or revenue generating potential.

5. Physician Liability for Use of Augmented Intelligence-Enabled Technologies
    a. Current AMA policy states that liability and incentives should be aligned so that the individual(s) or entity(ies) best positioned to know the AI system risks and best positioned to avert or mitigate harm do so through design, development, validation, and implementation. [See Augmented Intelligence in Health Care H-480.939]
        i. Where a mandated use of AI systems prevents mitigation of risk and harm, the individual or entity issuing the mandate must be assigned all applicable liability.
        ii. Developers of autonomous AI systems with clinical applications (screening, diagnosis, treatment) are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users.
        iii. Health care AI systems that are subject to non-disclosure agreements concerning flaws, malfunctions, or patient harm (referred to as gag clauses) must not be covered or paid and the party initiating or enforcing the gag clause assumes liability for any harm.
    b. When physicians do not know or have reason to know that there are concerns about the quality and safety of an AI-enabled technology, they should not be held liable for the performance of the technology in question.
    c. Liability protections for physicians using AI-enabled technologies should align with both current and future AMA medical liability reform policies.
6. Data Privacy and Augmented Intelligence
    a. Entity Responsibility:
        i. Entities, e.g., AI developers, should make information available about the intended use of generative AI in health care and identify the purpose of its use. Individuals should know how their data will be used or reused, and the potential risks and benefits.

ii. Individuals should have the right to opt-out, update, or request deletion of their data from generative AI tools. These rights should encompass AI training data and disclosure to other users of the tool.
iii. Generative AI tools should not reverse engineer, reconstruct, or reidentify an individual's originally identifiable data or use identifiable data for nonpermitted uses, e.g., when data are permitted to conduct quality and safety evaluations. Preventive measures should include both legal frameworks and data model protections, e.g., secure enclaves, federated learning, and differential privacy.

b. User Education:
i. Users should be provided with training specifically on generative AI. Education should address:
1. Legal, ethical, and equity considerations.
2. Risks such as data breaches and re-identification.
3. Potential pitfalls of inputting sensitive and personal data.
4. The importance of transparency with patients regarding the use of generative AI and their data.

[See H-480.940, Augmented Intelligence in Health Care, at (4) and (5)]

7. Augmented Intelligence Cybersecurity
a. AI systems must have strong protections against input manipulation and malicious attacks.
b. Entities developing or deploying health care AI should regularly monitor for anomalies or performance deviations, comparing AI outputs against known and normal behavior.
c. Independent of an entity's legal responsibility to notify a health care provider or organization of a data breach, that entity should also act diligently in identifying and notifying the individuals themselves of breaches that impact their personal information.
d. Users should be provided education on AI cybersecurity fundamentals, including specific cybersecurity risks that AI systems can face, evolving tactics of AI cyber attackers, and the user's role in mitigating threats and reporting suspicious AI behavior or outputs.

8. Mitigating Misinformation in AI-Enabled Technologies
a. AI developers should ensure transparency and accountability by disclosing how their models are trained and the sources of their training dat Clear disclosures are necessary to build trust in the accuracy and reliability of the information produced by AI systems.
b. Algorithms should be developed to detect and flag potentially false and misleading content before it is widely disseminated.
c. Developers of AI should have mechanisms in place to allow for reporting of mis- and disinformation generated or propagated by AI-enabled systems.
d. Developers of AI systems should be guided by policies that emphasize rigorous validation and accountability for the content their tools generate, and, consistent with AMA Policy H-480.939(7), are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users.
e. Academic publications and journals should establish clear guidelines to regulate the use of AI in manuscript submissions. These guidelines should include requiring the disclosure that AI was used in research methods and data collection, requiring the exclusion of AI systems as authors, and should outline

the responsibility of the authors to validate the veracity of any referenced content generated by AI.

f. Education programs are needed to enhance digital literacy, helping individuals critically assess the information they encounter online, particularly in the medical field where mis- and disinformation can have severe consequences.

9. Payor Use of Augmented Intelligence and Automated Decision-Making Systems
    a. Use of automated decision-making systems that determine coverage limits, make claim determinations, and engage in benefit design should be publicly reported, based on easily accessible evidence-based clinical guidelines (as opposed to proprietary payor criteria), and disclosed to both patients and their physician in a way that is easy to understand.
    b. Payors should only use automated decision-making systems to improve or enhance efficiencies in coverage and payment automation, facilitate administrative simplification, and reduce workflow burdens. Automated decision-making systems should never create or exacerbate overall or disparate access barriers to needed benefits by increasing denials, coverage limitations, or limiting benefit offerings. Use of automated decision-making systems should not replace the individualized assessment of a patient's specific medical and social circumstances and payors' use of such systems should allow for flexibility to override automated decisions. Payors should always make determinations based on particular patient care needs and not base decisions on algorithms developed on "similar" or "like" patients.
    c. Payors using automated decision-making systems should disclose information about any algorithm training and reference data, including where data were sourced and attributes about individuals contained within the training data set (e.g., age, race, gender). Payors should provide clear evidence that their systems do not discriminate, increase inequities, and that protections are in place to mitigate bias.
    d. Payors using automated decision-making systems should identify and cite peer-reviewed studies assessing the system's accuracy measured against the outcomes of patients and the validity of the system's predictions.
    e. Any automated decision-making system recommendation that indicates limitations or denials of care, at both the initial review and appeal levels, should be automatically referred for review to a physician (a) possessing a current and valid non-restricted license to practice medicine in the state in which the proposed services would be provided if authorized and (b) be of the same specialty as the physician who typically manages the medical condition or disease or provides the health care service involved in the request prior to issuance of any final determination. Prior to issuing an adverse determination, the treating physician must have the opportunity to discuss the medical necessity of the care directly with the physician who will be responsible for determining if the care is authorized.
    f. Individuals impacted by a payor's automated decision-making system, including patients and their physicians, must have access to all relevant information (including the coverage criteria, results that led to the coverage determination, and clinical guidelines used).
    g. Payors using automated decision-making systems should be required to engage in regular system audits to ensure use of the system is not increasing overall or disparate claims denials or coverage limitations, or otherwise decreasing access to care. Payors using automated decision-making systems should make statistics regarding systems' approval, denial, and appeal rates available on their website

(or another publicly available website) in a readily accessible format with patient population demographics to report and contextualize equity implications of automated decisions. Insurance regulators should consider requiring reporting of payor use of automated decision-making systems so that they can be monitored for negative and disparate impacts on access to care. Payor use of automated decision-making systems must conform to all relevant state and federal laws.

[BOT Rep. 01, I-24; Reaffirmed: CSAPH Rep. 08, A-25; Reaffirmed in lieu of the first resolve: Res. 226, A-25]

**H-406.987 Medical Information and Its Uses**

DATA TRANSPARENCY PRINCIPLES TO PROMOTE IMPROVEMENTS IN QUALITY AND CARE DELIVERY

Our AMA seeks to help physicians improve the quality reporting of patient care data and adapt to new payment and delivery models to transform our health care system. One means of accomplishing this goal is to increase the transparency of health care data. The principles outlined below ensure that physicians, practices, care systems, physician-led organizations, patients and other relevant stakeholders can access and proactively use meaningful, actionable health care information to achieve care improvements and innovations. These principles do not replace but build upon existing AMA policies H-406.990, H-406.989, H-406.991, and H-406.996 that address safeguards for the release of physician data and physician profiles, expanding these guidelines to reflect the new opportunities and potential uses of this information.

Transparency Objectives and Goals

Engaging Physicians - Our AMA encourages greater physician engagement in transparency efforts, including the development of physician-led quality measures to ensure that gaps in measures are minimized and that analyses reflect the knowledge and expertise of physicians.

Promoting New Payment and Delivery Models - Our AMA supports appropriate funding and other support to ensure that the data that are used to inform new payment and delivery models are readily available and do not impose a new cost or additional burden on model participants.

Improving Care Choices and Decisions - Our AMA promotes efforts to present data appropriately depending on the objective and the relevant end-user, including transparently identifying what information is being provided, for what purpose, and how the information can or cannot be used to influence care choices.

Informing Physicians - Our AMA encourages the development of user interfaces that allow physicians or their staff to structure simple queries to obtain and track actionable reports related to specific patients, peer comparisons, provider-level resource use, practice patterns, and other relevant information.

Informing Patients - Our AMA encourages patients to consult with physicians to understand and navigate health care transparency and data efforts.

Informing Other Consumers - Our AMA seeks opportunities to engage with other stakeholders to facilitate physician involvement and more proactive use of health care data.

Data Transparency Resources

Data Availability - Our AMA supports removing barriers to accessing additional information from other payers and care settings, focusing on data that is valid, reliable, and complete.

Access to Timely Data - While some datasets will require more frequent updates than others, our AMA encourages use of the most current information and that governmental reports are made available, at a minimum, from the previous quarter.

Accurate Data - Our AMA supports proper oversight of entities accessing and using health care data, and more stringent safeguards for public reporting, so that information is accurate, transparent, and appropriately used.

Use of Quality Data - Our AMA supports definitions of quality based on evidence-based guidelines, measures developed and supported by specialty societies, and physician-developed metrics that focus on patient outcomes and engagement.

Increasing Data Utility - Our AMA promotes efforts by clinical data registries, regional collaborations, Qualified Entities, and specialty societies to develop reliable and valid performance measures, increase data utility and reduce barriers that currently limit access to and use of the health care data.

Challenges to Transparency
Standardization - Our AMA supports improvements in electronic health records (EHRs) and other technology to capture and access data in uniform formats.

Mitigating Administrative Burden - To reduce burdens, data reporting requirements imposed on physicians should be limited to the information proven to improve clinical practice. Collection, reporting, and review of all other data and information should be voluntary.

Data Attribution - Our AMA seeks to ensure that those compiling and using the data avoid attribution errors by working to correctly assign services and patients to the appropriate provider(s) as well as allowing entities to verify who or where procedures, services, and items were performed, ordered, or otherwise provided. Until problems with the current state of episode of care and attribution methodologies are resolved, our AMA encourages public data and analyses primarily focused at the system-level instead of on individual physicians or providers. [BOT Rep. 6, A-15; Reaffirmation: I-18; Reaffirmed: CSAPH Rep. 2, I-19]

**H-315.983 Patient Privacy and Confidentiality**

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

   e. that the Health Insurance Portability and Accountability Act of 1996 (HIPAA) be the minimal standard for protecting clinician-patient privilege, regardless of where care is received.
2. Our AMA affirms:
   a. that physicians and medical students who are patients are entitled to the same right to privacy and confidentiality of personal medical information and medical records as other patients;
   b. that when patients exercise their right to keep their personal medical histories confidential, such action should not be regarded as fraudulent or inappropriate concealment and;
   c. that physicians and medical students should not be required to report any aspects of their patients' medical history to governmental agencies or other entities, beyond that which would be required by law.
3. Employers and insurers should be barred from unconsented access to identifiable medical information lest knowledge of sensitive facts form the basis of adverse decisions against individuals.
   a. Release forms that authorize access should be explicit about to whom access is being granted and for what purpose, and should be as narrowly tailored as possible.
   b. Patients, physicians, and medical students should be educated about the consequences of signing overly-broad consent forms.
   c. Employers and insurers should adopt explicit and public policies to assure the security and confidentiality of patients' medical information.
   d. A patient's ability to join or a physician's participation in an insurance plan should not be contingent on signing a broad and indefinite consent for release and disclosure.
4. Whenever possible, medical records should be de-identified for purposes of use in connection with utilization review, panel credentialing, quality assurance, and peer review.
5. The fundamental values and duties that guide the safekeeping of medical information should remain constant in this era of computerization. Whether they are in computerized or paper form, it is critical that medical information be accurate, secure, and free from unauthorized access and improper use.
6. Our AMA recommends that the confidentiality of data collected by race and ethnicity as part of the medical record, be maintained.
7. Genetic information should be kept confidential and should not be disclosed to third parties without the explicit informed consent of the tested individual.
8. When breaches of confidentiality are compelled by concerns for public health and safety, those breaches must be as narrow in scope and content as possible, must contain the least identifiable and sensitive information possible, and must be disclosed to the fewest possible to achieve the necessary end.
9. Law enforcement agencies requesting private medical information should be given access to such information only through a court order. This court order for disclosure should be granted only if the law enforcement entity has shown, by clear and convincing evidence, that the information sought is necessary to a legitimate law enforcement inquiry; that the needs of the law enforcement authority cannot be satisfied by non-identifiable health information or by any other information; and that the law enforcement need for the information outweighs the privacy interest of the individual to whom the information pertains. These records should be subject to stringent security measures.
10. Our AMA must guard against the imposition of unduly restrictive barriers to patient records that would impede or prevent access to data needed for medical or public health

research or quality improvement and accreditation activities. Whenever possible, de-identified data should be used for these purposes. In those contexts where personal identification is essential for the collation of data, review of identifiable data should not take place without an institutional review board (IRB) approved justification for the retention of identifiers and the consent of the patient. In those cases where obtaining patient consent for disclosure is impracticable, our AMA endorses the oversight and accountability provided by an IRB.

11. Marketing and commercial uses of identifiable patients' medical information may violate principles of informed consent and patient confidentiality. Patients divulge information to their physicians only for purposes of diagnosis and treatment. If other uses are to be made of the information, patients must first give their uncoerced permission after being fully informed about the purpose of such disclosures
12. Our AMA, in collaboration with other professional organizations, patient advocacy groups and the public health community, should continue its advocacy for privacy and confidentiality regulations, including:
    a. the establishment of rules allocating liability for disclosure of identifiable patient medical information between physicians and the health plans of which they are a part, and securing appropriate physicians' control over the disposition of information from their patients' medical records;
    b. the establishment of rules to prevent disclosure of identifiable patient medical information for commercial and marketing purposes;
    c. the establishment of penalties for negligent or deliberate breach of confidentiality or violation of patient privacy rights.
13. Our AMA will pursue an aggressive agenda to educate patients, the public, physicians and policymakers at all levels of government about concerns and complexities of patient privacy and confidentiality in the variety of contexts mentioned.
14. Disclosure of personally identifiable patient information to public health physicians and departments is appropriate for the purpose of addressing public health emergencies or to comply with laws regarding public health reporting for the purpose of disease surveillance.
15. In the event of the sale or discontinuation of a medical practice, patients should be notified whenever possible and asked for authorization to transfer the medical record to a new physician or care provider. Only de-identified and/or aggregate data should be used for "business decisions," including sales, mergers, and similar business transactions when ownership or control of medical records changes hands.
16. The most appropriate jurisdiction for considering physician breaches of patient confidentiality is the relevant state medical practice act. Knowing and intentional breaches of patient confidentiality, particularly under false pretenses, for malicious harm, or for monetary gain, represents a violation of the professional practice of medicine.
17. Our AMA Board of Trustees will actively monitor and support legislation at the federal level that will afford patients protection against discrimination on the basis of genetic testing.
18. Our AMA supports privacy standards that would require pharmacies to obtain a prior written and signed consent from patients to use their personal data for marketing purposes.
19. Our AMA supports privacy standards that require pharmacies and drug store chains to disclose the source of financial support for drug mailings or phone calls.
20. Our AMA supports privacy standards that would prohibit pharmacies from using prescription refill reminders or disease management programs as an opportunity for marketing purposes.

21. Our AMA will draft model state legislation requiring consent of all parties to the recording of a physician-patient conversation.

[BOT Rep. 9, A-98 Reaffirmation I-98 Appended: Res. 4, and Reaffirmed: BOT Rep. 36, A-99 Appended: BOT Rep. 16 and Reaffirmed: CSA Rep. 13, I-99 Reaffirmation A-00 Reaffirmed: Res. 246 and 504 and Appended Res. 504 and 509, A-01 Reaffirmed: BOT Rep. 19, I-01 Appended: Res. 524, A-02 Reaffirmed: Sub. Res. 206, A-04 Reaffirmed: BOT Rep. 24, I-04 Reaffirmed: BOT Rep. 19, I-06 Reaffirmation A-07 Reaffirmed: BOT Rep. 19, A-07 Reaffirmed: CEJA Rep. 6, A-11 Reaffirmed in lieu of Res. 705, A-12 Reaffirmed: BOT Rep. 17, A-13 Modified: Res. 2, I-14 Reaffirmation: A-17 Modified: BOT Rep. 16, A-18 Appended: Res. 232, A-18 Reaffirmation: I-18 Reaffirmed: Res. 219, A-21 Reaffirmed: Res. 229, A-21 Reaffirmed: BOT Rep. 12, I-21 Reaffirmed: BOT Rep. 22, A-22 Reaffirmation: A-23 Reaffirmed: CSAPH Rep. 08, A-24]

**H-450.933 Clinical Data Registries**

1. Our AMA encourages multi-stakeholder efforts to develop and fund clinical data registries for the purpose of facilitating quality improvements and research that result in better health care, improved population health, and lower costs.
2. Our AMA encourages national medical specialty societies, state medical associations, and other physician groups to join the National Quality Registry Network and to participate in efforts to advance the development and use of clinical data registries.
3. Our AMA supports flexibility in the development and implementation of clinical data registries. The following guidelines can help maximize opportunities for clinical data registries to enhance the quality of care provided to patients:

a. Practicing physicians must be actively involved in decisions related to the development, maintenance and use of clinical data registries and registry data.
b. Data elements, risk-adjustment models and measures used in the registry should be fully transparent.
c. Registries should provide timely, actionable feedback reports to individual physicians or entities reporting at the organizational level.
d. Registries and electronic health records should be interoperable, and should be capable of sharing and integrating information across registries and with other data sources in a HIPAA-compliant and confidential manner.
e. Registry stewards should establish a formal process to facilitate the modification, expansion, or dissolution of the registry in order to accommodate advances in technology and changing clinical data needs to ensure continued utility of their registry.

4. Our AMA encourages physicians to participate in clinical data registries, and will encourage efforts that help physicians identify existing registries suitable for and of benefit to their patient populations and their practices.
5. Our AMA will continue to advocate for and support initiatives that minimize the costs and maximize the benefits of physician practice participation in clinical data registries.
6. Our AMA supports that, with the consent of the participating physician, physician-specific clinical registry data may be used to meet third-party quality reporting requirements, in accordance with the following principles:

a. Data should be used to improve the quality of patient care and the efficient use of resources in the delivery of health care services.
b. Data related to resource use and cost of care must be evaluated and reported in conjunction with quality of care information.
c. Effective safeguards must be established to protect against the dissemination of inconsistent, incomplete, invalid or inaccurate physician-specific medical practice data.
d. Case-matched, risk-adjusted quality measure and resource use data are provided to physicians to assist them in determining their relative utilization of resources in providing care to

their patients.
e. When data are collected and analyzed for the purpose of meeting quality reporting requirements, the methodologies used to create the profiles and report the results are developed in conjunction with relevant physician organizations and practicing physicians, and are disclosed in sufficient detail to allow each physician or medical group to re-analyze the validity of the reported results prior to more general disclosure.
[CMS Rep. 8, A-14; Reaffirmed: CMS Rep. 05, I-16; Reaffirmed: CMS Rep. 10, A-17; Reaffirmed: CMS Rep. 06, A-18; Reaffirmed: CSAPH Rep. 2, I-19]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 005
(I-25)

Introduced by: Young Physicians Section

Subject: Preserving Autonomy in the Patient-Physician Relationship

Referred to: Reference Committee on Ethics and Bylaws

---

Whereas, the patient physician relationship is core of our role as physicians; and

Whereas, our American Medical Association Code of Medical Ethics is intended to detail the ethical responsibilities of physicians across specialties and there is extensive AMA policy on many of these topics, but some of these key issues are not directly addressed in the Code; and

Whereas, the ethical responsibilities of physicians have continued to become more complex as physicians have moved from an environment of more heavily private practice to employed physicians. This comes with a greater potential for influence on the patient physician relationship as supervisors may be acting as fiduciaries of the institution rather than in the clinical interest of the patient. Current policy speaks to the potential of a physician to willingly enter into entanglements that they have chosen, but does not speak to the modern realities of physicians in some cases being forced into ethically dubious situations by an employer with whom they may be contractually obligated to remain employed; and

Whereas, there is an increasing possibility of undue influence in the patient physician relationship as medical practices have been purchased by investment groups. This could potentially lead to provision of more costly treatment, as is mentioned in the Code but also withholding expensive or poorly reimbursed interventions; and

Whereas, there has been increasing political attention to discussions in the clinical examination room between physicians and patients and the Code does not discuss external political influences on this relationship though AMA policy on this subject is robust; and

Whereas, trust in the patient physician relationship is paramount in providing high quality clinical care and even the suggestion of influence can cause a loss of trust; therefore be it

RESOLVED, that our American Medical Association study relevant sections of the *Code of Medical Ethics* to address outside political and administrative influences on the patient physician relationship and its impact on shared decision making in the clinical setting. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/25/25

**REFERENCES**

1. American Medical Association. (2017, February 17). Ama Praise Court ruling on Florida gun gag law. https://www.ama-assn.org/press-center/ama-press-releases/ama-praise-court-ruling-florida-gun-gag-law
2. American Medical Association. (2016). Issue brief: Protecting the patient-physician relationship. https://www.ama-assn.org/system/files/protecting-patient-physician-relationship-issue-brief.pdf
3.American Medical Association, Council on Constitution and Bylaws (2023). Responsibilities to Promote Equitable Care

## RELEVANT AMA POLICY

### AMA Stance on the Interference of the Government in the Practice of Medicine H-270.959

1. Our American Medical Association
   opposes the interference of government in the practice of medicine,
   including the use of government-mandated physician recitations.
2. Our AMA endorses the following statement of principles concerning the roles of federal and state governments in health care and the patient-physician relationship:
   a. Physicians should not be prohibited by law or regulation from discussing with or asking their patients about risk factors, or disclosing information to the patient (including proprietary information on exposure to potentially dangerous chemicals or biological agents), which may affect their health, the health of their families, sexual partners, and others who may be in contact with the patient.
   b. All parties involved in the provision of health care, including governments, are responsible for acknowledging and supporting the intimacy and importance of the patient-physician relationship and the ethical obligations of the physician to put the patient first.
   c. The fundamental ethical principles of beneficence, honesty, confidentiality, privacy, and advocacy are central to the delivery of evidence-based, individualized care and must be respected by all parties.
   d. Laws and regulations should not mandate the provision of care that, in the physician's clinical judgment and based on clinical evidence and the norms of the profession, are either not necessary or are not appropriate for a particular patient at the time of a patient encounter. [Res. 523, A-06; Appended: Res. 706, A-13; Reaffirmed: Res. 250, A-22]

### Government Interference in Patient Counseling H-373.995

1. Our American Medical Association vigorously and actively defends the physician-patient-family relationship and actively opposes state and/or federal efforts to interfere in the content of communication in clinical care delivery between clinicians and patients.

2. Our AMA strongly condemns any interference by government or other third parties that compromise a physician's ability to use their medical judgment as to the information or treatment that is in the best interest of their patients.

3. Our AMA supports litigation that may be necessary to block the implementation of newly enacted state and/or federal laws that restrict the privacy of physician-patient-family relationships and/or that violate the First Amendment rights of physicians in their practice of the art and science of medicine.

4. Our AMA opposes any government regulation or legislative action on the content of the individual clinical encounter between a patient and physician without a compelling and evidence-based benefit to the patient, a substantial public health justification, or both.

5. Our AMA will educate lawmakers and industry experts on the following principles endorsed by the American College of Physicians which should be considered when creating new health care policy that may impact the patient-physician relationship or what occurs during the patient-physician encounter:
A. Is the content and information or care consistent with the best available medical evidence on clinical effectiveness and appropriateness and professional standards of care?

B. Is the proposed law or regulation necessary to achieve public health objectives that directly affect the health of the individual patient, as well as population health, as supported by scientific evidence, and if so, are there no other reasonable ways to achieve the same objectives?
C. Could the presumed basis for a governmental role be better addressed through advisory clinical guidelines developed by professional societies?
D. Does the content and information or care allow for flexibility based on individual patient circumstances and on the most appropriate time, setting and means of delivering such information or care?
E. Is the proposed law or regulation required to achieve a public policy goal - such as protecting public health or encouraging access to needed medical care - without preventing physicians from addressing the healthcare needs of individual patients during specific clinical encounters based on the patient's own circumstances, and with minimal interference to patient-physician relationships?
F. Does the content and information to be provided facilitate shared decision-making between patients and their physicians, based on the best medical evidence, the physician's knowledge and clinical judgment, and patient values (beliefs and preferences), or would it undermine shared decision-making by specifying content that is forced upon patients and physicians without regard to the best medical evidence, the physician's clinical judgment and the patient's wishes?
G. Is there a process for appeal to accommodate individual patients' circumstances?

6. Our AMA strongly opposes any attempt by local, state, or federal government to interfere with a physician's right to free speech as a means to improve the health and wellness of patients across the United States.

[Res. 201, A-11; Reaffirmation: I-12; Appended: Res. 717, A-13; Reaffirmed in lieu of Res. 5, I-13; Appended: Res. 234, A-15; Reaffirmation: A-19; Modified: Speakers Rep. 02, I-24]

**Freedom of Communication Between Physicians and Patients H-5.989**

It is the policy of our American Medical Association:

1. to strongly condemn any interference by the government or other third parties that causes a physician to compromise their medical judgment as to what information or treatment is in the best interest of the patient.
2. working with other organizations as appropriate, to vigorously pursue legislative relief from regulations or statutes that prevent physicians from freely discussing with or providing information to patients about medical care and procedures or which interfere with the physician-patient relationship.
3. to communicate to HHS its continued opposition to any regulation that proposes restrictions on physician-patient communications.
4. to inform the American public as to the dangers inherent in regulations or statutes restricting communication between physicians and their patients.

[Sub. Res. 213, A-91; Reaffirmed: Sub. Res. 232, I-91; reaffirmed by Rules and Credentials Cmt., A-96; Reaffirmed by Sub. Res. 133 and BOT Rep. 26, A-97; Reaffirmed by Sub. Res. 203 and 707, A-98; Reaffirmed: Res. 703, A-00; Reaffirmed in lieu of Res. 823, I-07; Reaffirmation I-09; Reaffirmation: I-12; Reaffirmed in lieu of Res. 5, I-13; Reaffirmed: CEJA Rep. 05, A-23; Modified: Speakers Rep. 02, I-24]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 006
(I-25)

Introduced by: Resident and Fellow Section

Subject: Amendment to AMA Bylaws to Enable Continuity of Leadership

Referred to: Reference Committee on Ethics and Bylaws

---

Whereas, per the AMA Resident and Fellow Section IOPs, the Governing Council includes the Immediate Past Chair who serves an ex-officio, non-voting member; and

Whereas, the role of the Immediate Past Chair is to provide continuity of the leadership of the Section; and

Whereas, the Immediate Past Chair serves a 6-month term between the Annual and Interim Assembly Meetings after first serving a 6-month term as Chair-Elect and a 1-year term as Chair; and

Whereas, the Chair-Elect has often spent at least one year as a member of the Resident and Fellow Section prior to being elected; and

Whereas, some members of Resident and Fellow Section may only be part of the Section for 3 years, including Family Medicine, Internal Medicine, and Pediatrics residents who do not immediately pursue fellowship; and

Whereas, given this election structure and these training timelines, the Chair-Elect may no longer be in training by the time they would start their term as Immediate Past Chair; and

Whereas, current AMA bylaws specify that all Resident and Fellow Section Governing Council members including Immediate Past Chair must be a current resident or fellow; and

Whereas, the RFS Assembly has formally requested via >⅔ vote that the Immediate Past Chair be allowed to serve their term even as a graduate of the RFS so that the Section may benefit from continuity in leadership; therefore be it

RESOLVED, that our American Medical Association amend AMA Bylaw 7.1.2 to allow the Resident and Fellow Section (RFS) Immediate Past Chair to serve in the position even if they have graduated from the RFS. (Modify Current HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 9/29/25

**RELEVANT AMA POLICY**

**Resident and Fellow Section - Cessation of Eligibility B-7.1.2**
If any officer or Governing Council member ceases to meet the membership requirements of Bylaw 7.1.1 prior to the expiration of the term for which elected, the term of such officer or member shall terminate and the position shall be declared vacant. If the officer or member completes residency or fellowship within 90 days prior to an Annual Meeting, the officer or member shall be permitted to continue to serve in office until the completion of the Annual Meeting.

AMERICAN MEDICAL ASSOCIATION

Resolution: 007
(I-25)

Introduced by: California, Arizona, Hawaii, Idaho, Montana, New Mexico, Washington, American College of Obstetricians and Gynecologists

Subject: Improving Protection for Reproductive Health Information

Referred to: Reference Committee on Ethics and Bylaws

---

Whereas, existing AMA policies oppose the criminalization of accessing abortion services (H-5.980) and supports preservation and expansion of access for abortion services (D-5.996, D-5.999); and

Whereas, the 2024 federal regulatory modifications to the HIPAA Privacy Rule strengthen the protection of reproductive health information by prohibiting the use or disclosure of Protected Health Information (PHI) for criminal, civil, or administrative investigations or liabilities related to lawful reproductive health care[1]; and

Whereas, the enforcement of such privacy protections ensures that individuals can access reproductive health services without fear of legal repercussions; and

Whereas, the criminalization of reproductive health care has affected both patients and physicians[2], leading to interference in the practice of medicine and poor patient outcomes[3]; and

Whereas, this issue is urgent because these 2024 regulatory improvements are now being challenged in court or could be withdrawn by the Trump Administration in the near future[4] ; therefore be it

RESOLVED, that our American Medical Association support the prohibition against the use or disclosure of protected health information (PHI) to conduct a criminal, civil, or administrative investigation into or impose criminal, civil, or administrative liability for the mere act of seeking, obtaining, providing, or facilitating reproductive health care. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 9/30925

**REFERENCES**
1. https://www.hhs.gov/hipaa/for-professionals/special-topics/reproductive-health/final-rule-fact-sheet/index.html
2. https://www.pbs.org/newshour/health/new-york-doctor-indicted-over-online-prescription-of-abortion-pill-in-louisiana
3. https://www.npr.org/2023/09/12/1199068710/patients-and-doctors-in-3-states-announce-lawsuits-over-delayed-and-denied-abort
4. https://www.hipaajournal.com/texas-judge-vacates-hippa-reproductive-healthcare-privacy-rule/

**RELEVANT AMA POLICY**

**Oppose the Criminalization of Self-Managed Abortion H-5.980**

1. Our American Medical Association opposes the criminalization of self-managed abortion and the criminalization of patients who access abortions as it increases patients' medical risks and deters patients from seeking medically necessary services.
2. Our AMA will advocate against any legislative efforts to criminalize self-managed abortion and the criminalization of patients who access abortions.
3. Our AMA will oppose efforts to enforce criminal and civil penalties or other retaliatory efforts against these patients and requirements that physicians function as agents of law enforcement – gathering evidence for prosecution rather than as a provider of treatment.

[Res. 007, A-18 Modified: Res. 027, A-22]

**Expanding Support for Access to Abortion Care D-5.996**

1. Our American Medical Association will advocate for:
    a. broad and equitable access to abortion services, public and private coverage of abortion services, and funding of abortion services in public programs.
    b. explicit codification of legal protections to ensure broad, equitable access to abortion services.
    c. equitable participation by physicians who provide abortion care in insurance plans and public programs.
2. Our AMA opposes the use of false or inaccurate terminology and disinformation in policymaking to impose restrictions and bans on evidence-based health care, including reproductive health care.

[Res.229, I-22]

**Preserving Access to Reproductive Health Services D-5.999**

1. Our American Medical Association recognizes that healthcare, including reproductive health services like contraception and abortion, is a human right.
2. Our AMA opposes limitations on access to evidence-based reproductive health services, including fertility treatments, contraception, and abortion.
3. Our AMA will work with interested state medical societies and medical specialty societies to vigorously advocate for broad, equitable access to reproductive health services, including fertility treatments, fertility preservation, contraception, and abortion.
4. Our AMA supports shared decision-making between patients and their physicians regarding reproductive healthcare.
5. Our AMA opposes any effort to undermine the basic medical principle that clinical assessments, such as viability of the pregnancy and safety of the pregnant person, are determinations to be made only by healthcare professionals with their patients.
6. Our AMA opposes the imposition of criminal and civil penalties or other retaliatory efforts, including adverse medical licensing actions and the termination of medical liability coverage or clinical privileges against patients, patient advocates, physicians, other healthcare workers, and health systems for receiving, assisting in, referring patients to, or providing reproductive health services.
7. Our AMA will advocate for legal protections for patients who cross state lines to receive reproductive health services, including contraception and abortion, or who receive medications for contraception and abortion from across state lines, and legal protections for those that provide, support, or refer patients to these services.
8. Our AMA will advocate for legal protections for medical students and physicians who cross state lines to receive education in or deliver reproductive health services, including contraception and abortion.

[Res. 028, A-22 Reaffirmed: Res. 224, I-22 Modified: BOT Rep. 4, I-22 Appended: Res. 317, I-22 Reaffirmation: A-23 Appended: Res. 711, A-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 008
(I-25)

Introduced by: College of American Pathologists

Subject: Health Plan In-Network Steering of Pathology/Laboratory Services

Referred to: Reference Committee on Ethics and Bylaws

---

Whereas, the referral of pathology and laboratory specimens to in-network laboratories and pathologists should be at the exclusive discretion of referring physician's medical judgment to achieve best patient care; and

Whereas, the referral of pathology/laboratory specimens to in-network pathologists and laboratories should, under the AMA Code of Medical Ethics, ("Consultations, Referrals, and Second Opinions") be based "upon the patient's medical needs", or relevant medical factors, including convenient patient access, turnaround time, clinical expertise of the pathologist/laboratory for the specimen referred, and pathologist/laboratory unimpeded ease of consultation (i.e. clinical integration) with the medical system or medical practice of the ordering clinician; and

Whereas, health plan payers are now tiering and limiting laboratory in-network referrals and patient access across a suite of insurance products, including Medicaid Managed Care and within the state health insurance exchanges, by promulgating and enforcing contractual policies that deny ordering physicians the exercise of medical discretion and choice, and requiring referrals to "preferred" or "designated" in-network laboratories, which may even be a single designated laboratory; and

Whereas, health plan steering to a single laboratory and other specimen referral limitations to only certain in-network providers of pathology and laboratory services is contrary to the optimal practice of medicine and the medical interest of patients, disrupting local and regional health care delivery systems; therefore be it

RESOLVED, that our American Medical Association support state and federal legislative efforts to expressly prohibit in-network steering by health insurance plans, or by laboratory benefit managers under contract with such plans, to "preferred" or "designated" in-network laboratories or pathologists, thereby excluding other in-network pathology and laboratory providers (New HOD Policy); and be it further

RESOLVED, that our AMA advocate in partnership with state medical societies and medical specialty societies to protect ordering physician discretion to refer pathology and laboratory specimens to any in-network pathologist or in-network laboratory of their choice, based upon relevant medical considerations in the best interest of patient care, consistent with AMA Code of Medical Ethic. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/30/25

**RELEVANT AMA POLICY**
**Laboratory Benefit Managers H-260.962**
**1.2.3 Consultation, Referral & Second Opinions**

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 009
(I-25)

Introduced by: New England Delegation

Subject: Gender Equity in Disability Insurance for Physicians

Referred to: Reference Committee on Ethics and Bylaws

---

Whereas, disability insurance is a critical component of financial security for physicians, providing income protection if they are unable to work due to illness or injury. Research suggests that one in seven doctors will need disability insurance at some point in their careers.[1] Despite its importance, a significant disparity exists in disability insurance rates between male and female physicians, with women often charged premiums that are 40−50% higher for the same coverage. This gender-based pricing is rooted in outdated assumptions and statistical data that fails to account for the evolving role of women in medicine and the nuanced reality of modern-day health care practices[2]; and

Whereas, historically, insurance providers have relied on demographic data suggesting women may experience higher disability rates, often due to caregiving roles outside of work.[2] However, this model does not account for the increasing number of women in diverse specialties, leadership roles, and without the previous gender-based barriers. Today, women represent nearly 40% of all physicians in the United States, and this percentage continues to rise.[3] Despite these advancements, female physicians still face financial disadvantages, including higher disability insurance premiums, which may impact their financial security and career longevity; and

Whereas, factors such as individual health histories, specific specialties, or career risks are more accurate predictors of disability risk than broad gender-based assumptions[2] and should be the primary focus of these insurance plans; and

Whereas, the issue of gender-based pricing in disability insurance for physicians must be viewed within the broader context of ongoing efforts to eliminate gender disparities in health care and the medical profession; and

Whereas, our American Medical Association has emphasized the importance of ensuring that disability insurance policies are robust and accessible for all physicians, including those on visas (H-330.869); and

Whereas, it is clear that gender-neutral disability insurance premiums are not only a matter of fairness but also a necessary step toward a more inclusive and supportive health care system. The elimination of gender-based pricing would be a significant move toward ensuring that all physicians—especially women—can pursue their careers with the same financial security as their male counterparts, free from the financial burdens created by outdated assumptions and systemic biases; therefore be it

RESOLVED, that our American Medical supports gender-neutral disability insurance premiums for physicians. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 9/18/25

**REFERENCES**

1. https://www.whitecoatinvestor.com/why-disability-insurance-is-more-expensive-for-women/
2. https://www.whitecoatinvestor.com/what-you-need-to-know-about-disability-insurance/
3. https://publications.aap.org/pediatrics/article/148/Supplement%202/e2021051440C/183791/State-of-Women-in-Medicine-History-Challenges-and?autologincheck=redirected
4. https://www.mass.gov/info-details/disability-insurance#:~:text=What%20factors%20cannot%20determine%20my,or%20the%20person%20being%20pregnant
5. Click or tap here to enter text.

## RELEVANT AMA POLICY

### Updating Physician Job Description for Disability Insurance H-330.869

1. Our American Medical Association supports efforts to develop specialty-specific job descriptions that reflect the true physical and cognitive demands of each given specialty for use in the Occupational Information System under development by the Social Security Administration so as to ensure that physician disability policies are robust and protective if a coverage trigger occurs.

2. Our AMA supports removing the barriers to obtaining and claiming disability insurance for physicians on visas.

## Reference Committee B

**Report(s) of the Board of Trustees**

| | | |
|---|---|---|
| 01 | Calling for a Multifaceted Approach to the Illicit Fentanyl Crisis | B |
| 02 | Laser Surgery | B |
| 03 | Stark Law Self-Referral Ban | B |
| 04 | Addressing and Reducing Patient Boarding in Emergency Departments (EDs) | B |
| 06 | Information Blocking Rule | B |
| 07 | Codification of the Chevron Deference Doctrine | B |
| 12 | Support For Doula Care Programs | B |
| 13 | Antidiscrimination Protections for LGBTQ+ Youth in Foster Care | B |
| 15 | Protecting Evidence-Based Medicine, Public Health Infrastructure and Biomedical Research Report | B |
| 16 | Preservation of Medicaid | B |

**Resolutions**

| | | |
|---|---|---|
| 201 | Model State Legislation incorporating Medical Malpractice Tort Reform Based on Utah H.B. 503 (2025) | B |
| 202 | Deepfake Technology and Harm to Physicians and Patients | B |
| 203 | Restore and Enhance Federal Loan Programs for Medical Education | B |
| 204 | Addressing Anti-Physician Contractual Provisions | B |
| 205 | Restoring Balance Billing and Allowing Copay Forgiveness to Preserve Independent Practice and Improve Access to Care | B |
| 206 | Restore Funding to USAID | B |
| 207 | Support for a Federal Tax Incentive for Volunteer Community Preceptors | B |
| 208 | Centralization of Medicare Provider Data Sources | B |
| 209 | Support for Legislative Changes Allowing Partial Medicare Opt-Out for Physicians | B |
| 210 | PBM Divestiture and Transparency | B |
| 211 | Access to, and Retention of, Electronic Medical Records | B |
| 212 | Acknowledging Flexibility on Buprenorphine Mono-product Use for Opioid Use Disorder Opioid Use Disorder | B |
| 213 | Pathways to U. S. Permanent Residency for H-1B Physicians | B |
| 214 | Physician Visa Protection and Pathway to Serve Underserved Communities | B |
| 215 | Extending the Medicaid Work Requirement Exemption up to 12 Months Postpartum | B |
| 216 | Ensuring Timely J-1 Visa Processing to Protect IMG Participation in Residency Programs | B |
| 217 | Protecting Access to Public Service Loan Forgiveness (PSLF), Income-Driven Repayment (IDR), and Direct Plus Loans for Graduate or Professional Students (Grad PLUS Loans) | B |
| 218 | Amend AMA Policy D-160.921 on Sensitive Locations to Protected Areas | B |
| 219 | Addressing the Harms and Misleading Nature of Medicare Advantage Plans | B |
| 220 | Medicare Should not Unfairly Penalize Physicians | B |

| | | |
|---|---|---|
| 221 | Not-for-Profit Status | B |
| 222 | Tackling Administrative Waste—Let Us Be Part of the Solution to Putting Our Health System on a Sustainable Path | B |
| 223 | Halt the Rollout of New Payment Models by the Center for Medicare & Medicaid Innovation (CMMI)—A New Administration Offers an Opportunity | B |
| 224 | Recoupment by CMS Recovery and Audit Contractors (RAC)—Due Process | B |
| 225 | Federal Legislation to Prohibit the Corporate Practice of Medicine | B |
| 226 | Transparency with the Term "Emergency Department" | B |
| 227 | Call for Immediate and Aggressive Action by the AMA to Reverse Medicaid Cuts Impacting Seniors | B |
| 228 | Support Permanent Funding and Expansion of Native Hawaiian Healthcare | B |
| 229 | Protection of Medicaid Beneficiaries' Private Health Information from Immigration Enforcement | B |
| 230 | Banning Non-compete Agreements in States | B |
| 231 | Ensuring Equitable and Timely Medical Licensure for Physicians Providing Abortion and Gender-Affirming Care | B |
| 232 | Safeguarding Access to IVF Amid Restorative Reproductive Medicine Legislation | B |
| 233 | Renewing Mental Health Infrastructure in the School System | B |
| 234 | Study on Impact of Inflation Reduction Act on Oncology, Other Physician Practices | B |
| 236 | Deceptive Advertising in Accredited Allied Health Professional, Non-Physician Graduate Programs | B |
| 237 | Protecting and Improving Rural Health | B |

REPORT OF THE BOARD OF TRUSTEES

B of T Report 01-I-25

Subject: Calling for a Multifaceted Approach to the Illicit Fentanyl Crisis

Presented by: David H. Aizuss, MD, Chair

Referred to: Reference Committee B

---

At the 2024 Interim Meeting of the American Medical Association (AMA) House of Delegates (HOD), Resolution 202-I-24, "Calling for a Multifaceted Approach to the Illicit Fentanyl Crisis," was introduced by the North American Spine Society. The second resolve of the resolution was referred and asked:

> "that our AMA continue to support efforts by federal, state and local government officials and agencies to curb and/or stop the manufacturing, importation, and distribution of illicit drugs and related chemical compounds."

The remainder of Resolution 202-I-24 was adopted and is AMA Policy H-95.896, "Calling for a Multifaceted Approach to the Illicit Fentanyl Crisis." Testimony was mixed during the meeting. Delegates highlighted that the AMA already has robust policy advocating for a public health focus to combat the drug overdose and death epidemic, including the need for the AMA to continue its public health approach to the epidemic. Testimony further emphasized the need to avoid stigmatizing drug use and to increase support for prevention, treatment and harm reduction initiatives. Testimony questioned the AMA's expertise to engage in areas traditionally handled by law enforcement. Delegates' testimony understandably reflected their concerns about the ongoing nature of the epidemic. Particular concern was raised about the multiple, toxic substances in the nation's illicit drug supply. This report provides relevant background, discusses issues raised by the resolution, cites AMA policy, and makes recommendations.

## BACKGROUND

After more than a decade of deaths involving illegally-made fentanyl increasing at staggering rates year after year, fentanyl-related deaths decreased almost 27 percent nationally from 2023-2024, according to the Centers for Disease Control and Prevention (CDC).[1] Provisional CDC mortality data show that there were 77,677 drug-related deaths from January 2024-January 2025.[2] To put the decrease in context, the recent finding is similar to April 2019-April 2020 when 77,017 drug-related deaths were reported. The Board reflects that a public health emergency was first declared for the "opioid crisis" in 2017, when more than 70,000 Americans died from October 2016-2017. This is to say that the Board of Trustees (the Board) welcomes the decrease in overdose mortality, although we must also recognize the sobering reality that the epidemic of drug-related overdose deaths is far from over.

In the midst of the recent decreases of overall drug deaths, there are nuances related to the fact that polysubstance use—opioids and stimulants in combination—accounted for more than 46 percent of deaths in 2023.[3] Provisional CDC data, moreover, show that in the 12-month period from

© 2025 American Medical Association. All rights reserved.

January 2024-2025, deaths involving cocaine and methamphetamine also decreased slightly but remain at near-historic levels (21,297 and 28,753, respectively).[4] As discussed in more detail below, law enforcement has seized significant amounts of illicit drugs, but demand remains high. The Board highlights this data to caution that while illegally made fentanyl remains a national scourge, and other illicit substances remain a high concern, it is critical that neither the AMA nor public policy focus solely on one type of illicit substance to the detriment of acknowledging the multifaceted nature of the nation's drug overdose epidemic.[5]

Furthermore, while deaths have decreased, the Board also is well-aware that access to care for substance use disorders remains a challenge for most Americans. Patients with pain continue to face restrictions and barriers in accessing pharmacologic and non-pharmacologic treatment. And while harm reduction initiatives such as increased naloxone access have been highly effective,[6] there are ongoing concerns about access to sterile needle and syringe services programs,[7] as well as individuals' lack of knowledge about Good Samaritan state laws for layperson protections.[8] The reasons behind the drop in drug-related mortality also are multifaceted and unclear. When asked why drug-related deaths have decreased, Nora Volkow, MD, who directs the National Institute for Drug Abuse, pointed to several possible reasons including: increased availability of naloxone; decreased fentanyl availability and purity; increased screening and public education of the benefits of medications for opioid use disorder (MOUD); and the sobering reality that "the most vulnerable people have died."[9] The Board does not disagree with Dr. Volkow's assessment, but with the exception of increasing naloxone and MOUD access, there is limited data to inform physicians and policymakers about which initiatives have been the most successful and should be expanded and which should no longer be pursued.

DISCUSSION

There are multiple reasons why the drug-related overdose and death epidemic persists. These include the toxicity of illegally made fentanyl, polysubstance use, unavailability of naloxone and other overdose reversal agents, lack of effective primary prevention efforts, and the ongoing challenge with obtaining (or maintaining) treatment for a substance use disorder. The primary focus of this report, however, is to identify what the AMA can or cannot do to "support efforts by federal, state and local government officials and agencies to curb and/or stop the manufacturing, importation, and distribution of illicit drugs and related chemical compounds."

One of the defining aspects of the nation's drug overdose and death epidemic has been the deadly, polysubstance nature of illegally made fentanyl, including fentanyl analogs such as carfentanil and their presence in counterfeit medications. The data show how these illegally made fentanyls (IMFs) affect states across the nation, including spikes in adulterants such as xylazine,[10] which may be part of the so-called reduced purity of fentanyl in the past one to -two years. In addition to xylazine, the U.S. Drug Enforcement Administration (DEA) reported in its 2025 National Drug Threat Assessment (NDTA) that IMFs are also commonly mixed with heroin, acetaminophen, para-fluorofentanyl, 4-ANPP, fluorofentanyl, cocaine, methamphetamine, caffeine, and medetomidine.[11] Although many observers say that this epidemic began largely due to misuse of prescription opioids and heroin, the Board highlights that deaths involving cocaine and psychostimulants also were occurring at that time. As such, efforts to continue to detect which substances are present in a region—or local community—are essential to help support primary prevention and education efforts.

The ability to test and identify toxic substances in the illicit drug supply chain may help with reductions in distribution of deadly products. For example, for people who use drugs, the use of fentanyl test strips (FTS) has been shown to increase the use of harm reduction measures, such as

having naloxone on hand when using, not using alone, using less, or discarding substances that were not what they expected.[12] FTS are just one of many types of drug checking technologies[13] which can potentially help limit the distribution within the drug-using community of deadly batches of drugs, but the Board cautions that there is not reliable data to suggest that the use of drug checking technologies is a viable strategy to prevent the distribution of illicit substances. Data also show how the use of emergency medical services data can be used to identify "hot spots" of overdose so as to try and ensure naloxone and other overdose prevention supplies are present in an area experiencing a rapid influx of overdoses.[14] In other words, while preventing the manufacturing, importation, and distribution of illegal drugs can be viewed as primarily the domain of law enforcement authorities, the public health initiatives that are part of the AMA's mission and expertise also can contribute to reducing use of illegal drugs.

In addition to the complicated, polysubstance nature of the drug supply, overall supply-side concerns remain high. Consider, for example, the following information concerning drug seizures:

- The NDTA reported that between 2019 and 2024, DEA seized 100,983 kilograms of fentanyl, and in 2024 alone, more than 61 million pills containing fentanyl were seized.
- Earlier this year, the DEA announced a "historic drug bust" capturing 396 kilograms of fentanyl pills; 11.5 kilograms of fentanyl powder; 1.5 kilograms of cocaine; 3.5 kilograms of heroin; and 7 pounds of methamphetamine.
- U.S. Customs and Border Protection (CBP) reported illicit fentanyl "seized at the border and ports of entry topping more than 27,000 pounds from October 2022 to the end of September 2023." CBP highlighted one operation where it combined intelligence from multiple agencies in 2023 that ultimately "led to over 900 seizures, including more than 13,000 pounds of precursor chemicals and more than 467 pill presses and pill molds to make fentanyl and fentanyl-laced pills, over 270 pounds of finished fentanyl in powder and laced-pills, plus an additional 1,162 pounds of methamphetamine and over 11,233 pounds of other drugs."
- Additional operations seized "more than 3,635 pounds of fentanyl, plus another 29,734 pounds of other narcotics to include 5,340 pounds of cocaine, more than 14,272 pounds of marijuana, and meth seizures topping 10,014 pounds."[15]
- In the first six months of 2025, "the DEA has seized approximately 44 million fentanyl pills, 4,500 pounds of fentanyl powder, nearly 65,000 pounds of methamphetamine, more than 201,500 pounds of cocaine, and made over 2,105 fentanyl-related arrests."[16]

The Board provides this detail to not only showcase the excellent work by law enforcement, but also to highlight the massive amount of illicit drug supply in the United States. Even with the staggering volume of illicit substances seized, 2023 data from the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) show that among people aged 12 or older, in the past year, 61.8 million people used cannabis, 8.9 million people misused opioids, 8.8 million people used hallucinogens, and 2.6 million people used methamphetamine.[17] SAMHSA data also show that 627,000 people used IMFs, but that estimate may be very low as many individuals were likely unaware they were using an IMF. The Board supports these efforts by federal, state, and local government officials and agencies to take action to try and stop the manufacturing, importation, and distribution of illicit drugs and related chemical compounds. Yet, the Board is acutely aware that law enforcement activities are beyond the scope and mission of the AMA.

The Board is also aware of efforts by multiple Administrations to try and stop the manufacturing, importation, and distribution of illicit fentanyl and other toxic substances. This includes investing in additional detection equipment at ports and other border locations; international diplomacy;

prosecutions of those involved with drug cartels; and more.[18] Many local DEA offices have been active in seizing IMF pills and illegal use of pill presses that contributed to the 79 million fake pills containing fentanyl seized in 2023.[19] The AMA commends the DEA and other agencies for these efforts as well as law enforcement and other efforts to enhance the use of detection equipment at ports and land borders. Physicians, on the other hand, do not have the expertise to curb importation of illicit drugs into this country.

## A MULTIFACETED APPROACH TO THE NATION'S OVERDOSE AND DEATH EPIDEMIC

The Board emphasizes that while we do not believe we have the expertise to properly advise the DEA, CBP, or other law enforcement agencies about interdiction activities, we also are limited in our expertise to meaningfully advise on issues related to international cooperation between law enforcement agencies, investigators, and intelligence gathering. The Board highlights, however, that there is much the AMA can do to directly help end the nation's drug-related overdose and death epidemic. The Board further stresses that the AMA remains committed to focusing its advocacy, public health initiatives, and educational offerings on those elements that will: (1) increase access to evidence-based care for individuals with a substance use disorder or mental illness; (2) remove barriers to care for patients with pain, including pharmacologic and non-pharmacologic options when recommended by their physician; and (3) advocate for evidence-based harm reduction initiatives, including naloxone access, syringe services programs, Good Samaritan laws, and other policies to save lives and reduce the spread of infectious disease.

As part of the AMA's multifaceted campaign to end the nation's overdose and death epidemic, AMA advocacy has helped reduce the prior authorization burden on physicians and patients to access MOUD. This advocacy includes ensuring that nearly all states have removed prior authorization for at least one form of MOUD.[20] AMA advocacy also has resulted in increased access to MOUD via telemedicine,[21] as well as reduced barriers for youth and others to be treated in an opioid treatment program. AMA advocacy further has helped most states enhance their Good Samaritan overdose protection laws,[22] although the Board continues to encourage state medical associations to use AMA model state legislation to decriminalize possession of drug checking equipment, harm reduction supplies (e.g., fentanyl test strips), and provide comprehensive civil and criminal protections to all those at the scene of an overdose event to support calling for help or providing direct assistance. While these policies may not directly address manufacturing, importation, or distribution, they serve as important tools to save lives from overdose.

Saving lives from overdose also requires states to have comprehensive 911 Good Samaritan laws. Generally, these laws provide civil and criminal protection for individuals who call or assist others when there is an overdose event. Data show that approximately half of overdoses have a bystander present,[23] but the rate has increased in recent years.[24] Research shows positive effects of these laws on saving lives from overdose.[25] Similar to the discussion regarding drug checking technologies above, the Board is not aware of data to suggest that 911 Good Samaritan laws would have a meaningful impact on the manufacturing, importation, or distribution of illicit substances, but the Board nonetheless highlights this harm reduction intervention as an area where public health and law enforcement can work more closely together.

## AMA POLICY

AMA policy is clear in its support for "public education and awareness about the rapidly evolving US illicit drug epidemic due to dangers of illegally made fentanyl and other toxic substances." (Policy H-95.896, "Calling for a Multifaceted Approach to the Illicit Fentanyl Crisis") The AMA also, "recognizes that emerging drugs of abuse, especially new psychoactive substances, are a

public health threat." (Policy H-95.940, "Addressing Emerging Trends in Illicit Drug Use") AMA policy also already includes clear support for federal, state and local government action to not only address emerging trends in illicit drug use, but to take action to identify those drugs and take action to mitigate harms. (Policy H-95.940, "Addressing Emerging Trends in Illicit Drug Use") Consistent with the AMA's public health focus and expertise, AMA policy broadly supports education, prevention, and treatment efforts. (Policy D-95.987, "Prevention of Drug-Related Overdose") Increased education also is central to AMA policy to address emerging drug trends. (Policy H-95.940, "Addressing Emerging Trends in Illicit Drug Use")

With respect to law enforcement, AMA policy is generally silent on specific law enforcement actions related to the importation, manufacturing, or distribution of illicit substances. Rather, AMA policy more specifically focuses on not criminalizing individuals with a substance use disorder. (Policy H-95.901, "Drug Policy Reform") AMA policy also supports "the removal of fentanyl test strips (FTS) and other testing strips, devices or testing equipment used in identifying or analyzing whether a substance contains fentanyl or other adulterants from the legal definition of drug paraphernalia." (Policy D-95.987, "Prevention of Drug-Related Overdose") Similarly, AMA policy strongly supports broad Good Samaritan protections (Policy D-95.977, "911 Good Samaritan Laws") and the "decriminalization of harm reduction supplies that reduce the likelihood of injection drug use and mitigate health risks of all types of drug use, including injection drug use and smoking." (Policy H-95.900, "Supporting Harm Reduction") The Board is confident that these policies provide the AMA with a robust foundation on which to continue its public health advocacy.

## CONCLUSION

In conclusion, the AMA continues to have deep concerns about the ongoing, multifaceted nature of the nation's drug overdose and death epidemic. The AMA supports law enforcement's efforts to curb manufacturing, importation and distribution of IMFs and other deadly substances. The AMA also will continue to focus its efforts on public health and policy interventions where we have expertise and can have a meaningful impact on improving care and saving lives. Existing AMA policy provides more than sufficient guidance for the AMA to continue its public health advocacy.

At the same time, while the AMA is clear-eyed about supply-side concerns, including manufacturing, importation and distribution of IMFs, those are areas outside the scope of the AMA as well as beyond our expertise. As noted in this report, there are areas where public health and law enforcement can work together, and the AMA will continue to share its medical perspectives on substance use disorders and evidence-based approaches to treatment and prevention to inform public safety strategies, such as 911 Good Samaritan overdose protection statutes. This does not mean, however, that we have expertise on the specific focus of this report, i.e., how to "stop the manufacturing, importation, and distribution of illicit drugs and related chemical compounds." The Board, therefore, recommends the AMA continue its public health advocacy while making clear the AMA's support for appropriate law enforcement activities, including opportunities for partnership where it has potential to advance public health.

## RECOMMENDATIONS

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

1. That our American Medical Association amend Policy H-95.896 to read:

1. Our American Medical Association continue to support public education and awareness about the rapidly evolving US illicit drug epidemic due to dangers of illegally made fentanyl and other toxic substances.

2. That our American Medical Association (AMA) continue to support efforts by federal, state and local government officials and agencies to curb and/or stop the manufacturing, importation, and distribution of illicit drugs and related chemical compounds.

3. That our AMA continue to monitor trends in polysubstance use, including the potential for drug checking technologies to assist public health officials in identifying how such technologies can lead to public health interventions, such as rapid deployment of naloxone and other overdose reversal agents.

4. That our AMA encourage state medical associations and national medical specialty societies to support legislative and other efforts to strengthen state 911 Good Samaritan Overdose statutory protection consistent with AMA policy. (Modify HOD Policy)

2. That our AMA reaffirm Policy H-95.940, "Addressing Emerging Trends in Illicit Drug Use." (Reaffirm HOD Policy)

Fiscal Note: Less than $500.

REFERENCES

[1] "U.S. Overdose Deaths Decrease Almost 27% in 2024." National Center for Health Statistics. U.S. Centers for Disease Control and Prevention. May 14, 2025. Available at https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2025/20250514.htm
[2] Ahmad FB, Cisewski JA, Rossen LM, Sutton P. Provisional drug overdose death counts. National Center for Health Statistics. 2025. DOI: https://dx.doi.org/10.15620/cdc/20250305008
[3] SUDORS Dashboard: Fatal Drug Overdose Data. U.S. Centers for Disease Control and Prevention. https://www.cdc.gov/overdose-prevention/data-research/facts-stats/sudors-dashboard-fatal-overdose-data.html Last accessed July 3, 2025.
[4] Ahmad FB, Cisewski JA, Rossen LM, Sutton P. Provisional drug overdose death counts. National Center for Health Statistics. 2025. DOI: https://dx.doi.org/10.15620/cdc/20250305008
[5] The AMA Substance Use and Pain Care Task Force, in recommendations issued in 2015, 2019 and 2021, detailed many clinical and policy-related aspects of the multifaceted, public health approach needed. See, generally, https://end-overdose-epidemic.org/task-force-recommendations/
[6] Fischer, L.S., Asher, A., Stein, R. *et al.* Effectiveness of naloxone distribution in community settings to reduce opioid overdose deaths among people who use drugs: a systematic review and meta-analysis. *BMC Public Health* 25, 1135 (2025). https://doi.org/10.1186/s12889-025-22210-8
[7] Karsten MB. A Case for Needle Exchange Programs: Not Letting Perfection be the Enemy of the Good. *Georgetown Medical Review*. 2023;7(1). doi:10.52504/001c.83277
[8] John R. Pamplin II, Saba Rouhani, Corey S. Davis, Carla King, and Tarlise N. Townsend: Persistent Criminalization and Structural Racism in US Drug Policy: The Case of Overdose Good Samaritan Laws
American Journal of Public Health 113, S43_S48, https://doi.org/10.2105/AJPH.2022.307037
[9] "Top addiction researcher Nora Volkow on NIH cuts, optimism, and the limits of RFK Jr.'s 12-step experience." STAT News. March 13, 2025. Available at https://www.statnews.com/2025/03/13/nora-volkow-nida-addiction-researcher-qa-rfk-12-step-recovery-overdose-death-declines
[10] Tanz LJ, Stewart A, Gladden RM, Ko JY, Owens L, O'Donnell J. Detection of Illegally Manufactured Fentanyls and Carfentanil in Drug Overdose Deaths — United States, 2021–2024. MMWR Morb Mortal Wkly Rep 2024;73:1099–1105. DOI: http://dx.doi.org/10.15585/mmwr.mm7348a2

[11] 2025 National Drug Threat Assessment. U.S. Drug Enforcement Administration. Available at https://www.dea.gov/sites/default/files/2025-07/2025NationalDrugThreatAssessment.pdf
[12] Vickers-Smith RA, Gelberg KH, Childerhose JE, et al. Fentanyl Test Strip Use and Overdose Risk Reduction Behaviors Among People Who Use Drugs. *JAMA Netw Open.* 2025;8(5):e2510077. doi:10.1001/jamanetworkopen.2025.10077
[13] Gozdzialski, L., Wallace, B. & Hore, D. Point-of-care community drug checking technologies: an insider look at the scientific principles and practical considerations. *Harm Reduct J* **20**, 39 (2023). https://doi.org/10.1186/s12954-023-00764-3
[14] Cash RE, Kinsman J, Crowe RP, Rivard MK, Faul M, Panchal AR. Naloxone Administration Frequency During Emergency Medical Service Events — United States, 2012–2016. MMWR Morb Mortal Wkly Rep 2018;67:850–853. DOI: http://dx.doi.org/10.15585/mmwr.mm6731a2
[15] CBP: America's Front Line Against Fentanyl. U.S. Customs and Border Protection. Last Modified: May 22, 2025. Last accessed July 9, 2025. Available at https://www.cbp.gov/frontline/cbp-america-s-front-line-against-fentanyl
[16] "Justice Department Highlights DEA Drug Seizures for First Half of 2025, Successful Operations Over the Last Several Weeks." News release. U.S. Department of Justice. July 15, 2025. Available at https://www.justice.gov/opa/gallery/justice-department-highlights-dea-drug-seizures-first-half-2025-successful-operations
[17] Substance Abuse and Mental Health Services Administration. (2024). *Key substance use and mental health indicators in the United States: Results from the 2023 National Survey on Drug Use and Health* (HHS Publication No. PEP24-07-021, NSDUH Series H-59). Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/data/report/2023-nsduh-annual-national-report
[18] *See,* for example, "FACT SHEET: Biden-Harris Administration Announces New Actions to Counter the Scourge of Fentanyl and Other Synthetic Drugs." July 31, 2024. Available at https://bidenwhitehouse.archives.gov/briefing-room/statements-releases/2024/07/31/fact-sheet-biden-%E2%81%A0harris-administration-announces-new-actions-to-counter-the-scourge-of-fentanyl-and-other-synthetic-drugs/; and also Statement of Drug Policy Priorities. White House Office of National Drug Control Policy. April 1, 2025. Available at https://www.whitehouse.gov/wp-content/uploads/2025/04/2025-Trump-Administration-Drug-Policy-Priorities.pdf
[19] Recent DEA Seizures of Pill Presses. U.S. Drug Enforcement Administration. April 9, 2024. Available at https://www.dea.gov/stories/2024/2024-04/2024-04-09/recent-dea-seizures-pill-presses
[20] State Approaches to Addressing the Opioid Epidemic: Findings from a Survey of State Medicaid Programs. Kaiser Family Foundation. February 6, 2024. Available at https://www.kff.org/medicaid/issue-brief/state-approaches-to-addressing-the-opioid-epidemic-findings-from-a-survey-of-state-medicaid-programs
[21] See, New rules enable telemedicine treatment for opioid-use disorder. March 12, 2024. Available at https://www.ama-assn.org/delivering-care/nation-s-overdose-epidemic/new-rules-enable-telemedicine-treatment-opioid-use
[22] For a comprehensive review of state laws, *see* Harm Reduction and Overdose Prevention 50-State Survey. Network for Public Health Law. Current as of August 1, 2023. Available at https://www.networkforphl.org/wp-content/uploads/2024/10/50-State-Survey-Harm-Reduction-Laws-in-the-United-States.pdf
[23] Flavin L, Rosen JG, St John K, Hallowell BD, Weidele HR, Krieger MS, McKenzie M, Green TC, Rich JD, Park JN. Bystander Presence and Naloxone Administration During Fatal Opioid-involved Overdoses in Rhode Island: Implications for Naloxone Coverage Among Families and Peers. J Addict Med. 2025 Apr 25:10.1097/ADM.0000000000001502. doi: 10.1097/ADM.0000000000001502. Epub ahead of print. PMID: 40277214; PMCID: PMC12217843.
[24] Gage CB, Powell JR, Ulintz A, et al. Layperson-Administered Naloxone Trends Reported in Emergency Medical Service Activations, 2020-2022. *JAMA Netw Open.* 2024;7(10):e2439427. doi:10.1001/jamanetworkopen.2024.39427
[25] DRUG MISUSE: Most States Have Good Samaritan Laws and Research Indicates They May Have Positive Effects. U.S. Government Accountability Office. GAO-21-248. Available at https://www.gao.gov/assets/gao-21-248.pdf

REPORT OF THE BOARD OF TRUSTEES

B of T Report 02-I-25

Subject: Laser Surgery
(Resolution 210-I-24)

Presented by: David H. Aizuss, MD, Chair

Referred to: Reference Committee B

---

This American Medical Association (AMA) Board of Trustees Report arises from Resolution 210-I-24, which was introduced by the American Academy of Ophthalmology and was referred. It asked the following:

> RESOLVED, that our American Medical Association amend policy H-475.989, "Laser Surgery," to read that laser surgery should be performed only by individuals licensed to practice medicine and surgery or by those categories of practitioners appropriately trained and currently licensed by the state to perform surgical services; and be it further
>
> RESOLVED, that our AMA amend policy H-475.980, "Addressing Surgery Performed by Optometrists" to read:
>
> 1. Our AMA will support legislation prohibiting optometrists from performing surgical procedures as defined by AMA Policies H-475.983, "Definition of Surgery," and H-475.989~~H-475.988~~, "Laser Surgery."
> 2. Our AMA encourages state medical associations to support state legislation and rulemaking prohibiting optometrists from performing surgical procedures as defined by AMA Policies H-475.983, "Definition of Surgery," and H-475.989~~H-475.988~~, "Laser Surgery."

Testimony centered on the amendment to Policy H-475.989, "Laser Surgery," and was generally supportive of strengthening our existing policy. Perspectives varied, however, on the correct approach. Multiple alternative amendments were offered that would clarify who should and should not be permitted to perform laser surgery, ultimately leading to a decision for referral.

Resolution 210-I-24 also asked our AMA to amend Policy H-475.980, "Addressing Surgery Performed by Optometrists." These amendments, however, focused only on correcting a typographical error and were not the basis of discussion. While the resolution was referred in its entirety, the primary focus of this report will be on H-475.989, "Laser Surgery," as this was the genesis of the referral. This report provides relevant background, discusses AMA policy, and makes recommendations.

© 2025 American Medical Association. All rights reserved.

BACKGROUND

Scope of practice is a priority issue for the AMA, state medical associations, and national medical specialty societies. Every year, legislation is introduced in state legislatures that would allow non-physicians to provide care or perform procedures that are considered the practice of medicine often without physician supervision. This year the AMA tracked hundreds of bills related to scope of practice, including legislation that would allow non-physicians, such as optometrists, to perform surgery, including laser surgery. The AMA, working alongside our state medical association and national medical specialty society colleagues, has strongly advocated in opposition to these bills.

Resolution 210-I-24 sought to clarify AMA Policy H-475.989, "Laser Surgery," which currently specifies that laser surgery should only be performed by (1) individuals licensed to practice medicine and surgery or (2) those categories of practitioners currently licensed by the state to perform surgical services. Since optometrists are licensed to perform surgery in twelve states, the amendment proposed in Resolution 210-I-24 by the American Academy of Ophthalmology added qualifying language "appropriately trained" to the second category of practitioners to clarify that these individuals must be both licensed to perform surgical services and appropriately trained to do so—the implication being that optometrists are not appropriately trained to perform laser surgery. The proposed amendment was also deemed necessary to provide consistency between this policy and Policy H-475.980, "Addressing Surgery Performed by Optometrists," which expressly states that our AMA support legislation prohibiting optometrists from performing surgical procedures, including laser surgery.

Ophthalmologists may use lasers to perform delicate eye surgeries to treat eye conditions such as glaucoma, cataracts, diabetic retinopathy, macular degeneration, retinal tears or detachment, and to perform refractive surgery, such as LASIK. Policy H-475.989, "Laser Surgery," however, addresses laser surgery more broadly, not just laser surgery on the eyes. In fact, there are multiple types of lasers that are used in a variety of surgical procedures across many physician specialties. For example, laser surgery is often used by dermatologists for scar revision, treatment of vascular lesions, tattoo removal, hair removal, or for ablative or non-ablative cutaneous rejuvenation. Other surgical specialties regularly use lasers in place of a scalpel in their surgical procedures. Depending on the type of laser and indication, some laser procedures may be performed by non-physicians who are appropriately trained and working under the direct supervision of a physician. Since lasers, which use focused, coherent light beams to remove, cut, burn or vaporize tissue, can cut as easily as a knife, laser procedures are considered medical procedures and included in the AMA's definition of surgery (Policy H-475.983).

Given the wide range of laser use by many physician specialties, several amendments were offered during testimony to further clarify the language around who should or should not be able to perform laser surgery. In general, these amendments would have added qualifiers to the physician language while also modifying the language around "other categories of practitioners." For example, one amendment suggested language that laser surgery should only be performed by "appropriately trained physicians:" removing the reference to other practitioners entirely. Another amendment would have largely retained the language of the original resolution but would have defined the term licensed physician as only "Doctor of Medicine or Doctor of Osteopathy." Finally, another amendment would have allowed laser surgery to only be performed by "appropriately trained licensed physicians or by individuals appropriately trained and under the supervision of a physician."

DISCUSSION

The Board of Trustees (the Board) understands the concerns that prompted Resolution 210-I-24 and the concerns raised by those who testified on this issue and agrees that Policy H-475.989, "Laser Surgery," should be amended to more clearly align with our AMA policy on surgery, physician-led care, and the definition of physician.

First, the Board notes three policies that are particularly relevant to the discussion of who should and should not perform surgery, including physicians and other categories of practitioners: Policy H-475.983, "Definition of Surgery," Policy H-480.981 "Cryotherapy, Therapeutic Ultrasound and Diathermy," and Policy H-410.950, "Pain Management."

First, Policy H-475.983, "Definition of Surgery," unequivocally states that surgery is the practice of medicine and that lasers, or instruments used to cut, burn, vaporize, or freeze, or otherwise alter tissue by thermal or light-based means is considered surgery. This policy also includes language on point related to the qualifications of physicians performing laser surgery, specifically that "…patients should be assured that individuals who perform these types of surgery are licensed physicians (defined as doctors of medicine or osteopathy) who meet appropriate professional standards."

Policy H-480.981 "Cryotherapy, Therapeutic Ultrasound and Diathermy," provides guidance on language around the qualifications of both physicians and other categories of practitioners who may perform surgery under the supervision of a physician. This policy addresses specific surgical modalities and the use of such modalities by appropriately trained physicians or individuals practicing under the supervision of a physician. This policy states that the application of heat or cold can be used as a therapeutic modality to cause tissue destruction and specifies that when they are used in such a manner, "the AMA recommends that those using the modality be appropriately trained, licensed physicians or be individuals appropriately trained and under the supervision of a physician."

Similarly, Policy H-410.950, "Pain Management," which is related to interventional pain management, also provides relevant language around the training required to perform and supervise these procedures, which can include surgical techniques using a laser. This policy informs the Board's recommendations and specifies that:

> Invasive pain management procedures require physician-level training. However, certain technical aspects of invasive pain management procedures may be delegated to appropriately trained, licensed or certified, credentialed non-physicians under direct and/or personal supervision of a physician who possesses appropriate training and privileges in the performance of the procedure being supervised, and in compliance with local, state, and federal regulations.

Our AMA's robust policy on scope of practice is also relevant here and clearly supports physician-led care and appropriate physician supervision of non-physicians. For example, Policy H-160.949, "Practicing Medicine by Non-Physicians," states that, "[o]ur AMA continues to actively oppose legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision;" and "through legislative and regulatory efforts, vigorously support and advocate for the requirement of appropriate physician supervision of non-physician clinical staff in all areas of medicine."

In addition to these policies, Policy H-405.969, "Definition of Physician," and Policy H-405.951, "Definition and Use of the Term Physician," are also relevant to this discussion. To ensure alignment with these policies, the Board recommends adding qualifying language to Policy H-475.989, "Laser Surgery," defining physician as "Doctor of Medicine, Doctor of Osteopathic Medicine, or a recognized equivalent physician degree and who would be eligible for an Accreditation Council for Graduate Medical Education (ACGME) residency." The Board also recommends adding language that physicians "must meet appropriate professional standards."

Finally, the Board wants to make clear that per Policy H-475.980, "Addressing Surgery Performed by Optometrists," our AMA opposes optometrists performing surgical procedures, including laser surgery, and encourages state medical associations to support state legislation and rulemaking prohibiting optometrists from performing surgical procedures as defined by AMA policies on surgery and laser surgery.

CONCLUSION

The Board agrees that Policy H-475.989, "Laser Surgery," should be amended to more clearly align with AMA policy on surgery, physician-led care, and the definition of physician. After carefully examining this policy along with the varying perspectives offered by the author of the original resolution and those who testified at the House of Delegates, the Board offers the following recommendations.

RECOMMENDATIONS

The Board of Trustees recommends that the following be adopted in lieu of Resolution 210-I-24 and the remainder of the report be filed.

1. That our American Medical Association (AMA) amend Policy H-475.989, "Laser Surgery," to read:

    1. Our American Medical Association adopts the policy that laser surgery should be performed only by ~~individuals~~ licensed physicians (defined as individuals who have a Doctor of Medicine, Doctor of Osteopathic Medicine, or a recognized equivalent physician degree and who would be eligible for an Accreditation Council for Graduate Medical Education (ACGME) residency)~~to practice medicine and surgery~~ who meet appropriate professional standards, or by those categories of practitioners who are appropriately trained, credentialed, and currently licensed by the state to perform surgical services, and are working under the direct supervision of a physician who possesses appropriate training and privileges in performance of the procedure being supervised. ~~currently licensed by the state to perform surgical services.~~ (Modify Current HOD Policy)

2. That our AMA amend Policy H-475.980, "Addressing Surgery Performed by Optometrists," to read:

    1. Our AMA will support legislation prohibiting optometrists from performing surgical procedures as defined by AMA Policies H-475.983, "Definition of Surgery," and H-475.989 ~~H-475.988~~, "Laser Surgery". (Modify Current HOD Policy)

    2. Our AMA encourages state medical associations to support state legislation and rulemaking prohibiting optometrists from performing surgical procedures as defined

by AMA Policies H-475.983, "Definition of Surgery," and H-475.989 ~~H-475.988~~, "Laser Surgery". (Modify Current HOD Policy)

Fiscal Note: Less than $500.

## APPENDIX

## AMA POLICY

**H-475.980, "Addressing Surgery Performed by Optometrists"**

1. Our AMA will support legislation prohibiting optometrists from performing surgical procedures as defined by AMA policies H-475.983, "Definition of Surgery," and H-475.988, "Laser Surgery."

2. Our AMA encourages state medical associations to support state legislation and rulemaking prohibiting optometrists from performing surgical procedures as defined by AMA policies H-475.983, "Definition of Surgery," and H-475.988, "Laser Surgery".

**H-475.983, "Definition of Surgery"**

Our American Medical Association adopts the following definition of "surgery" from American College of Surgeons Statement ST-11:

Surgery is performed for the purpose of structurally altering the human body by the incision or destruction of tissues and is part of the practice of medicine. Surgery also is the diagnostic or therapeutic treatment of conditions or disease processes by any instruments causing localized alteration or transposition of live human tissue which include lasers, ultrasound, ionizing radiation, scalpels, probes, and needles. The tissue can be cut, burned, vaporized, frozen, sutured, probed, or manipulated by closed reductions for major dislocations or fractures, or otherwise altered by mechanical, thermal, light-based, electromagnetic, or chemical means. Injection of diagnostic or therapeutic substances into body cavities, internal organs, joints, sensory organs, and the central nervous system also is considered to be surgery (this does not include the administration by nursing personnel of some injections, subcutaneous, intramuscular, and intravenous, when ordered by a physician). All of these surgical procedures are invasive, including those that are performed with lasers, and the risks of any surgical procedure are not eliminated by using a light knife or laser in place of a metal knife, or scalpel.

Patient safety and quality of care are paramount and, therefore, patients should be assured that individuals who perform these types of surgery are licensed physicians (defined as doctors of medicine or osteopathy) who meet appropriate professional standards.

**H-475.989, "Laser Surgery"**

Our American Medical Association adopts the policy that laser surgery should be performed only by individuals licensed to practice medicine and surgery or by those categories of practitioners currently licensed by the state to perform surgical services.

Our AMA encourages state medical associations to support state legislation and rulemaking in support of this policy.

**H-480.981, "Cryotherapy, Therapeutic Ultrasound and Diathermy"**

Our American Medical Association recognizes that the application of heat or cold is a therapeutic modality used by a variety of practitioners. When these modalities are used and are expected to cause tissue destruction, the AMA recommends that those using the modality be appropriately trained, licensed physicians or be individuals appropriately trained and under the supervision of a physician.

**H-410.950, "Pain Management"**
Our AMA adopts the following guidelines on Invasive Pain Management Procedures for the Treatment of Chronic Pain, Including Procedures Using Fluoroscopy:

Invasive pain management procedures include interventions throughout the course of diagnosing or treating pain which is chronic, persistent and intractable, or occurs outside of a surgical, obstetrical, or post- operative course of care. Invasive pain management techniques include:

1. ablation of targeted nerves;
2. procedures involving any portion of the spine, spinal cord, sympathetic nerves or block of major peripheral nerves, including percutaneous precision needle placement within the spinal column with placement of drugs such as local anesthetics, steroids, and analgesics, in the spinal column under fluoroscopic guidance or any other radiographic or imaging modality; and
3. surgical techniques, such as laser or endoscopic diskectomy, or placement of intrathecal infusion pumps, and/or spinal cord stimulators.

At present, invasive pain management procedures do not include major joint injections (except sacroiliac injections), soft tissue injections or epidurals for surgical anesthesia or labor analgesia.

When used for interventional pain management purposes such invasive pain management procedures do not consist solely of administration of anesthesia; rather, they are interactive procedures in which the physician is called upon to make continuing adjustments based on medical inference and judgments. In such instances, it is not the procedure itself, but the purpose and manner in which such procedures are utilized, that demand the ongoing application of direct and immediate medical judgment. These procedures are therefore within the practice of medicine, and should be performed only by physicians with appropriate training and credentialing.

Invasive pain management procedures require physician-level training. However, certain technical aspects of invasive pain management procedures may be delegated to appropriately trained, licensed or certified, credentialed non-physicians under direct and/or personal supervision of a physician who possesses appropriate training and privileges in the performance of the procedure being supervised, and in compliance with local, state, and federal regulations. Invasive pain management procedures employing radiologic imaging are within the practice of medicine and should be performed only by physicians with appropriate training and credentialing."

**H-35.989, "Physician Assistants"**
1. Our American Medical Association opposes legislation to increase public funding for programs to train physician assistants and supports a careful reevaluation of the need for public funding at the time that present legislative authorities expire.
2. A physician assistant should provide patient care services only in accord with the medical practice act and other applicable state law, and such law should provide that the physician assistant's utilization by a physician or group of physicians be approved by the medical licensing board. A licensed physician or group of physicians seeking to utilize a physician assistant should submit to the medical licensing board an application for utilization that identifies: the qualifications and experience of the physician assistant, the qualifications and experience of the supervising physician and a description of their practice, and a description of the manner and the health care settings in which the assistant will be utilized, and the arrangements for supervision by the responsible physician. Such an application should also specify the number of physician assistants that the physician or group of physicians plans to employ and supervise. A physician assistant should be authorized to provide patient care

services only so long as the assistant is functioning under the direction and supervision of a physician or group of physicians whose application for utilization has been approved by the medical licensing board. State medical licensing boards, in their review of applications for utilization of a physician assistant, should take special care to insure that the proposed physician assistant functions not be of a type which:

a. would unreasonably expand the professional scope of practice of the supervising physician;
b. cannot be performed safely and effectively by the physician assistant, or
c. would authorize the unlicensed practice of medicine.

3. The physician assistant should function under the direction of and supervision by a duly qualified licensed physician. The physician must always maintain the ultimate responsibility to assure that high quality care is provided to every patient. In discharging that responsibility, the physician should exercise that amount of control or supervision over a physician assistant which is appropriate for the maintenance of quality medical care and in accord with existing state law and the rules and regulations of the medical licensing authority. Such supervision in most settings includes the personal presence or participation of the physician. In certain instances, such as remote practice settings, where the physician assistant may function apart from the supervising physician, such remote function (if permitted by state law) should be approved by the state medical licensing board on an individual basis. Such approval should include requirements for regular reporting to the supervising physician, frequent site visits by that physician, and arrangements for immediate communication with the supervising physician for consultation at all times. The physician assistant may serve the patients of the supervising physician in all types of health care settings, including but not limited to: physician's office, ambulatory or outpatient facility, clinic, hospital, patient's home, long-term care facility or nursing home. The state medical licensing board should determine on an individual basis the number of physician assistants that a particular physician may supervise or a group of physicians may employ.
4. While it is preferable and desirable that the physician assistant be employed by a physician or group of physicians so as to ensure appropriate physician supervision in the interests of the patient, where a physician assistant is employed by a hospital, the physician assistant must provide patient care services in accordance with the rules and procedures established by the organized medical staff for utilization of physician-employed physician assistants functioning in that institution, and under the direction and supervision of a designated physician who has been approved by the state medical licensing board to supervise that physician assistant in accordance with a specific utilization plan and who shall be directly responsible as the attending physician for the patient care services delegated to their physician assistant.
5. Our AMA opposes legislation or proposed regulations authorizing physician assistants to make independent medical judgments as to the drug of choice for an individual patient.
6. In view of an announced interest by HHS in considering national legislation which would override state regulatory systems for health manpower, the AMA recommends that present Association policy supporting state prerogatives in this area be strongly reaffirmed.
7. Our AMA opposes legislation or regulation that allows physician assistant independent practice.

**H-160.906, "Models / Guidelines for Medical Health Care Teams"**

1. Our AMA defines 'physician-led' in the context of team-based health care as the consistent use by a physician of the leadership knowledge, skills and expertise necessary to identify, engage and elicit from each team member the unique set of training, experience, and qualifications needed to help patients achieve their care goals, and to supervise the application of these skills.

2. Our AMA supports the following elements that should be considered when planning a team-based care model according to the needs of each physician practice:

   Patient-Centered:
   a. The patient is an integral member of the team.
   b. A relationship is established between the patient and the team at the onset of care, and the role of each team member is explained to the patient.
   c. Patient and family-centered care is prioritized by the team and approved by the physician team leader.
   d. Team members are expected to adhere to agreed-upon practice protocols.
   e. Improving health outcomes is emphasized by focusing on health as well as medical care.
   f. Patients' access to the team, or coverage as designated by the physician-led team, is available twenty-four hours a day, seven days a week.
   g. Safety protocols are developed and followed by all team members.

   Teamwork:
   h. Medical teams are led by physicians who have ultimate responsibility and authority to carry out final decisions about the composition of the team.
   i. All practitioners commit to working in a team-based care model.
   j. The number and variety of practitioners reflects the needs of the practice.
   k. Practitioners are trained according to their unique function in the team.
   l. Interdependence among team members is expected and relied upon.
   m. Communication about patient care between team members is a routine practice.
   n. Team members complete tasks according to agreed-upon protocols as directed by the physician leader.

   Clinical Roles and Responsibilities:
   o. Physician leaders are focused on individualized patient care and the development of treatment plans.
   p. Non-physician practitioners are focused on providing treatment within their scope of practice consistent with their education and training as outlined in the agreed upon treatment plan or as delegated under the supervision of the physician team leader.
   q. Care coordination and case management are integral to the team's practice.
   r. Population management monitors the cost and use of care, and includes registry development for most medical conditions.

   Practice Management:
   s. Electronic medical records are used to the fullest capacity.
   t. Quality improvement processes are used and continuously evolve according to physician-led team-based practice assessments.
   u. Data analytics include statistical and qualitative analysis on cost and utilization, and provide explanatory and predictive modeling.
   v. Prior authorization and precertification processes are streamlined through the adoption of electronic transactions.

**H-160.947, "Physician Assistants and Nurse Practitioners"**
Our American Medical Association will develop a plan to assist the state and local medical societies in identifying and lobbying against laws that allow advanced practice nurses to provide medical care without the supervision of a physician.

The suggested Guidelines for Physician/Physician Assistant Practice are adopted to read as follows (these guidelines shall be used in their entirety):

1. The physician is responsible for managing the health care of patients in all settings.
2. Health care services delivered by physicians and physician assistants must be within the scope of each practitioner's authorized practice, as defined by state law.
3. The physician is ultimately responsible for coordinating and managing the care of patients and, with the appropriate input of the physician assistant, ensuring the quality of health care provided to patients.
4. The physician is responsible for the supervision of the physician assistant in all settings.
5. The role of the physician assistant in the delivery of care should be defined through mutually agreed upon guidelines that are developed by the physician and the physician assistant and based on the physician's delegatory style.
6. The physician must be available for consultation with the physician assistant at all times, either in person or through telecommunication systems or other means.
7. The extent of the involvement by the physician assistant in the assessment and implementation of treatment will depend on the complexity and acuity of the patient's condition and the training, experience, and preparation of the physician assistant, as adjudged by the physician.
8. Patients should be made clearly aware at all times whether they are being cared for by a physician or a physician assistant.
9. The physician and physician assistant together should review all delegated patient services on a regular basis, as well as the mutually agreed upon guidelines for practice.
10. The physician is responsible for clarifying and familiarizing the physician assistant with their supervising methods and style of delegating patient care.

**H-160.949, "Practicing Medicine by Non-Physicians**

1. Our American Medical Association urges all people, including physicians and patients, to consider the consequences of any health care plan that places any patient care at risk by substitution of a non-physician in the diagnosis, treatment, education, direction and medical procedures where clear-cut documentation of assured quality has not been carried out, and where such alters the traditional pattern of practice in which the physician directs and supervises the care given;
2. Our AMA continues to work with constituent societies to educate the public regarding the differences in the scopes of practice and education of physicians and non-physician health care workers.
3. Our AMA continues to actively oppose legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision.
4. Our AMA continues to encourage state medical societies to oppose state legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision.
5. Our AMA, through legislative and regulatory efforts, vigorously support and advocate for the requirement of appropriate physician supervision of non-physician clinical staff in all areas of medicine.
6. Our AMA opposes special licensing pathways for "assistant physicians" (i.e., those who are not currently enrolled in an Accreditation Council for Graduate Medical Education training program or have not completed at least one year of accredited graduate medical education in the U.S).

**H-160.950, "Guidelines for Integrated Practice of Physician and Nurse Practitioner"**
Our American Medical Association endorses the following guidelines and recommends that these guidelines be considered and quoted only in their entirety when referenced in any discussion of the roles and responsibilities of nurse practitioners:

1. The physician is responsible for the supervision of nurse practitioners and other advanced practice nurses in all settings.
2. The physician is responsible for managing the health care of patients in all practice settings.
3. Health care services delivered in an integrated practice must be within the scope of each practitioner's professional license, as defined by state law.
4. In an integrated practice with a nurse practitioner, the physician is responsible for supervising and coordinating care and, with the appropriate input of the nurse practitioner, ensuring the quality of health care provided to patients.
5. The extent of involvement by the nurse practitioner in initial assessment, and implementation of treatment will depend on the complexity and acuity of the patients' condition, as determined by the supervising/collaborating physician.
6. The role of the nurse practitioner in the delivery of care in an integrated practice should be defined through mutually agreed upon written practice protocols, job descriptions, and written contracts.
7. These practice protocols should delineate the appropriate involvement of the two professionals in the care of patients, based on the complexity and acuity of the patients' condition.
8. At least one physician in the integrated practice must be immediately available at all times for supervision and consultation when needed by the nurse practitioner.
9. Patients are to be made clearly aware at all times whether they are being cared for by a physician or a nurse practitioner.
10. In an integrated practice, there should be a professional and courteous relationship between physician and nurse practitioner, with mutual acknowledgment of, and respect for each other's contributions to patient care.
11. Physicians and nurse practitioners should review and document, on a regular basis, the care of all patients with whom the nurse practitioner is involved. Physicians and nurse practitioners must work closely enough together to become fully conversant with each other's practice patterns.

**H-360.987, "Principles Guiding AMA Policy Regarding Supervision of Medical Care Delivered by Advanced Practice Nurses in Integrated Practice"**
Our American Medical Association endorses the following principles:

1. Physicians must retain authority for patient care in any team care arrangement, e.g., integrated practice, to assure patient safety and quality of care.
2. Medical societies should work with legislatures and licensing boards to prevent dilution of the authority of physicians to lead the health care team.
3. Exercising independent medical judgment to select the drug of choice must continue to be the responsibility only of physicians.
4. Physicians should recognize physician assistants and advanced practice nurses under physician leadership, as effective physician extenders and valued members of the health care team.
5. Certified nurse practitioners, certified registered nurse anesthetists, certified nurse midwives, and clinical nurse specialists shall be licensed and regulated jointly by the state medical and nursing boards.
6. Physicians must be responsible and have authority for initiating and implementing quality control programs for nonphysicians delivering medical care in integrated practices.

**H-405.969, "Definition of a Physician"**

1. Our American Medical Association affirms that a physician is an individual who has received a "Doctor of Medicine" or a "Doctor of Osteopathic Medicine" degree or an equivalent degree following successful completion of a prescribed course of study from a school of medicine or osteopathic medicine.
2. Our AMA policy requires anyone in a hospital environment who has direct contact with a patient who presents himself or herself to the patient as a "doctor," and who is not a "physician" according, according to the AMA definition above, must specifically and simultaneously declare themselves a "non-physician" and define the nature of their doctorate degree.
3. Our AMA actively supports the Scope of Practice Partnership in the Truth in Advertising campaign.

**H-405.951, "Definition and Use of the Term Physician"**

1. Our American Medical Association Affirms that the term physician be limited to those people who have a Doctor of Medicine, Doctor of Osteopathic Medicine, or a recognized equivalent physician degree and who would be eligible for an Accreditation Council for Graduate Medical Education (ACGME) residency.
2. Our AMA will, in conjunction with the Federation, aggressively advocate for the definition of physician to be limited as defined above:
3. In any federal or state law or regulation including the Social Security Act or any other law or regulation that defines physician.
4. To any federal and state legislature or agency including the Department of Health and Human Services, Federal Aviation Administration, the Department of Transportation, or any other federal or state agency that defines physician.
5. To any accrediting body or deeming authority including the Joint Commission, Health Facilities Accreditation Program, or any other potential body or authority that defines physician.
6. Our AMA urges all physicians to insist on being identified as a physician, to sign only those professional or medical documents identifying them as physicians, and to not let the term physician be used by any other organization or person involved in health care.
7. Our AMA ensures that all references to physicians by government, payers, and other health care entities involving contracts, advertising, agreements, published descriptions, and other communications at all times distinguish between physician, as defined above, and non-physicians and to discontinue the use of the term provider.
8. Policy requires any individual who has direct patient contact and presents to the patient as a doctor, and who is not a physician, as defined above, must specifically and simultaneously declare themselves a non-physician and define the nature of their doctorate degree.
9. Our AMA will review and revise its own publications as necessary to conform with the House of Delegates' policies on physician identification and physician reference and will refrain from any definition of physicians as providers that is not otherwise covered by existing Journal of the American Medical Association (JAMA) Editorial Governance Plan, which protects the editorial independence of JAMA.
10. Our AMA actively supports the Scope of Practice Partnership in the Truth in Advertising campaign

REPORT OF THE BOARD OF TRUSTEES

B of T Report 03-I-25

Subject: Stark Law Self-Referral Ban

Presented by: David H. Aizuss, MD, Chair

Referred to: Reference Committee B

---

At the 2024 Interim Meeting, the House of Delegates (HOD) referred Board of Trustee Report 3, "Stark Law Self-Referral Ban," which recommended the following be adopted in lieu of Resolution 227-I-23:

1. That our American Medical Association reaffirm AMA Policies H-140.861, "Physicians Self-Referral," D-270.995, "Physician Ownership and Referral for Imaging Services," and H-385.914, "Stark Law and Physician Compensation." (Reaffirm HOD Policy)
2. That our American Medical Association supports initiatives to expand Stark law waivers to allow independent physicians, in addition to employed or affiliated physicians, to work with hospitals or health entities on quality improvement initiatives to address issues including care coordination and efficiency. (New HOD Policy)

The Reference Committee heard mixed testimony concerning BOT 03-I-24. The Reference Committee heard that the Stark law has contributed to creating an uneven playing field for physician practices which must go to great lengths to avoid violating the Stark law's prohibition on self-referral. Other testimony noted that the Report should go further to remove burdens on physician practices that large, consolidated entities do not face. Testimony recommended referral for stronger support to eliminate the Stark law's unfair barrier to competition on physician practices. Therefore, the Reference Committee recommended that BOT 03-I-24 be referred, and the HOD concurred.

BACKGROUND

The Physician Self-Referral Law, commonly referred to as the Stark law, prohibits physicians from referring patients to receive "designated health services" payable by Medicare or Medicaid from entities with which the physician or an immediate family member has a financial relationship, unless an exception applies. Financial relationships include both ownership/investment interests and compensation arrangements. For example, if a physician invests in an imaging center, the Stark law requires the resulting financial relationship to fit within an exception or the physician may not refer patients to the facility and the entity may not bill for the referred imaging services.

"Designated health services" are:

- clinical laboratory services;
- physical therapy, occupational therapy, and outpatient speech-language pathology services;
- radiology and certain other imaging services;
- radiation therapy services and supplies;
- DME and supplies;

© 2025 American Medical Association. All rights reserved.

- parenteral and enteral nutrients, equipment, and supplies;
- prosthetics, orthotics, and prosthetic devices and supplies;
- home health services;
- outpatient prescription drugs; and
- inpatient and outpatient hospital services.

The Stark law is a strict liability statute, which means proof of specific intent to violate the law is not required. The Stark law prohibits the submission, or causing the submission, of claims in violation of the law's restrictions on referrals. Penalties for physicians who violate the Stark law include fines as well as exclusion from participation in federal health care programs.

AMA POLICY AND ADVOCACY

The AMA has longstanding policy on the issue of self-referral by physicians. AMA Policy H-140.861, "Physicians' Self-Referral," states that physicians should not refer patients to a health care facility that is outside their office practice and at which they do not directly provide care or services, when they have a financial interest in that facility.

In a similar vein, the AMA has well developed policy regarding physician ownership and referral for imaging services. AMA Policy D-270.995, "Physician Ownership and Referral for Imaging Services," states that the AMA will work collaboratively with state medical societies and specialty societies to actively oppose any and all federal and state legislative and regulatory efforts to repeal the in-office ancillary services exception to physician self-referral laws, including as they apply to imaging services.

In addition, the AMA has adopted principles emphasizing that, in regard to their involvement with Accountable Care Organizations (ACOs), the physician's primary ethical and professional obligation is the well-being and safety of the patient. AMA Policy H-160.915, "Accountable Care Organization Principles," emphasizes in Clause 5 that federal and state anti-kickback and self-referral laws and the federal Civil Monetary Penalties (CMP) statute (which prohibits payments by hospitals to physicians to reduce or limit care) should be sufficiently flexible to allow physicians to collaborate with hospitals in forming ACOs without being employed by the hospitals or ACOs.

Also, Policy H-385.914, "Stark Law and Physician Compensation," calls on the AMA to oppose and continue to advocate against the misuse of the Stark Law and regulations to cap or control physician compensation.

Finally, AMA Code of Medical Ethics 9.6.9, "Physician Self-Referral," states that, in general, physicians should not refer patients to a health care facility that is outside their office practice and at which they do not directly provide care or services when they have a financial interest in that facility.

In May – July 2025, the AMA advocated to the Office of Management and Budget, U.S. Department of Justice, the HHS Centers for Medicare & Medicaid Services (CMS), and U.S. Department of Health and Human Services that these agencies promulgate a "rural exemption" to the Stark law's Site-of-Service requirements and the In-Office Ancillary Services Exception. These recent advocacy efforts were undertaken in furtherance of current AMA policy and in response to the AMA members' expressed desire at the 2024 Interim Meeting for stronger support to eliminate the Stark law's unfair barriers to competition on physician practices.

DISCUSSION

The Board recognizes the challenges the Stark law may pose to many physician practices. The Board also recognizes that restrictions on self-referral may be a contributing factor to market consolidation. Current AMA policy, however, generally addresses the concerns expressed in Resolution 227-I-23. For example, AMA policy opposes and advocates against the misuse of the Stark law and regulations to cap or control physician compensation. Resolution 227-I-23, the genesis of BOT Report 03-I-24 and this report, indicated that the Stark law provides a "blanket ban on self-referral practices." This, however, is not the case. The Stark law contains numerous exceptions, which if met, allow physicians to self-refer, e.g., when physicians self-refer to risk-bearing arrangements. Most importantly for the purposes of this report, the Stark law has a broad exception for both ownership interests and compensation arrangements that applies specifically to physician practices—the in-office ancillary services exception. Regarding any contributing factor the Stark law may have on consolidation, the AMA has extensive policy addressing issues raised by consolidated hospital markets and advocates aggressively with the goal of preventing further consolidation and restoring competition in those markets.

CONCLUSION

The Board considered the views expressed at the AMA's 2024 Interim Meeting urging stronger support for eliminating the Stark law's unfair barriers to competition on physician practices. With these considerations in mind, the Board's recommendations serve to more effectively target those Stark law restrictions that place an unfair barrier on independent physician practices, remove the inaccurate reference to a Stark law blanket ban on self-referral, and ensure alignment with AMA policy including AMA Code of Ethics Policy 9.6.9.

RECOMMENDATIONS

The Board of Trustees recommends that the following be adopted in lieu of Resolution 227-I-23 and BOT 03-I-24 and the remainder of the report be filed:

1. That our American Medical Association (AMA) recognizes the substantial impact of the Stark law's unequal restrictions on independent physicians, contributing to the growing trend of hospital consolidation, which has led to negative consequences of restricted access to care and inflated costs. (New HOD Policy)

2. That our AMA supports comprehensive Stark law reform aimed at rectifying the disparities that disadvantage independent physician practices while preserving the intent of AMA Code of Ethics Policy 9.6.9, "Physician Self-Referral." (New HOD Policy)

3. That our AMA supports equitable and balanced Stark law reform that fosters fair competition, incentivizes innovation, and facilitates the delivery of high-quality, patient-centered care. (New HOD Policy)

Fiscal Note: Less than $500.

REPORT 04 OF THE BOARD OF TRUSTEES (I-25)
American Medical Association (AMA) Efforts on Addressing and Reducing Patient Boarding in Emergency Departments (EDs)
(Reference Committee B)

## EXECUTIVE SUMMARY

At the 2024 Interim Meeting, the AMA House of Delegates adopted alternate Resolution 201, which established Policy D-130.957, "Addressing and Reducing Patient Boarding in EDs." This report responds to the directive to report back at the 2025 Interim Meeting on progress made addressing and reducing patient boarding in EDs, recognizing that more recent developments may not be reflected due to report preparation timelines.

ED boarding, which occurs when patients remain in the ED after admission or placement in observation status, is a growing national crisis, with more than 90 percent of EDs reporting crowded conditions. Boarding delays treatment, worsens patient outcomes, contributes to staff burnout, and increases violence against health care workers. The AMA's advocacy has included federal and state engagement, collaboration with the American College of Emergency Physicians and other organizations, and input on quality measurement initiatives. Recently, the AMA supported the "Addressing Boarding and Crowding in the Emergency Department Act of 2025," (H.R. 2936/S. 1974) bipartisan legislation that would enable public health data modernization grants to support the development of real-time hospital bed capacity tracking systems, establish public-facing dashboards to promote accountability and transparency, and promote pilot programs through the Center for Medicare and Medicaid Innovation to address causes of ED boarding. The AMA has also advanced multiple policy levers to mitigate the root causes of boarding including improving behavioral health and substance use disorder care, extending the Acute Care Hospital at Home Program, strengthening access to primary and specialty care, expanding social supports, reducing prior authorization and other administrative burdens, increasing workforce and post-acute care capacity, expanding telehealth flexibilities, increasing the efficiency of staff and practice workflows, strengthening Medicare reimbursement, and protecting Medicaid and affordable coverage options. The AMA has also prioritized physician well-being, working to reduce burnout and address the increased risk of workplace violence associated with boarding.

Sustained progress on ED boarding will require coordinated solutions at the federal, state, and local levels. The AMA will continue to advocate for policy and payment reforms, support the Agency for Healthcare Research and Quality's stakeholder convenings, and collaborate with industry partners to identify high-impact interventions that improve system-wide throughput and reduce the harmful impacts of boarding. This work advances the goals of Policy D-130.957 and positions the AMA as a national leader in addressing this significant public health challenge.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 04-I-25

Subject: Addressing and Reducing Patient Boarding in Emergency Departments (EDs)

Presented by: David H. Aizuss, MD, Chair

Referred to: Reference Committee B

---

At the 2024 Interim Meeting, the American Medical Association (AMA) House of Delegates (HOD) adopted alternate Resolution 201 which resulted in Policy D-130.957, "Addressing and Reducing Patient Boarding in Emergency Departments (EDs)," which directs the AMA as follows:

1. Our American Medical Association will collaborate with interested parties, such as hospitals, insurance companies, the Centers for Medicare & Medicaid Services (CMS), and accrediting bodies such as the Joint Commission, to address and reduce emergency department boarding and overcrowding.
2. Our AMA supports appropriate staffing and standards of care for all patients admitted to the hospital or awaiting transfer, including emergency department patients and admitted patients physically located in the emergency department, to mitigate patient harm and physician burnout.
3. Our AMA advocates for increased state and federal assistance to address the systemic factors contributing to emergency department boarding.
4. Our AMA supports other medical societies, hospital associations, accrediting organizations, and patient advocacy groups to raise awareness of the impacts of emergency department boarding and to identify and propose solutions.
5. Our AMA will continue to monitor the development of CMS quality measures related to patient boarding and work in collaboration with relevant medical specialty associations to support improvements in quality standards related to emergency department care.
6. Our AMA will report back to the House of Delegates at the 2025 Interim Meeting on progress addressing and reducing patient boarding in emergency departments.

Note: This report is in response to the request in the sixth clause of Policy D-130.957. It was prepared in July, 2025, based on approval deadlines; therefore, more recent developments may not be reflected.

## BACKGROUND AND PREVIOUS AMA ADVOCACY

A "boarded patient" is one who remains in the ED after being admitted or placed into observation status, which can contribute to ED crowding.[1] ED boarding is on the rise and is widely considered a crisis, with harmful impacts on patients, hospital staff, public safety, and health care costs.[2] Over 90 percent of EDs routinely report crowded conditions.[3] Patients can wait days, or even weeks after a physician has decided to admit them waiting for an inpatient bed to become available. The Emergency Medical Treatment and Labor Act (EMTALA) is a factor in ED boarding, since in emergency medicine uniquely anyone who presents to the ED with an emergency must be treated or stabilized, regardless of their insurance status or ability to pay. The causes of ED boarding are multifactorial with health system-wide dysfunction that impedes ED throughput and drives

© 2025 American Medical Association. All rights reserved.

multiple adverse effects as shown in this American College of Emergency Physicians (ACEP) diagram.

Recent developments are summarized below.

- November 2022: The AMA, ACEP and 33 other organizations signed a letter to President Biden declaring ED boarding a national public health emergency.
- May 2023: 42 members of Congress authored a letter to then-Health and Human Services (HHS) Secretary Xavier Becerra expressing concern about the nationwide patient boarding crisis and urging HHS to convene a multi-stakeholder taskforce to develop solutions.
- December 2023: Secretary Becerra responded with a letter charging the Agency for Healthcare Research and Quality (AHRQ) with convening a multistakeholder roundtable.
- October 2024: AHRQ held a summit to address ED boarding and issued a report in January 2025. Solutions included enhanced measurement and public reporting; aligning payment and incentive policies; facilitating telehealth and care transfers; diversion strategies, especially for behavioral health (BH) patients; and supports for staff dealing with boarding.
- December 2024: AHRQ issued a Special Emphasis Notice that describes its "strong and continued interest in receiving health services research grant applications for addressing ED boarding and hospital crowding." In the notice, AHRQ recognizes that boarding harms patients and is linked to higher mortality rates, increased medical errors, longer hospital stays, increased health care costs, staff burnout, ED violence, and strain that ripples through entire health care systems and communities. AHRQ solicited applicants for related research grant opportunities, stating it is particularly interested in supporting research focusing on financial and regulatory pressure, throughput, data measurement and tracking, workforce solutions, resources and toolkits, and/or the patient experience.
- April 2025: A RAND research report *Strategies for Sustaining Emergency Care in the United States* included several recommendations to address ED boarding including "smoothing" elective admissions; allocating funds to ED care and broader care for substance use disorders and mental health conditions; compensating EDs commensurate with the level of indigent care they provide; investing in expanding primary care capacity; using strategies for efficient inpatient and observation discharge; protecting health care workers by enforcing hospital anti-violence policies and increasing the legal consequences for violence against health care workers; Medicaid expansion and payment parity with Medicare; fixing the No Surprises Act flaws so payers must pay in full any independent dispute resolution judgments to the prevailing physicians within a preset time frame; and advocating for state or federal ED boarding policies that provide financial incentives and/or penalties for hospitals to address ED boarding.
- July 2025: At its annual Quality Conference, CMS hosted a panel session on hospital boarding. Solutions included boarding metrics in value-based programs, enhanced BH interventions, reductions in prior authorization (PA) and other administrative burdens, and improving post-acute care transfers. AMA advocacy was cited in materials.

## RECENT AMA ADVOCACY

The AMA is committed to addressing ED boarding directly and advocating for enhanced federal and state supports to address its root causes and impacts on clinical staff, as outlined below.

*The Addressing Boarding and Crowding in the ED (ABC-ED) Act of 2025*

The AMA recently sent letters to the House and Senate in support of the "Addressing Boarding and Crowding in the Emergency Department (ABC-ED) Act of 2025" (H.R. 2936/S. 1974). This bipartisan legislation would offer multiple solutions to the multifaceted ED boarding problem by enabling public health data modernization grants to support the development of real-time hospital bed capacity tracking systems, establishing public-facing dashboards to promote accountability and transparency, and promoting pilot programs through the Center for Medicare and Medicaid Innovation to support emergency department redesign, interdisciplinary staffing, improved infrastructure, and better transitions of care for patients who are older adults or experiencing psychiatric emergencies. These populations are particularly vulnerable to extended emergency department stays and would benefit greatly from tailored care models and improved coordination between emergency and post-acute care settings.

*Addressing Root Causes: Improving Health Care Infrastructure to Reduce Avoidable ED Visits*

Measurement and Public Reporting Efforts

Measurement is a potential tool to assist with improving the complex boarding problem. CMS is in the process of updating and improving how it measures boarding in the Hospital Outpatient Quality Reporting Program (HOQPR). In 2024, CMS removed the Admit Decision Time to ED Departure Time for Admitted Patients measure from the HOQPR because it was in the process of developing an improved measure. The Admit measure was also penalizing EDs and physicians for factors outside of their direct control. However, CMS has maintained the Left Without Being Seen (LWBS) Measure in HOPQR, which relates to boarding and crowding. Research indicates that boarding reduces the throughput of non-boarded patients, thereby directly affecting LWBS rates.

To improve how CMS is addressing boarding in the HOPQR, CMS has contracted with the Yale Center for Outcomes Research and Evaluation (Yale CORE) to develop an Equity of Emergency Care Capacity and Quality (ECCQ) measure. CMS placed the measure on the 2024-2025 measure under consideration list. It was reviewed by the Pre-Rulemaking Measure Review Hospital Committee during the 2024-2025 cycle for the Hospital Outpatient Quality Reporting (OQR) Program and Rural Emergency Hospital (REH) Quality Reporting Program. The AMA submitted detailed feedback on the measure and "recommend with conditions" for the Outpatient Quality Reporting program. In its feedback, the AMA acknowledged appreciation for developing a measure to address boarding and underscored that such a measure will hopefully facilitate hospital efforts to improve care within the ED setting, while recommending several important revisions before the measure would be implemented in any CMS programs. The AMA did not recommend the measure for the REH Quality Program because REHs cannot have inpatient beds except those furnished through a skilled nursing facility. Consensus was ultimately not reached by the Review Committee as to whether to recommend the measure for CMS' OQR or REH Quality Programs. CMS put forward the measure for endorsement review in the Fall 2024 cycle. In February 2025, the consensus-based entity endorsed the measure for the OQR Program with conditions including exploring unintended consequences to patients and providers, including burden and engaging with stakeholders to address challenges. In the 2026 OPPS Proposed Rule released in July 2025, CMS proposed adoption of the measure in the OQR Program beginning with voluntary reporting for the 2027 reporting period followed by mandatory reporting beginning with the 2028 reporting period/2030 payment period and to adopt the measure for the REH Program beginning with the 2027 reporting period/2029 payment period. The AMA is currently reviewing the rule and intends to submit comments on the proposed measure by the September comment deadline. All AMA advocacy letters can be accessed through our correspondence finder.

Curbing Increased ED Utilization for Individuals with a Mental Illness or Substance Use Disorder

ED utilization for individuals with a mental illness or substance use disorder (SUD) continues to increase for both adults and children, exacerbated by a lack of inpatient and outpatient beds due in part to closure of inpatient psychiatric facilities around the country due a decades-long trend towards deinstitutionalization.[4] People, particularly those who are uninsured or under-insured, are often unable to connect to a full continuum of care, including a lack of ambulatory care options, limited crisis intervention services, and a scarcity of community programs to help maintain stability and avert declines and relapses, and are thus driven to use the ED as a last resort. This rise in mental health and SUD-related admissions has become a major contributor to the ED boarding problem. Upstream contributors to this crisis include network insufficiency, payer barriers, and structural barriers such as Medicaid's Institution for Mental Diseases exclusion. With respect to network insufficiency and payer barriers, the AMA has strongly urged regulators to enforce mental health and substance use disorder parity laws. At the state level, the AMA supported multiple new laws in 2025 and joined The Kennedy Forum and Third Horizon to launch an interactive tool visualizing commercial insurer data to evaluate parity between mental health and SUD care compared to physical health. The Mental Health Parity Index is being piloted in Illinois with a planned expansion nationwide. It will help uncover parity violations for inpatient and outpatient care—violations that, if rectified, could help reduce patient boarding. The AMA also continues to urge the Administration to enforce parity under the Mental Health Parity and Addiction Equity Act. Recently, the AMA reiterated its ongoing support for increased access to and destigmatization of medications for treating opioid use disorder and how telehealth and mobile medical units can help increase access to treatment, which could mitigate the influx of SUD-related ED visits. The AMA also discusses the need for further study into effective drug overdose prevention strategies particularly for youths in hopes of curbing the steady rise in SUD-related admissions in recent years. The AMA also notes the importance of ensuring that lifesaving SUD medications are stocked by pharmacies and not unnecessarily restricted by dosage limits or PA policies for those who need it.

Increasing Social Supports

Social admissions are another common contributor to ED crowding and boarding because once patients are admitted, they may have no place else to go, taking up hospital beds for weeks, even months. Further, insurance will not likely cover the entirety of such a hospital stay, contributing to financial and resource constraints for hospitals and patients. The AMA has been a vocal advocate of providing additional resources to help close these gaps, including advocating for funding for community-based resources. In comments in response to the 2025 proposed Medicare Physician Fee Schedule, the AMA emphasized that a 2.8 percent cut would impact services for connecting patients with health-related social needs to community-based resources including care coordination services to aid Medicare patients who are transitioning out of the acute care hospital or who have multiple chronic conditions.

Strengthening the Non-ED Care Infrastructure

Hospital EDs serve as a de facto safety net provider of health care services for communities that lack robust access to regular primary and specialty care physicians. As such, strengthening the primary and specialty care infrastructure of local communities to better manage care and avoid unnecessary ED visits is one critical tactic to avoid ED boarding, particularly in rural and underserved areas where boarding issues may be exacerbated. With decreases in Medicare reimbursement and looming cuts to Medicaid reimbursement, patients will be forced into EDs as primary care clinics and specialists close practices or stop accepting these patients. The AMA

strongly advocates for strengthening Medicare physician payment through an inflation-based update and safeguarding Medicaid federal funding to ensure patients' access to care in non-ED settings. The AMA actively supports efforts to improve patient access to primary and specialty care and improve coordination, thereby alleviating pressure on the ED safety net through several relevant ongoing advocacy initiatives to expand the number of graduate medical education positions, ensure continued visas for foreign born physicians, strengthen the Conrad 30 Waiver Program, authorize loans for specialty physicians in rural areas, and promote the Patients for Accountable Specialty Care Model which would facilitate care coordination between specialists and primary care physicians participating in Accountable Care Organizations (ACOs). Lack of available beds in inpatient rehabilitation facilities and skilled nursing facilities (SNFs) to transfer hospital ED patients is another contributor to hospital boarding. Increasing their supply, particularly in rural and underserved areas, and removal of PA impediments to transferring inpatients to these facilities, could help to alleviate boarding. The AMA supports flexibilities that would help to promote the survival of these key institutions and improve ED throughput, including counting outpatient stays towards the SNF three-day requirements and SNF three-day waivers for ACOs. The AMA consistently advocates for strengthening the rural physician workforce; this, in turn, may decrease the need for rural patients to visit the ED.[5] If rural ED patients require transfer to tertiary care facility EDs that are unable to receive them due to boarding and crowding, this contributes to rural ED boarding and these patients can have worsened outcomes.[6]

Ensuring Medicare Flexibility for Telehealth and Remote Care/Supervision

Telehealth has the ability to help smooth demand for medical services and reduce ED boarding. The AMA strongly advocates for continued access to Medicare telehealth services through support of the CONNECT for Health Act, as well as its creation of a set of 16 telehealth codes through the Current Procedural Terminology (CPT®) process that were introduced in 2025. The AMA continues to advocate for Medicare reimbursement for at-home blood pressure (BP), glucose, pulse oximetry, heart-rhythm and other self-measuring tools, which help patients to better manage their conditions and seek medical attention if necessary before it becomes an emergent situation, avoiding unnecessary trips to the ED. The AMA also supports a permanent allowance of remote supervision for care delivered outside the ED. In recent comments, the AMA advocated for Stark Law flexibilities for rural providers as it relates to site of service requirements.

Reducing PA and Other Administration Burdens

PA requirements and other sources of administrative burden contribute to physician stress, lead to delays in care, which can allow conditions to worsen leading to more ED visits, take time away from treating patients, all of which can exacerbate ED boarding issues. Reducing administration burden remains one of the AMA's hallmark advocacy priorities. According to a recent AMA survey, 47 percent of physicians responded that PAs directly contributed to emergencies requiring immediate care/ED visits, and 33 percent reported that delays due to PAs resulted in related hospitalizations. The AMA is committed to mitigating the negative impacts of PA, including ED boarding. An AMA-convened workgroup of 17 state and specialty medical societies, national provider associations and patient representatives developed *Prior Authorization and Utilization Management Reform Principles*. Separately, in 2018 the AMA played a key role in developing a *Consensus Statement on Improving the Prior Authorization Process* along with five other prominent national health care and insurance organizations. The AMA works with patient coalitions and has presented to the National Conference of Insurance Legislators and the National Association of Insurance Commissioners - national policy-making organizations that significantly impact state activity and national conversations – to advance PA reform. The AMA has created model legislation for states to implement, and supported many states' advocacy over the years,

including more than a dozen states in enacting laws in 2025 that reduce care delays and wasted time experienced by patients and physicians due to PA requirements. The AMA also developed a webpage called FixPriorAuth.org to collect patient testimonials, allow patients and physicians to sign a petition to fix PA, and provide a social media toolkit to support PA reform efforts. The AMA was instrumental in the finalization of CMS regulations making important reforms to PA to cut patient care delays and electronically streamline the process for physicians. PA reform is a priority for Mehmet Oz, MD, the CMS Administrator. The AMA has offered its expertise and will continue to look for opportunities to work with the administration to advance the issue. The regulatory changes to PA mirrored many of the key provisions within the Improving Seniors' Timely Access to Care Act (H.R. 3514/S. 1816). This bipartisan, bicameral piece of legislation, which was a direct result of the PA Consensus Statement, has been introduced in multiple Congresses. As the long-term stability of the regulation remains unclear, passage of this Act remains a crucial advocacy goal for the AMA. To date, the legislation has secured more than 150 bipartisan House and 50 bipartisan Senate cosponsors. The AMA also recently expressed concerns to CMS regarding its proposed Wasteful and Inappropriate Service Reduction (WISeR) model, including that it risks patient harms and care disruptions, will exacerbate administrative burdens, and serves as a precedent for expanded mandatory PA requirements in traditional Medicare. In addition, the AMA testified before an advisory council tasked with recommending to the Department of Labor (DOL) possible regulatory changes to improve how employer-sponsored health plans regulated under the Employee Retirement Income Security Act of 1974 (ERISA) use PA requirements to manage their claims and appeals procedures. The AMA urged the advisory council to recommend changes to DOL's rules to reduce the burden and harm these programs have on physicians and patients. The advisory council's report aligned with many of the AMA's recommendations.

Increasing the Efficiency of Staff and Practice Workflows

The AMA continues to be a vocal proponent of the importance of a physician-led care team as an important component to ensure maximized efficiency of managing staff workflows in ED settings to mitigate boarding issues. As part of the AMA's ongoing efforts in this area, the AMA developed a playbook entitled, "Saving Time: Stop Unnecessary Work, Share Necessary Tasks With the Broader Team, and Gain Leadership Support," which covers a number of topics including more effectively leveraging technology such as clinical decision support tools and practice management software to improve practice efficiency, which in the ED setting can be used to speed and improve triage protocols, which can help to reduce wait times and ED boarding. The AMA is also hosting a Practice Innovation Boot Camp in September 2025 designed to equip attendees with time saving tools and strategies to reform their organizations and improve professional satisfaction amongst staff. Physician oversight of EDs can contribute to reduced wait times because physician involvement in the triage and care process can lead to more efficient patient flow and faster treatment. When physicians are involved early in the process, they can make informed decisions about which tests, treatments, and consults are needed, potentially shortening the overall time to diagnosis and treatment. A clear chain of command can also reduce the complexity of communication in the ED, involving multiple interactions between nurses, physicians, and other clinicians, a critical factor for efficient ED operations.

ADDRESSING ROOT CAUSES: ALIGNING PAYMENT AND INCENTIVE POLICIES TO MITIGATE ED BOARDING

*Extending the Acute Care Hospital at Home Program*

The Acute Care Hospital at Home (HaH) Program waiver was created during the COVID-19 Public Health Emergency to help alleviate hospital capacity issues by allowing hospitals to provide acute care services in patients' homes. More than 300 hospitals across 129 health systems in 37 states now operate under the waiver[7] representing approximately five percent of U.S. hospitals and 15 percent of academic medical centers. Numerous studies have found that patients and family caregivers prefer HaH, which delivers excellent clinical outcomes, decreased mortality rates, better patient and family experience, lower caregiver stress, high provider satisfaction, and lower costs of care.[8] The HaH Initiative has been extended by Congress several times, most recently until September 30, 2025. The AMA supports making the HaH program permanent and has continued to advocate for Congress to extend HaH. Of note, on July 10, bipartisan, bicameral legislation (H.R. 4313/S. 2237, the Hospital Inpatient Services Modernization Act) was introduced to extend the HaH waiver through 2030 and conduct a study regarding its effectiveness.

*Protecting Access to Affordable Coverage Options and Ensuring Adequacy of Medicaid Funding*

Uninsured and under-insured patients are more likely to lack access to scheduled care and have difficulty affording care, particularly emergency care, which can contribute to hospital and physician uncompensated care costs. Furthermore, Medicaid often reimburses hospitals and physicians at lower rates than private insurance or Medicare. Therefore, hospitals and physicians that treat a high number of Medicaid, uninsured, and/or underinsured patients can disproportionately experience financial pressures and resource shortages, which impact their ability to hire and retain staff and maintain or expand inpatient beds, leading to boarding issues. In the buildup to the passage of the "One Big Beautiful Bill Act" (OBBBA), the AMA pushed back against Medicaid and ACA reforms that would hinder access to care, decrease coverage affordability, and lower federal Medicaid funding to states. The expiring premium tax credits along with changes made in the OBBBA could result in millions of additional uninsured patients, further exacerbating the boarding issue. The AMA also urged the Trump administration to reconsider a similar proposal to restrict certain types of Medicaid provider taxes, which states rely on to fund their Medicaid programs and separately asked HHS to reconsider several provisions expected to reduce the affordability and availability of ACA coverage.

*Strengthening Medicare Reimbursement*

The AMA routinely advocates for strengthening Medicare physician payment through an inflation-based update and has repeatedly opposed mandatory Medicare payment models that essentially equate to Medicare reimbursement cuts through mechanisms such as "target pricing." In our advocacy on the issue, we point out that models that transfer financial risk to physicians and prioritize short-term financial savings above all else are shortsighted and will not improve patient care or generate sustainable financial savings long-term and will disproportionately impact rural and safety net hospitals. The AMA recently reiterated its opposition to the Transforming Episode Accountability Model (TEAM) model, a mandatory model that would force participating hospitals to accept a discounted rate of 1.5 to 2 percent for certain clinical episodes citing concerns that TEAM would lead to hospital closures and called for more exceptions and protections for low-volume, rural, and safety net hospitals.

*Addressing No Surprises Act Implementation and Prompt Pay Issues*

The AMA continues to be vocal on the need to enforce No Surprises Act statutory timelines requiring that payment for disputed claims be made to the prevailing party within 30 days of the decision. This is critical for hospitals and physicians to avoid cash flow issues that can lead to under-resourcing and understaffing, both of which contribute to boarding issues. The AMA recently sent a letter in support of the No Surprises Enforcement Act which features increased penalties for parties that fail to comply with such statutory timelines.

ADDRESSING ROOT CAUSES: SUPPORTING PHYSICIANS FACING THE NEGATIVE OUTCOMES OF BOARDING

ED boarding puts increased pressure on physicians and other clinical staff, which can quickly degrade their mental health and contribute to feelings of burnout. Burnout contributes to workforce shortages with physicians retiring early from clinical practice. Reducing physician burnout is a critical component of the AMA's focus on *Fighting for Physicians*. The AMA is working to address the drivers of burnout, with advocacy to reform Medicare physician payment, protect Medicaid, reduce administrative burdens, promote physician-led care, and make technology work for physicians. Providing physicians access to mental health resources to deal with the resulting stress of boarding is critical. Through collaborative efforts with partners, the AMA helped to achieve a record number of licensure boards and hospitals updating their applications to support physician wellness. There are now 34 medical licensure boards and 521+ hospitals that have verified their licensing or credentialing applications are free from intrusive mental health questions and stigmatizing language. The AMA advocated for and supported new laws and policies in over a dozen states that protect physicians who seek care for wellness and burnout; and continues to work to advance the Dr. Lorna Breen Health Care Provider Protection Reauthorization Act, which supports the mental health and resiliency of health care workers. As part of its ongoing efforts to combat physician burnout, the AMA recently coauthored a study with the Mayo Clinic entitled, "*Changes in Burnout and Satisfaction with Work–Life Integration in Physicians and the General US Working Population.*" The AMA also developed the *AMA Organizational Biopsy*® a tool that helps organizations holistically measure and take action to improve the well-being of their physicians and other health professionals.

ED boarding increases stress on patients and physicians alike and has been shown to contribute to increased incidents of violence against physicians and other hospital staff.[9] Along with an increase in ED boarding, violence against physicians has risen in recent years. According to a January 2024 poll of ACEP members, 91 percent of emergency physicians said that they, or a colleague, were a victim of violence in the past year. In a 2022 ACEP survey, 85 percent of emergency physicians said they believe the rate of violence experienced in EDs has increased over the past five years. The AMA supports a multi-pronged "all hands on deck" strategy to mitigate violence against physicians, including continued research and making investments in enhanced security for hospital staff. The AMA also hosted an AMA Update podcast with Ramin Davidoff, MD, co-CEO, the Permanente Federation, in which he linked threats of violence against clinical staff to increased stress, which impacts their ability to provide high-quality care to their patients, and contributes to clinical staff leaving the profession, which can further exacerbate staffing shortages, a contributor to ED boarding. To aid states in advocacy to address workplace violence, the AMA Advocacy Resource Center (ARC) has developed a "State Legislative Template: Protecting Physicians from Workplace Violence" with a companion "Chart: State Legislative Template: Protecting Physicians from Workplace Violence." This is in addition to an "ARC Issue Brief: Campaign to support medical student, resident and physician health and wellbeing." In accordance with D-405.975 *Due Process and Independent Contractors* the AMA has developed a "State Legislative Template:

Protecting Physicians from Retaliation" in order to protect physicians who report safety concerns, among other potential instances of retaliation.

## CONCLUSION

Mitigating ED boarding will require a combination of solutions at the federal, state, and local levels. The AMA will continue to support regulatory and legislative changes and promising innovative models/solutions at the federal and state levels that address the root causes and consequences of boarding. In addition, the AMA will continue to collaborate with ACEP and other stakeholders to further identify and advance solutions to ED boarding, including supporting ongoing efforts by AHRQ to convene stakeholders to identify an ED boarding standard and high-impact policy and practice levers that could be used to reduce ED boarding, decrease hospital crowding, and enhance system-wide throughput.

## RECOMMENDATION

The Board of Trustees recommends that Policy D-130.957 be amended by deletion of the sixth clause since it has been accomplished by this report and the remainder of the report be filed:

Fiscal Note: Less than $500.

## REFERENCES

[1] Moore, C., & Heckmann, R. (2025, March 12). Hospital boarding in the ED: Federal, state, and other approaches. Health Affairs Forefront. https://doi.org/10.1377/forefront.20250310.355985.
[2] Weinick, R. M., Bruna, S., Boicourt, R. M., Michael, S. S., & Sessums, L. L. (2025, January). AHRQ summit to address emergency department boarding: Technical report. Agency for Healthcare Research and Quality. https://www.ahrq.gov/sites/default/files/wysiwyg/topics/ed-boarding-summit-report.pdf.
[3] "Emergency Department Crowding: High Impact Solutions." Emergency Medicine Practice Committee. American College of Emergency Physicians. May 2016.
[4] Raphelson, Samantha. "How The Loss Of U.S. Psychiatric Hospitals Led To A Mental Health Crisis." National Public Radio. November 30, 2017. https://www.npr.org/2017/11/30/567477160/how-the-loss-of-u-s-psychiatric-hospitals-led-to-a-mental-health-crisis.
[5] Greenwood-Ericksen MB, Kocher K. Trends in Emergency Department Use by Rural and Urban Populations in the United States. JAMA Netw Open. 2019;2(4):e191919. doi:10.1001/jamanetworkopen.2019.1919. https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2730472
[6] Mohr NM, Wu C, Ward MJ, McNaughton CD, Faine B, Pomeranz K, Richardson K, Kaboli PJ. Transfer boarding delays care more in low-volume rural emergency departments: A cohort study. J Rural Health. 2022 Jan;38(1):282-292. doi: 10.1111/jrh.12559. Epub 2021 Feb 28. PMID: 33644911; PMCID: PMC8715860. https://pmc.ncbi.nlm.nih.gov/articles/PMC8715860/#:~:text=Transfer%20boarding%20delays%20care%20more,departments:%20A%20cohort%20study%20%2D%20PMC.
[7] "Approved Facilities/Systems for Acute Hospital Care at Home." CMS QualityNet. January 26, 2024. https://qualitynet.cms.gov/acute-hospital-care-at-home/resources.
[8] Federman, Alex D., Tacara Soones, Linda V. DeCherrie, Bruce Leff, and Albert L. Siu. "Association of a bundled hospital-at-home and 30-day post-acute transitional care program with clinical outcomes and patient experiences." JAMA Internal Medicine (2018).
[9] See Moore supra at 1.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 06-I-25

Subject: Information Blocking Rule

Presented by: David H. Aizuss, MD, Chair

Referred to: Reference Committee B

---

At the 2024 Interim Meeting of the American Medical Association (AMA), the House of Delegates (HOD) referred Resolution 226-I-24, "Information Blocking Rule." Resolution 226-I-24 included four Resolves, urging the AMA to take the following actions:

1. Support the use of short-term embargo of reports or results and individual tailoring of preferences for release of information as part of the harm exception to the Information Blocking Rule (New HOD Policy);
2. Supports the requirement of review of report and result information by the ordering physician or physician surrogate prior to release of medical information to the patient (New HOD Policy);
3. Support expansion of the harm exception to the Information Blocking Rule to include harassment or potential harm of medical staff or others (New HOD Policy);
4. Advocate for expansions to the harm exception to the Information Blocking Rule and for the requirement of review by the ordering physician or surrogate prior to the application of the Information Blocking Rule provisions. (Directive to Take Action).

There was mixed testimony on Resolution 226-I-24. Testimony indicated that any limits on patients' access to their medical records must be undertaken only at the request of the patient to avoid violation of the HIPAA patient right of access and the Information Blocking Rules. However, testimony also noted that requiring physician review of every result would unnecessarily increase physician burden. Testimony emphasized the need to differentiate between delays of normal results versus abnormal results with serious implications. Some testimony opposed the delay of results only when directed by a patient.

BACKGROUND

The Information Blocking Rule, part of the 21st Century Cures Act, mandates that patients receive immediate access to their electronic health information (EHI), including clinical notes, imaging, and lab results. While this improves transparency, it has led to some patients receiving distressing news without a physician providing context. Prior to the Cures Act, some data (e.g., radiology reports) had embargoes allowing physician review. These embargoes were lifted, drastically reducing the time patients wait for results—from 45 hours to just 5.5 hours post-finalization. Exceptions to the information blocking rule include the "Preventing Harm Exception," which allows delays if releasing EHI would cause physical harm. AMA policy (D-315.972) advocates for expanding this to include emotional and psychological harm.

© 2025 American Medical Association. All rights reserved.

DISCUSSION

The Information Blocking Rule, while designed to improve transparency and empower patients, has introduced new complexities in clinical practice. Specifically, the automatic and immediate release of sensitive test results before the treating physician has reviewed them can result in patient distress, confusion, and a potential erosion of the patient-physician relationship. Resolution 226-I-24 proposed several changes to address these concerns, including support for a short-term embargo of results, mandatory physician review prior to release, and expansion of the harm exception. These proposals must be carefully examined in light of federal regulations, patient rights, and existing AMA policy.

*Short-Term Embargoes and Patient Preferences*

AMA policy (D-315.972,"Redefining the Definition of Harm") supports allowing physicians to withhold sensitive information temporarily when its immediate release would likely cause significant emotional or psychological harm. However, such delays must be consistent with federal rules and typically require justification under the "Preventing Harm Exception." In an AMA survey of 1,000 patients, while nearly 43 percent said they want immediate access to their results, of this group more than 50 percent first want a physician to review and contact them in cases of debilitating, life-limiting, or terminal illness. AMA policy does not support embargoes imposed unilaterally by physicians without patient involvement. Additionally, current federal law does not permit patients to customize how they receive their information—such as requesting physician review prior to release—though the Assistant Secretary for Technology Policy ASTP/ONC is considering modifications to support "requestor preference" exceptions in the future.

*Mandatory Physician Review Requirements*

Testimony indicated strong opposition to requiring physician or surrogate review of all test results prior to patient access. While well-intentioned, such a policy would create an undue administrative burden, particularly in the context of routine lab results. A large-scale study published in JAMA Network Open involving 8,139 respondents found that 96 percent of patients wanted their results delivered immediately, even before their physician reviewed them—including in cases involving abnormal findings. The latter study is cited in Office of the National Coordinator for Health Information Technology's blog. Accordingly, the Board does not recommend adoption of the second resolve clause of Resolution 226-I-24.

*Staff Harassment and Safety Concerns*

The third resolve of Resolution 226-I-24 calls for expanding the harm exception to include potential harassment or harm to medical staff. A proposal to expand the harm exception to the Information Blocking Rule to include harassment or potential harm to medical staff or others would be problematic, both legally and from a policy standpoint. The Information Blocking Rule explicitly limits the harm exception to instances where the release of EHI would pose a risk to the life or physical safety of the patient or another natural person. Extending this exception to include generalized concerns about staff harassment stretches the rule beyond its intended purpose and could lead to inconsistent, overly broad interpretations that undermine patient access rights.

In addition, the Information Blocking Rule prohibits imposing fees on patients for accessing their EHI. If a physician withholds results to require a virtual or in-person consultation, this may introduce costs—such as copays—that conflict with the Cures Act's principle of a patient's free access to their own health information.

CONCLUSION

In balancing the goal of minimizing patient distress with the patient's legal right to timely access to medical reports and results, the AMA must advocate for clear, narrowly tailored policies that respect both clinical judgment and patient autonomy. Resolution 226-I-24, in its original form, does not adequately achieve this balance. The Board, therefore, recommends alternative language that better aligns with AMA policy and legal constraints.

RECOMMENDATIONS

The Board of Trustees recommends that the following be adopted in lieu of Resolution 226-I-24 and the remainder of the report be filed:

1. Our American Medical Association supports the use of patient-directed, short-term embargoes for results that indicate debilitating, life-limiting, or terminal illnesses, and supports individual tailoring of preferences for release of such information, consistent with the harm exception to the Information Blocking Rule. (New HOD Policy)
2. Our AMA supports the ability of patients to request physician or surrogate review of potentially life-altering report and result information prior to its release, when consistent with the harm exception to the Information Blocking Rule. (New HOD Policy)
3. Our AMA reaffirms Policy D-315.972, supporting expansion of the harm exception to the Information Blocking Rule to include emotional and psychological harm and urge relevant government agencies to adopt enforcement discretion that would afford medical practices additional compliance flexibilities. (Reaffirm HOD Policy)

Fiscal Note: Less than $500.

RELEVANT AMA POLICY

**Policy D-315.972, "Redefining the Definition of Harm"**
Our AMA will: (1) advocate to the Office for Civil Rights to revise the definition of harm to include mental and emotional distress. Such a revision would allow additional flexibility for clinicians under the Preventing Harm Exception, based on their professional judgement, to withhold sensitive information they believe could cause physical, mental or emotional harm to the patient; (2) advocate that the Office for Civil Rights assemble a commission of medical professionals to help the office review the definition of harm and provide scientific evidence demonstrating that mental and emotional health is intertwined with physical health; (3) continue to urge the Department of Health and Human Services (HHS)'s Office of the National Coordinator for Health Information Technology (ONC) and its Office of Inspector General (OIG) to leverage their enforcement discretion that would afford medical practices additional compliance flexibilities; and (4) urge the ONC to earnestly consult with relevant stakeholders about unintended or unforeseen consequences that may arise from the information blocking regulations.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 07-I-25

Subject: Codification of the Chevron Deference Doctrine

Presented by: David H. Aizuss, MD, Chair

Referred to: Reference Committee B

---

Resolution 228-I-24, "Codification of the Chevron Deference Doctrine," was introduced by the Medical Student Section and was referred for further study. The resolution called for the following:

> RESOLVED, that our American Medical Association support codification of the Chevron deference doctrine at the federal and state levels, which would:
> a. generally leave reasonable interpretation of ambiguous regulatory statutes to the purview of the executive branch, including agencies comprised of scientific and medical experts evaluating robust evidence and
> b. generally prioritize legislative oversight and modification of ambiguous regulatory statutes and agency rules, instead of deferring to the judicial branch for this function.

Testimony on the resolution was mixed. Supporters emphasized the value of agency expertise in health care, public health, scientific, and technological regulation, warning that the overturning of *Chevron* could weaken protections in these fields. Others raised concerns that codification could limit the AMA's ability to challenge regulations that conflict with its policy priorities. Additional testimony questioned the risk of expanding executive authority and the potential implications for the AMA's broader advocacy strategy.

This report provides background on the *Chevron* doctrine and its reversal, examines implications of codifying a Chevron-like framework, including those raised in testimony, reviews relevant AMA policy, and offers recommendations.

DISCUSSION

*Administrative Law: Agency Rulemaking and the APA*

To better understand the *Chevron* doctrine and the impact of its overturning, it is important to review the function of the Administrative Procedure Act (APA) and administrative law more broadly.

Federal laws are enacted through the legislative process, in which Congress passes a bill and the President signs it into law. Congress often delegates rulemaking authority to federal agencies to implement and enforce those laws. Regulations issued pursuant to this authority are developed through a process governed by the APA and, once final, carry the force and effect of law. Even after a regulation becomes final, it generally remains subject to judicial review, under standards also established by the APA. A party may challenge a regulation on the grounds that the agency exceeded its statutory authority—that is, the regulation rests on an interpretation of the statute that is beyond the scope granted to the agency. In resolving such challenges, courts must interpret the

© 2025 American Medical Association. All rights reserved.

relevant statute and determine whether the agency's regulation is consistent with its text and purpose. For decades, this type of judicial review was guided by the *Chevron* deference doctrine.

*The Chevron Deference Doctrine*

The Chevron deference doctrine emerged from the United States Supreme Court's 1984 decision in *Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc*., which established a two-step framework for reviewing an agency's interpretation of a statute it administers.[1] At the first step, courts were to determine whether Congress had "directly spoken to the precise question at issue."[2] If the statute clearly addressed the issue, the court's review ended there, and Congress's directive would control.[3] But if the statute was silent or ambiguous, courts proceeded to the second step, which asked whether the agency's interpretation was "permissible," which is to say, reasonable.[4] If permissible, the court would defer to the agency's interpretation, even if it might have reached a different conclusion on its own.[5]

*Chevron* frequently guided judicial review in areas involving scientific or technical subject matter, including health care. For example, in *Gentiva Health Services, Inc. v. Becerra*, the U.S. Court of Appeals for the D.C. Circuit upheld the Centers for Medicare & Medicaid Services' (CMS) methodology for calculating Medicare reimbursements for hospice care during a budget sequestration imposed by the Budget Control Act of 2011.[6] The court found ambiguity in the Medicare statute's provision regarding the hospice aggregate cap, and, under *Chevron*, deferred to CMS' interpretation as a reasonable reading of the statute. The resulting rule, which was based on that interpretation and accounted for sequestration-related reductions when determining reimbursement, prevailed.

Ultimately, *Chevron* rested on the premise that agencies have subject-matter expertise regarding the statutes they administer, and on the presumption that when Congress left ambiguity in a statute intended for agency implementation, it expected the agency to exercise discretion in resolving that ambiguity.

*The Overturning of Chevron*

On June 28, 2024, the U.S. Supreme Court overturned the *Chevron* deference doctrine in *Loper Bright Enterprises v. Raimondo* and *Relentless, Inc. v. Dept. of Commerce*.[7] The Court held that the APA requires courts to exercise independent judgment in determining whether an agency exceeded its statutory authority.[8] The *Chevron* framework, the Court concluded, conflicted with that requirement by requiring judges to forego their independent judgment and defer to reasonable agency interpretations of ambiguous statutes.[9] The Court also rejected Chevron's core presumption that Congress intends for agencies to fill statutory gaps, reasoning that ambiguity may result for many reasons unrelated to delegation of interpretative authority.[10]

Despite overturning *Chevron*, the Supreme Court acknowledged that agency deference may still be appropriate in certain circumstances.[11] When Congress explicitly authorizes an agency to exercise discretion, courts must honor that delegation of authority.[12] The Court also noted that the best reading of a statute "may well be that the agency is authorized to exercise a degree of discretion."[13] In such cases, a reviewing court's role under the APA remains to interpret the statute independently and effectuate the will of Congress, subject to constitutional limits.[14] The Court further recognized that agency interpretations may still warrant respect or be considered persuasive. Courts may give weight to an agency's interpretation where its expertise is helpful, and particularly when the interpretation has remained consistent over time. Still, the Court emphasized that it is the judiciary

that must have the final say on what the law means, thus significantly reducing the level of deference afforded to federal agencies.

*Opportunities to Codify the Chevron Framework*

The *Loper Bright* decision does not prevent Congress from explicitly delegating interpretive discretion to the agencies. As the Supreme Court acknowledged, courts must give effect to statutory text, and Congress may delegate interpretive authority to agencies through an amendment to the APA, through targeted provisions in individual statutes, or through standalone legislation. In other words, while Chevron's presumption of implicit delegation was rejected, Congress retains the power to make such delegation explicit, consistent with constitutional principles and the APA. Although the Resolution asks the AMA to support codification of the *Chevron* doctrine at the state level, this is constitutionally impractical as doing so conflicts with the Supremacy Clause and separation of powers doctrine.

While bills aimed at codifying Chevron-like deference have been introduced in Congress, there has been no substantive effort from either party to advance such legislation. Between 2021 and 2023, Representative Pramila Jayapal (D-WA) introduced the "Stop Corporate Capture Act" in three consecutive sessions (H.R. 6107 – 117th Congress; H.R. 9390 – 117th Congress; and H.R. 1507 – 118th Congress), each proposing to provide statutory authority for (i.e., codify) *Chevron* deference. Although these bills predated *Loper Bright*, they were introduced amid growing judicial skepticism toward the doctrine. More recently, in 2024, Senator Elizabeth Warren (D-MA) introduced S. 4749 – 118th Congress, building on Representative Jayapal's efforts and citing the urgency of restoring the *Chevron* framework following the Court's decision. Like the earlier proposals, this bill was referred to committee but did not advance.

BENEFITS

*Preserving the Role of Subject-Matter Expertise in Regulation*

As noted, the *Chevron* doctrine rested on the premise that federal agencies are subject-matter experts regarding the statutes they administer and are therefore well positioned to resolve statutory gaps and ambiguities. Codifying a Chevron-like framework could preserve the role of agency expertise, which is often necessary for effective statutory implementation. Not only can agency expertise guide interpretation in technical contexts, but agencies are typically better equipped to respond to evolving evidence and public input as the rulemaking process allows for greater fluidity.

In contrast, courts are typically generalists whose decisions are guided by principles of legal interpretation, which may or may not give weight to an agency's view. While *Loper Bright* left room for courts to consider agency interpretations, it does not require them to do so unless specifically required by statute. Preserving a framework that allows agencies to reasonably interpret ambiguous statutes may support informed, evidence-based regulatory outcomes.

*Democratic Accountability*

Delegating interpretive authority to administrative agencies may help preserve democratic accountability in the policymaking process. Agency leaders are appointed by the President, confirmed by the Senate, and subject to ongoing congressional oversight. As a result, their decisions are shaped, at least in part, by electoral outcomes and evolving policy priorities. In contrast, federal judges hold life tenure and are insulated from political shifts by design. If Congress codified a Chevron-like framework that delegates broad interpretive authority to agencies

rather than courts, it may support statutory implementation that reflects public needs and goals of the elected legislative and executive leadership.

CONSIDERATIONS

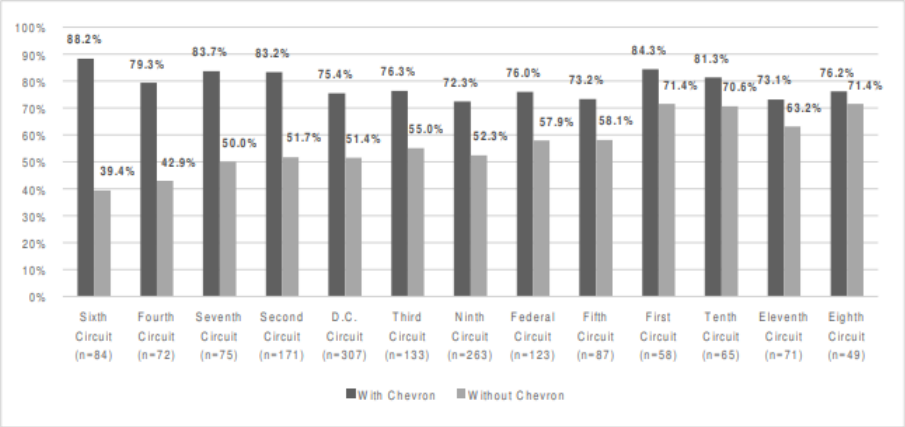
*Risks of Executive Discretion*

While executive agencies often bring subject-matter expertise to their interpretations and rulemaking, their actions are ultimately shaped by the priorities of the executive branch. In periods of political polarization or concentrated executive control, agency decision-making may diverge from established clinical or scientific standards. Codifying a Chevron-like framework that insulates agency interpretations from independent judicial review could reduce opportunities to challenge such decision-making. For the AMA, whose policies rely heavily on regulatory integrity across areas such as drug approvals, public health initiatives, and physician payment models, this concern is more than theoretical. Entrenching broad interpretive authority in the executive branch may limit the AMA's ability to contest policies that conflict with its mission and long-term advocacy goals.

*Preserving Opportunities for Legal Advocacy*

In some contexts, the narrowing of judicial deference may strengthen the AMA's ability to challenge regulations that adversely affect physicians or patient care. The AMA has previously turned to legal advocacy in response to agency rules it found harmful or overreaching and remains prepared to do so when necessary. Recently, following the *Loper Bright* decision, the AMA submitted amicus briefs in support of the Texas Medical Association's (TMA) lawsuit challenging a Department of Health and Human Services (HHS) rule implementing the No Surprises Act. The reviewing court invalidated the rule, finding that it exceeded the authority granted by Congress and impermissibly favored health plans over physicians, hospitals, and other providers.

FIGURE 9. CIRCUIT-BY-CIRCUIT COMPARISON OF WIN RATES WITH AND WITHOUT *CHEVRON* FRAMEWORK (n=1558)




An empirical study reviewed by the Congressional Research Service (CRS) determined that, in the Fifth Circuit, where TMA filed suit, agencies were 15.1 percent more likely to prevail when *Chevron* deference was applied. This difference may have significantly impacted TMA's ability to successfully challenge the statutory interpretation of the No Surprises Act. Thus, a post-Chevron framework, such as the one applied in that case, may strengthen the AMA's ability to pursue legal advocacy as a means of protecting patients and physicians when agencies exceed their statutory authority.

The CRS-reviewed study also suggests that the application of *Chevron* varied widely across circuits, areas, and subject areas. In some circuits, courts frequently reached similar outcomes regardless of whether the doctrine was applied. In other circuits, the application of *Chevron* so drastically increased an agency's ability to prevail that it would hinder, if not outright prevent, the AMA from being able to successfully challenge harmful statutory interpretations. Further, prior to its ruling in *Loper Bright* in mid-2024, the Supreme Court had not applied the *Chevron* doctrine since 2016.[15] Thus, while *Chevron* established a highly cited framework for judicial review, its actual impact on case outcomes may not have been as consistent as is widely assumed. Accordingly, codifying Chevron could introduce greater unpredictability into AMA's legal strategy.

*Regulatory Changes Across Administrations*

Agency interpretation is inherently fluid. Unlike courts, which operate with institutional continuity and are generally guided by precedent, agencies may repeal or modify statutory interpretation with each change in administration. Codifying a framework that presumes or requires judicial deference to permissible agency interpretations could increase the variability of regulatory policy, particularly in contentious areas of health care. This may hinder AMA's long-term advocacy, especially when seeking durable reform.

## AMA POLICY

AMA policy reflects strong support for agencies' authority to promulgate rules as vehicles for evidence-based regulation, alongside a clear recognition that agency action is not infallible. The AMA has supported federal agencies when they ground policies in "objective scientific data,"[16] shield decision-making from "political considerations or conflicts of interest [that] overrule scientific evidence,"[17] and revise regulations only when "sufficient scientific evidence supports such changes."[18]

At the same time, AMA policy recognizes that agency rulemaking has not always aligned with congressional intent or served the best interest of patients and physicians. The AMA has raised concerns and opposed agency rules, including an Environmental Protection Agency proposal that would have permitted the sale of diesel engines not compliant with emissions standards;[19] HHS regulations prescribing impractical conditions of participation for small, rural hospitals;[20] and a CMS effort to lower surgical fees through third-party redefinition of global surgical periods.[21] Consistently, AMA policy reflects a commitment to regulatory integrity, accountability, and responsiveness to the needs of physicians and the patients they serve.

## CONCLUSION

AMA policy does not support judicial deference to agency decisions as a categorical principle. Rather, it favors frameworks that preserve the role of agency expertise while maintaining safeguards to ensure federal rules are consistent with congressional intent and grounded in sound clinical judgment. The APA already provides such a framework by requiring courts to exercise independent judgment in statutory interpretation, while still leaving room for consideration of agency expertise where appropriate. Given these considerations, the Board recommends that our AMA continue its advocacy with Congress toward statutory clarity rather than advocating for deference to agencies. Additionally, our AMA has strong policy directing us to support the development of clear rules by regulatory bodies with evidence-based input from advisory groups. Therefore, your board recommends that resolution 228-I-24 not be adopted and the remainder of the report be filed.

RECOMMENDATION

The Board of Trustees recommends that resolution 228-I-24 not be adopted and that the remainder of the report be filed.

Fiscal Note: Less than $500.

REFERENCES

[1] *Chevron U.S.A., Inc. v. NRDC,* 467 U.S. 837 (1984).
[2] *Id.*
[3] *Id.*
[4] *Id.*
[5] *Id.*
[6] *Gentiva Health Servs., Inc. v. Becerra*, 31 F.4th 766 (D.C. Cir. 2022).
[7] *Loper Bright Enters. v. Raimondo*, 603 U.S. 369 (2024).
[8] *Id.*
[9] *Id.*
[10] *Id.* at 399.
[11] *Id.* at 371.
[12] *Id.* at 394.
[13] *Id.*
[14] *Id.* at 404.
[15] *Loper Bright*, 603 U.S. at 406.
[16] Policy H-480.959, "Reprocessing of Single-Use Medical Devices."
[17] Policy H-100.992, "FDA."
[18] Policy D-50.998, "Blood Donor Recruitment."
[19] Policy D-135.996, "Reducing Sources of Diesel Exhaust."
[20] Policy H-465.999, "Certification of Rural Hospitals for Medicare."
[21] Policy H-70.948, "Exclusion of Preoperative Services from Surgical Global Fee."

REPORT OF THE BOARD OF TRUSTEES

B of T Report 12-I-25

Subject: Support For Doula Care Programs

Presented by: David H. Aizuss, MD, Chair

Referred to: Reference Committee B

---

At the 2024 Interim Meeting of the American Medical Association (AMA) House of Delegates (HOD), Resolution 908 entitled, "Support for Doula Care Programs," was introduced by the Medical Student Section and called on the AMA to:

> Support access to continuous one-to-one emotional support provided by nonmedical support personnel, such as doulas, including for patients who are incarcerated or detained.

Resolution 908-I-24 was referred to the Board of Trustees because testimony noted concerns surrounding doulas' scope of practice and highlighted a need for additional information concerning doulas' level of training and credentialing. There were also several calls for referral for study of this item to better detail the role of the doula within physician-led, team-based maternity care.

BACKGROUND

*Doulas*

Doulas are trained individuals that provide "non-clinical physical, emotional, and informational support during the perinatal period. Doula work has also expanded to include the full spectrum of pregnancy outcomes (e.g., birth, abortion, adoption, miscarriage, stillbirth, and perinatal loss), as well as services to women, men, transgender, and gender non-conforming people."[1]

Doulas are meant to perform tasks such as providing emotional support for the birthing individual and their family, helping individuals and families navigate the health care system, assisting with referrals to community-based social services, aiding in creating an individual's birth plan, and performing additional non-clinical tasks throughout the pregnancy, birth, and up to one year postpartum.[2] Most states that cover doula services in some capacity ensure that in the state's definition of a certified doula they emphasize that these individuals provide only non-clinical support.

Studies have shown that, when doulas provide appropriate non-clinical care, there can be improved outcomes for both the mother and the infant. For example, individuals that utilized a doula were four times less likely to deliver a baby with a low birth weight, two times less likely to experience a birth complication, more likely to breastfeed, and more likely to report a positive birth experience.[3] Additionally, a study found that women enrolled in Medicaid had a 47 percent lower risk of having a Cesarean section, were 46 percent more likely to attend a postpartum checkup, and had a 29 percent lower risk of preterm birth when utilizing non-clinical doula support.[4]

© 2025 American Medical Association. All rights reserved.

*Medicaid*

Medicaid is jointly funded through the states and the federal government with the federal government providing 69 percent of the approximately $880 billion that were spent on Medicaid in FY 2023.[5] States have a significant amount of control over how Medicaid is administered in their state including which benefits will be covered, which services are provided (such as dental care, prescription drugs, vision and more), and how much providers are paid.[6] These terms are defined either through statute or through state plans which set the scope of the Medicaid plans for each state and specify the terms for receiving matching funds from the federal government.[7] Changes and expansions to how and what states cover in their Medicaid programs can be made through State Plan Amendments (SPAs).

In 2021, Medicaid paid for about 41 percent of all births nationally and plays a critical role in providing maternity-related services.[8] In alignment with this, a growing number of states have submitted SPAs to allow for the coverage of doula care through Medicaid in some capacity.[9]

Medicaid can cover doula services under "multiple benefit categories, including preventive services, [or] services of licensed practitioners, clinic services, and freestanding birth center services."[10] Additionally, states can cover doula services through different state plan benefits. For example, "while there is no distinct Medicaid state plan benefit called home visiting, states may cover many of the individual component services of home visiting programs through existing Medicaid coverage authorities" thus allowing Medicaid payment for at home doula services.[11]

If doula services are categorized as preventive services, doulas would need to be recommended by a physician or other licensed practitioner in order to bill Medicaid. However, if care provided by a doula is considered to be part of the services of a licensed practitioner the doula would need to be licensed, or supervised by, and bill under a licensed practitioner.[12] The states that do cover doula services through Medicaid vary in what services they will cover, the number of visits that will be allowed, and the length of time that a doula can remain with a birthing individual.[13]

Many doulas are "solo practitioners and lack the capacity and infrastructure to manage health plan contracting and billing requirements, so many doulas require women to pay for their services out-of-pocket without using insurance."[14] However, when doulas do participate in Medicaid, payment rates for their services vary significantly by state and are often billed based on a combination of HCPCS, ICD-10, and CPT codes.[15,16] Moreover, some states have begun to try and increase the usage of doula services by utilizing "value-based payment arrangements to incentivize the use of innovative maternal health care delivery models and improve health outcomes."[17] However, Medicaid funding for each state has an overall limit and therefore payment for some providers, such as doulas, could limit payment for other providers, such as obstetricians and gynecologists (OB-GYN).

*Training and Certification*

Currently no mandatory licensure, certification, or credentialing requirements exist for doulas in the United States, but to be paid by Medicaid doulas are required to meet the qualifications put in place by the state in which they are providing services.[18] States vary significantly in what they require for doulas to be covered by Medicaid. (Please see Appendix A). However, in order to be able to receive payment from Medicaid almost all states require some form of certification.

Most states that cover doula services under Medicaid have multiple training pathways that doulas can undertake to gain certification. These pathways are usually divided into training pathways and experience pathways. Experience pathways are based on either preexisting credentials or hands-on experience that has been gained by the doula throughout the course of their career. Training pathways are based on undertaking classes and programs that cover needed competencies as determined by the state. The training pathway for each state differs in terms of the courses required, competencies that are needed, and the length of the program. States that have this pathway often have a list of preapproved state and national organizations that offer a certificate upon completion of the training.

For example, there are numerous national organizations that offer some form of doula training and certification which most states that cover doula service via Medicaid will accept. Within this there are two larger organizations that are commonly used within the United States. These organizations are DONA International and the Childbirth and Postpartum Professional Association (CAPPA).

To be certified by DONA International as a birth doula, individuals must participate in a DONA International approved birth doula workshop that has at least 16 hours of instruction time and receive education in childbirth and lactation support. Education in this space includes eight hours of observation at classes taught to expectant parents, a three-hour lactation support class, provision of in person labor support for 15 hours, attendance at three births, and reading two position papers and four books from an approved reading list.[19]

To become a certified labor doula by CAPPA an individual must attend a CAPPA Labor Doula training class, read selected books from an approved reading list, pass the scope of practice pretest, watch certain training materials, attend three births, and pass an examination.[20]

Additionally, the National Doula Certification Board is gaining in influence. To be certified as a professional doula an individual must participate in an approved training course and complete at least 200 hours of training and 75 hours of hands-on clinical experience including attending five births, being current in CPR training, having OSHA/Bloodborne Pathogens and Universal Precautions training, and having professional liability insurance.[21]

The core competencies in each training program and state differ. However, all the training that doulas acquire is non-clinical. For example, most states require doulas to attend a certain number of births and birthing classes in a non-clinical support role, and undertake training on topics such as ethics, cultural competency, grief, lactation support, labor support techniques, anatomy throughout pregnancy, and engagement with hospital systems and community support systems. Please see the chart in Appendix A which covers the state-required core competencies where they exist.

Moreover, most states require that doulas complete some training on Health Insurance Portability and Accountability Act (HIPAA) compliance, possess up to date CPR certifications for both adults and infants, pass a background check, provide necessary documentation of any required training or certifications, fill out an application, and pay associated fees.

It should be noted that many states do not preclude doulas who are not certified from practicing but rather prevent these individuals from calling themselves “certified doulas” and do not allow these individuals to bill Medicaid for their services.

Nevertheless, throughout all states, doulas must remain within the scope of their practice when providing support and must “always remain non-clinical and non-medical...Birth doulas do not perform vital sign checks, fetal heart tone checks, nor any cervical examinations. When practicing

as a birth doula, it is outside scope of practice to provide any medical advice, diagnose, or treat anything. This includes but is not limited to specific dietary recommendations, suggestions for over-the-counter medication, or 'natural' products such as supplements…All clients should be redirected back to their health care provider or qualified professional for medical advice, [and] treatment…."[22] In alignment with this a number of states have created some form of oversight for certified doulas, usually in the form of a Doula Registry or Certification Board which can suspend or revoke licensure if doulas are not following the requirements surrounding their training and certification.

*Private Insurance*

As of April 2025, only Rhode Island and Louisiana require coverage of doula services from private insurance plans. Rhode Island has fully implemented and requires both private plans and Medicaid to cover doula services.

In addition to these two states, four states are currently working to implement mandated doula coverage for private insurance plans. These states are Colorado, Illinois, Virginia, and Delaware. Colorado is trying to begin implementation of its doula services requirement this year but has experienced challenges in implementation including difficulties with creating a provider registration system. Virginia is also slated to begin implementation this year, but the State Corporation Commission has not yet included doula care in its mandated benefits list. Illinois and Delaware will begin enforcing this benefit in 2026.

Furthermore, Utah has made doula services available to state employees via the Public Employees' Benefit and Insurance Program, and California covers doula services through CalPERS for public employees. However, neither state mandates that state-regulated private insurance plans must cover doula care. [23]

DISCUSSION

Doulas can play a beneficial role for pregnant, birthing, and postpartum individuals and their families. However, it is imperative that doulas remain strictly within their defined scope of practice by providing only support services that do not involve clinical care. To help ensure this, a number of states have begun to require doulas who want to become Medicaid providers to gain a certificate and register with the state. Though education, certification, disciplinary, and insurance requirements differ significantly among the states that offer doula services through their Medicaid plans, most states do have some form of oversight for these providers. These additional competencies and checks can help to ensure that doulas are properly educated and perform duties only within their non-clinical support role. Nevertheless, there are still states that do not yet cover doula services and do not yet have training, licensure, and other requirements for doulas in place.

Additionally, doulas are not yet widely utilized due to several issues including access, payment, and a lack of knowledge surrounding doula services.[24] With certified doula services either not covered or only recently covered by insurance, many providers and birthing individuals do not yet understand the services offered by and the scope of practice of a doula. Additionally, many Doula Registry or Certification Boards are new, and their oversight capability is uncertain. Colloquially, it has been noted that doulas have at times exceeded the scope of their support role and provided medical advice such as recommending that birthing individuals continue to push rather than receive a Cesarean section, recommending individuals not receive an epidural, and providing other advice that could be categorized as clinical. Furthermore, though some states require liability insurance for certified doulas, others do not. (See Appendix A). This means that if doulas exceed the scope of

their nonclinical support role, have ethical violations, engage in professional negligence or misconduct, patients may not be able to recover adequate compensation for any damage that occurs. Moreover, doulas themselves do not have the added layer of protection that insurance offers in some states.

The Board further notes that there are multiple types of doulas and doula certifications, including birthing doulas, lactation doulas, postpartum doulas, and even doulas who do not engage in birthing care but instead provide care to other populations such as individuals who are dying. As such, the Board believes that carte blanche support for doulas cannot be given at this time.

However, when doulas are working as part of a physician-led care team, there can be positive outcomes for the birthing individual and the infant. To help facilitate this, some hospital systems are beginning to issue guidebooks to help physicians and other care providers understand the role of a doula and to outline ways in which doulas can be utilized.[25] For example, New York has highlighted that doulas can be utilized to do things like help the birthing individual ambulate while in labor, access and understand hospital labor and delivery policies, facilitate discussions surrounding a birth plan, acquire their placenta, and more.[26] Additionally, some states require that doulas either work under or are referred by a physician in order to receive payment from Medicaid. Therefore, increased education about how to effectively utilize a doula as part of a birth team can have positive impacts and aid physicians providing maternal care. So long as doulas remain within their scope of practice they can help facilitate increased communication, compliance, and comfort for patients within the health care system.

Moreover, since Medicaid funds a large percentage of births across the United States it is important that the addition or maintenance of doula services in state plans does not disrupt or minimize payment for physicians who participate in Medicaid, especially OB-GYNs and other physicians who provide maternal and infant care. States have limited budgets that they must allocate within their Medicaid programs and Medicaid providers are already typically paid less than they are by private insurance. (See Appendix B). According to the Medicaid-To-Medicare Fee Index, developed by researchers at the Urban Institute, Medicaid physician fees were approximately 87 percent for obstetric care in 2024.[27] Using data from FAIR Health's private health insurance claims database from March 2019 to February 2020, researchers at the Urban Institute estimated that commercial rates averaged 110 percent of Medicare for obstetrics and gynecology, without providing specific information about maternity care.[28] However, we do know that Medicare physician payment rates are inadequate, having declined 33 percent from 2001 to 2025 when adjusted for inflation in practice costs.[29] The national Medicare physician fee schedule payment amounts for maternity care services in 2025 include:

- $2,355.47 for CPT code 59400, which describes a global maternity care package, including vaginal delivery with antepartum and postpartum care.
- $2,616.51for CPT code 59510, which describes a global maternity care package, including Cesarean delivery, antepartum and postpartum care.
- $2,467.39 for CPT code 59610, which describes a global maternity care package, including vaginal delivery after previous cesarean delivery, antepartum and postpartum care.[i]

Additionally, with the passage of H.R.1, the "One Big Beautiful Bill Act," states will likely begin to face tighter budgets and experience budget deficits in Medicaid and as a result may have to cut

[i] Maternity care services are on the agenda for the CPT Editorial Panel's September 2025 meeting and following any coding changes, new or revised codes may be reviewed by the AMA/Specialty Society Relative Value Scale Update Committee (RUC).

services and payment rates for Medicaid providers.[30] Therefore, it is important that core services, such as access to reproductive and obstetrical services, are not compromised in favor of doula services.

Though the original Resolution 908-I-24 mostly considered care provided by doulas, there was a slightly broader context to the proposed resolution regarding non-medical support personnel. Existing AMA policy H-373.994, "Patient Navigation Programs," applies to patient navigators, community health workers, and other non-clinical public health workers and already acknowledges the beneficial role these individuals can play in patient care while providing guidelines for patient navigators to follow. Since the existing AMA policy already covers these non-medical support personnel, the existing policy should be reaffirmed.

## CONCLUSION

Doulas can play an important role in maternal care, as part of a physician-led care team, if they strictly adhere to their non-clinical support role. As part of this, especially if funding for doula services will be incorporated into Medicaid funding, it is imperative to ensure that doulas are required to undertake adequate training so that they can provide the necessary support to birthing individuals and their families within the scope of their support role. Therefore, there should be oversight of doula services that help ensure that doulas provide only non-clinical support, ensure that licensure is a required component of providing services, confirm that doulas are overseen by an appropriate disciplinary board, and that doulas obtain liability insurance. Moreover, access to and payment for doula services should never compromise patient access to and payment for physician services.

## RECOMMENDATIONS

The Board of Trustees recommends that the following be adopted in lieu of Resolution 908-I-24, and the remainder of the report be filed.

1. Our American Medical Association (AMA) recognizes that access to doula services for pregnant and birthing individuals can have a positive impact on birth outcomes.

2. To help ensure that doula services enhance patient care, our AMA supports doula services only when doulas provide non-clinical peripartum and birthing support and:
    a. possess licenses/certifications that include training specifically limited to nonclinical support and adhere to state certification requirements;
    b. retain licenses/certifications that are continuously monitored and overseen by a disciplinary board within the state that the doula is certified and delivering services;
    c. obtain liability insurance that has an adequate level of coverage;
    d. fully disclose relevant training, experience, and credentials, to help patients understand the scope of non-clinical support the doula is qualified to provide;
    e. work in partnership with a physician-led care team; and
    f. do not compromise access to physician care. (New HOD Policy)

3. That existing AMA Policy H-373.994, "Patient Navigation Programs," be reaffirmed. (Reaffirm HOD Policy)

Fiscal Note: Less than $500.

APPENDIX A: DOULA STATE LICENSURE AND TRAINING REQUIREMENTS

| State | Licensure Requirements | Training/Pathways |
|---|---|---|
| Alabama | There are not any licensure requirements or any statutory coverage requirements for Doula services in Alabama. | |
| Alaska | There are not any licensure requirements or any statutory coverage requirements for Doula services in Alaska. | |
| Arizona [31, 32, 33] | Doula certification is voluntary but is needed to bill for services.<br><br>Must be 18 years of age or older.<br><br>Must have at least a high school diploma or high school equivalency diploma.<br><br>A social security number and documentation of citizenship or alien status.<br><br>Complete first aid and adult basic CPR through a course recognized by the American Heart Association.<br><br>Complete neonatal resuscitation through a course recognized by the American Academy of Pediatrics or American Heart Association.<br><br>Agree to a code of ethics as prescribed by the Department. The Department may deny, suspend, or revoke a certification.<br><br>Does to have a complaint, allegation, or investigation pending from another regulatory entity in another state or country related to unprofessional conduct and has not voluntarily surrendered a certification or license in any other state or country while under investigation for unprofessional conduct.<br><br>Complete a background check. | For all pathways an individual must have written documentation of:<br>• Observing at least one birth after completing the specified training or education, signed and dated by the medical provider or licensed midwife who assisted the laboring mother<br>• Attending a minimum of three births while serving as the primary doula, including evaluations from the laboring mother and from the medical provider or licensed midwife who assisted the laboring mother<br>  o Proof of current certification from a nationally recognized doula organization may substitute for some of the education requirements<br><br>Pathway One:<br>• Completion of at least 30 hours of in-person instruction or a combination of in person and online instruction in core competency<br>• Must have a doula competency attestation form<br><br>Pathway Two<br>• Community training in non-western doula practices, as determined by the Department, documentation confirming that core competencies have been met through culturally specific |

| | | |
|---|---|---|
| | Submit an application.<br><br>Pay the fees.<br><br>Must renew their license every three years by putting in an application and paying the necessary fees and completing 15 hours of continuing education.<br><br>Must be recommended by a physician or other licensed practitioner of the healing arts acting within the scope of authorized practice under State law. Services must be documented in the member's medical record and may include care coordination, social support, coaching, and emotional support. | training or education subject to Department review<br>• Must have a doula competency attestation form<br><br>Pathway Three<br>• Other related individualized or experiential training or education that is subject to review by the Director<br>• Must have a doula competency attestation form<br><br>Pathway Four<br>• Proof of current certification from an approved training organization<br><br>Pathway Five – Practice Pathway:<br>• Individuals practicing as a doula in Arizona for at least five years before September 29, 2021, may be eligible to be a certified doula if the individual has:<br>o Proof of current certification from a nationally recognized doula organization<br>o Three letters of recommendation from medical providers or licensed midwives who have worked with the individual within the preceding two years and can attest to the individual's competency in providing doula services<br><br>Pathway 6 – Reciprocity Pathway:<br>• Must complete application<br>• Must have been credentialed in another states for at least one year<br><br>Meet the requirements of core competencies and certified doula scope of practice. Core competencies include:<br><br>• Entrepreneurship<br>• Standards of practice and ethics<br>• The childbirth processes<br>• Parental engagement<br>• Postpartum care |

| | | |
|---|---|---|
| | | • Grief<br>• Trauma-informed care<br>• Cultural doula practices<br>• Anatomy and physiology<br>• HIPAA |
| Arkansas [34] | Must be 18 years of age or older.<br><br>Must maintain a certification from a doula certification organization designated by the department in conjunction with the Doula Alliance of Arkansas, or hold a certificate as a doula from the Doula Alliance of Arkansas.<br><br>Must create and maintain a publicly accessible registry for certified doulas.<br><br>Pay application fee.<br><br>Must recertify every two years and complete 10 hours of professional development over that time and pay applicable fees.<br><br>Department of Health may suspend, revoke, or refuse to issue or renew the certification of a certified community-based doula. | |
| California [35, 36] | Must be at least 18 years old.<br><br>Enroll as a Medicaid provider.<br><br>Obtain a National Provider Identifier (NPL).<br><br>Have a social security number.<br><br>Possess an adult/infant CPR certification.<br><br>Complete basic HIPAA training.<br><br>Must be certified but the certificate does not need to be from a specific organization as long as it covers the requirements listed in the Medi-Cal Provider Manual: Doula Services. | Training Pathway:<br>• Complete a minimum of 16 hours of training in the following areas:<br>  ○ Lactation support<br>  ○ Childbirth education<br>  ○ Foundations on anatomy of pregnancy and childbirth<br>  ○ Nonmedical comfort measures, prenatal support and labor support techniques<br>  ○ Developing a community resource list<br>• Attest that they have provide support as a doula at a minimum of three births<br><br>Experience Pathway:<br>• At least five years of active doula experience in either a paid or |

| | | |
|---|---|---|
| | The requirement for different types of insurance is dependent on the local requirements (county/city) where the doula provides services.<br><br>Must complete three hours of continuing education every three years. | volunteer capacity within the previous seven years.<br>• Attestation to skills in prenatal, labor, and postpartum care as demonstrated by three written client testimonial letters or professional letters of recommendation from any of the following: a physician, licensed behavioral health provider, nurse practitioner, nurse midwife, licensed midwife, enrolled doula, or community-based organization.<br>o Letters must be written within the last seven years. One letter must be from either a licensed provider, a community-based organization, or an enrolled doula |
| Colorado [37, 38] | Must be at least 18 years of age.<br><br>Enroll as a Medicaid provider, register as a doula, and obtain an NPI.<br><br>Complete the Doula Provider Attestation Form.<br><br>Submit a copy of current CPR certification.<br><br>Sign the Doula Code of Conduct.<br><br>Must pass a background check.<br><br>Must recertify every five years. | The Certification Pathway:<br>• Completion of a training program that is approved by the Department<br>• Attendance at a minimum of three births within the last five years<br><br>The Experience Pathway:<br>• Attendance at 10 births in the role of a Doula with five births within the past two years<br>• Submission of four letters of recommendation that include two letters from clinical members of a birth team (e.g., Nurse, Nurse Practitioner, Midwife, Obstetrician) for a previously attended birth, and two letters from previous clients<br>• Attesting to having knowledge and competency in specific prenatal, labor/delivery, postpartum lactation, and newborn areas of care |
| Connecticut [39] | Allows for doulas to perform services but they may only be called certified | Training Pathway: |

| | | |
|---|---|---|
| | doulas if they meet the delineated criteria.<br><br>Must be eighteen years of age or older.<br><br>Apply to and be certified by the Department of Public Health and pay an application fee.<br><br>Must have two reference letters from families or professionals with direct knowledge of the applicant's experience as a doula verifying the applicant's training or experience.<br><br>If the rules are not followed disciplinary action may be taken.<br><br>Must renew certification every three years and complete continuing education requirements. | • Demonstration of the applicant's completion of a doula training program or a combination of approved programs<br><br>Experience Pathway:<br>• An attestation by the applicant that such applicant has provided doula services to at least three families and training in not less than four core competencies identified by the Doula Training Program Review Committee during the five years preceding the date of the application<br><br>Certification by Endorsement:<br>• Present evidence satisfactory to the commissioner that the applicant is certified as a doula in another state or jurisdiction whose requirements for certification are substantially similar to those of this state for not less than two years before the date such doula submits an application for certification.<br>• No certification shall be issued under this section to any applicant against whom professional disciplinary action is pending or who is the subject of an unresolved complaint. |
| Delaware [40, 41] | Must have an insurance policy that meets the requirements.<br><br>Documentation of fingerprint background check.<br><br>Must live or work in Delaware.<br><br>Must sign a Code of Ethics.<br><br>There will be a demographic collection.<br><br>Must attest to being a doula, obtaining the credentials for Medicaid reimbursement purposes, and to | Training Pathway:<br>• Documentation of a total of three births, of which one the applicant is the primary doula providing labor support to the client within the last three years.<br>• Documentation of a minimum of 16 total hours of birth and labor doula education which includes: lactation support, childbirth education, nonmedical comfort measures, prenatal support, labor support techniques, and postpartum support.<br>• Documentation of current CPR certification; certificate(s) must |

| | | |
|---|---|---|
| | understanding the credential is not a certification or verification of education.<br><br>Must be recertified every three years with 20 hours of continuing education and documentation of one birth. | include competencies for adults and infants.<br>• Documentation of HIPAA training: one hour<br><br>Legacy Doula:<br>• Documentation of a minimum of 15 clients within the last three years.<br>• Documentation of nine births attended within the last three years.<br>• Documentation of current CPR certification; certificate(s) must include competencies for adults and infants.<br>• Documentation of HIPAA training: one hour<br>• Documentation of two professional evaluations<br>• Submission of an essay on lived experience that is at least 250 words |
| Florida [42] | Services are up to the individual state managed care plans, and so the Agency for Health Care Administration does not have broader authority or control over implementation of the doula benefit.<br><br>Each Medicaid managed care plan in the state is able to determine the scope and administration of the benefit, as well as credentialing requirements and reimbursement. | |
| Georgia | There are not any licensure requirements or any statutory coverage requirements for Doula services in Georgia. | |
| Hawaii | There are not any licensure requirements or any statutory coverage requirements for Doula services in Hawaii. | |
| Idaho | There are not any licensure requirements or any statutory coverage | |

| | | |
|---|---|---|
| | requirements for Doula services in Idaho. | |
| Illinois [43] | Must be 18 years old or older.<br><br>Submit all application paperwork to Southern Illinois University (SIU) School of Medicine (SOM). Office of Certification System.<br><br>Must be certified by the Illinois Medicaid-Certified Doula Program, a partnership between HFS and the SIU SOM.<br><br>Must enroll in the Department of Healthcare and Family Services IMPACT system.<br><br>Must recertify every three years. | Training Program Pathway:<br>• Active doula (three perinatal doula experiences within past 12 months)<br>• Completion of labor and postpartum doula certification from an approved training organization<br>• Completion of courses below if they are not a part of approved provider training:<br>o Cultural Competency/Bias Training<br>o HIPAA (Health Insurance Portability and Accountability Act)<br>o Trauma-informed Care<br>o CPR/Basic Life Support<br>o Anatomy and Physiology (Pregnancy and Birth)<br><br>Legacy Doula Pathway:<br>• Active doula (five perinatal doula experiences in the past three years)<br>• Completion of courses below:<br>o Cultural Competency/Bias Training<br>o HIPAA (Health Insurance Portability and Accountability Act)<br>o Trauma-informed Care<br>o CPR/Basic Life Support<br>o Anatomy and Physiology (Pregnancy and Birth) |
| Indiana [44] | Must be trained and certified by a nationally recognized institution in providing emotional and physical support, but not medical or midwife care, to pregnant women before, during, and after childbirth.<br><br>Medicaid coverage is allowed but no budget has been allocated for this coverage. | |

| | | |
|---|---|---|
| Iowa [45] | There is currently a pilot program underway called the Maternal Health Doula Project, but there do not appear to be any licensure requirements associated with this program at this time. | |
| Kansas [46] | Complete the Doula Attestation Form.<br><br>Must have a W9.<br><br>Provide support at a minimum of three births.<br><br>Must recertify every three years and complete 10 hours of continuing education. | Current Doula Pathway:<br>• Must have a Doula certification from an approved training program<br><br>New Enrollment Training Pathway:<br>• Certificate of Completion for 30 hours of training in any combination of the following areas:<br>o Birth Doula Training<br>o Antepartum Doula Training<br>o Postpartum Doula Training<br>o Lactation Support<br>o Childbirth Education<br>o Foundations on Anatomy of Pregnancy and Childbirth<br>o Nonmedical Comfort Measures, Prenatal Support, and Labor Support Techniques<br>o Postpartum Health<br>o Reproductive Health Counseling<br>o Pregnancy Loss and Support<br>o Cultural Competency<br>o HIPAA Training<br>o Adult and Children/Infant CPR Certification<br>o Developing a Community Resource List |
| Kentucky [47] | There do not appear to be any licensure requirements or any statutory coverage requirements for Doula services in Kentucky.<br><br>However, companies such as Humana do cover doula services in Kentucky. | |
| Louisiana [48, 49, 50] | Must be at least 18 years of age. | Experience Pathway:<br>• Submission of three letters of recommendation from clients to |

| | | |
|---|---|---|
| | Possess either a high school diploma or high school equivalency documentation.<br><br>Be a citizen of or lawfully authorized to be employed in the United States.<br><br>Apply to and be registered by the Louisiana Doula Registry Board.<br><br>Acceptance as a Medicaid provider and have an NPI.<br><br>The board can revoke the registration of a doula who violates professional standards.<br><br>Must recertify every five years and must complete 20 contact hours of continuing education during that time. If an applicant does not recertify in time, they may still have their credentials reinstated if they apply within one year of their credentials elapsing. | whom the individual has provided doula services within the previous five years. Such letters must provide specific details concerning the names, dates, and services provided or<br>• Submission of proof that the individual contracted with and provided doula services to at least three clients within the previous five years<br><br>Training Pathway:<br>• Demonstrate receipt of a certificate of completion of training as a doula by a board approved doula training organization<br>• The curriculum for training doulas must include at least eight hours of instruction having significant intellectual, practical, or clinical content, dealing with matters related to maternal healthcare, including during pregnancy, intrapartum, and postpartum |
| Maine [51] | Maine is in the process of developing standards. | |
| Maryland [52, 53, 54, 55] | Enroll as a Medicaid provider and meet all conditions for participation.<br><br>Have an NPI.<br><br>Be at least 18 years of age.<br><br>Maintain up to date certification through a doula certification program approved by Maryland Medicaid and present proof of all specified certifications.<br><br>Maintain up to date certification through an accepted doula certification program.<br><br>Have adequate liability insurance. | |

| | | |
|---|---|---|
| | Pass a background check.<br><br>An obstetrician-gynecologist, family medicine practitioner, or certified nurse midwife must be present while doula services are provided during labor and delivery. | |
| Massachusetts [56] | Must be at least 18 years old.<br><br>Enroll as a MassHealth doula provider and get an NPI.<br><br>Complete trainings provided by the Executive Office of Health and Human Services (EOHHS) on topics including, but not limited to:<br><br>• Overview of the MassHealth Doula Services Program, including best practices for meeting the needs of diverse MassHealth members and their families<br>• Federal and state laws and regulations established for the protection of the privacy and security of the member information doulas create, use, collect, store, and/or transmit<br>• Navigating MassHealth-covered services and community resources for MassHealth members | Formal Training Pathway:<br>• Provide a certificate of completion or other proof of doula training(s) attended, and/or proof of doula certification by a doula-certifying organization and a completed attestation form, using the template provided by EOHHS, stating that the completed formal training(s) covered the required competencies listed above.<br><br>Experience Pathway:<br>• Provide the following recommendations using templates provided by EOHHS:<br>o Recommendations from at least three different former clients for whom the prospective MassHealth doula provided doula services (either paid or volunteer) within the last five years<br>o Recommendations from at least two different licensed health care providers such as physicians, midwives, social workers, or nurses who observed the applicant providing doula services within the last five years<br><br>Out-of-state Providers:<br>• Obtain a MassHealth provider number and meet the following criteria:<br>o Be legally authorized to perform the services of a doula in their own state |

| | | |
|---|---|---|
| | | ○ Participate in their state's Medicaid program (or the equivalent)<br>○ Meet the conditions for Out-of-state Services.<br><br>Formal Training Pathway and Experience Pathway must have the core competencies which include:<br>• Basic understanding of the following topics at a minimum, as those topics relate to the ability to provide emotional, informational, and physical support to individuals and families during the perinatal period, regardless of the outcome of the pregnancy:<br>○ Maternal anatomy and physiology during the perinatal period, including basic fetal growth and development in each trimester of pregnancy<br>○ Common medical interventions during pregnancy, childbirth, and the postpartum period<br>○ Common potential complications associated with pregnancy, childbirth, and the postpartum period, including but not limited to:<br>▪ Pregnancy and infant loss<br>▪ Mental health conditions including Perinatal Mood and Anxiety Disorders (PMADs)<br>▪ Substance use disorder (SUD)<br>▪ High blood pressure<br>○ Labor and delivery comfort measures<br>○ Best practices for supporting members in advocating for their needs and making informed decisions using a trauma-informed approach<br>○ Basic newborn care, including the fundamentals |

| | | |
|---|---|---|
| | | of breastfeeding/chest feeding |
| Michigan [57, 58] | Must be at least 18 years of age.<br><br>Possess a high school diploma or equivalent.<br><br>Must be on the Michigan Department of Health and Human Services (MDHHS) Doula Registry.<br><br>Enroll as a Medicaid provider, obtain an NPI, and complete an online application.<br><br>Possess a certification for completing training provided by an MDHHS approved doula training program or organization.<br><br>Have liability insurance | At a minimum, a doula training program must include skill development in the following areas:<br><br>• Communication, including active listening, cross-cultural communication, and interprofessional communication<br>• Perinatal self-care measures<br>• Coordination of and linkage to community services and resources<br>• Labor and coping strategies<br>• Newborn care and supportive measures<br><br>MDHHS is currently researching pathways for legacy certification, or certification for doulas by providing proof of experience in lieu of training, within the confines of state and federal regulations. |
| Minnesota [59, 60] | Submit an application by going to the Minnesota Department of Health Licensing System.<br><br>Provide evidence of maintaining a certification from one of the designated/approved Doula Certification Organizations and pay the requisite fee.<br><br>Pass a criminal background check.<br><br>Must renew certification and provide updated information to the doula registry every three years. | |
| Mississippi | There are not any licensure requirements or any statutory coverage requirements for Doula services in Mississippi. | |
| Missouri [61] | Must be at least 18 years of age. | Must possess a current certificate issued by a national or Missouri-based doula training organization |

| | | |
|---|---|---|
| | Must be enrolled as a MO HealthNet provider and have an NPI.<br><br>Must have liability insurance as an individual or through a supervising organization.<br><br>Complete a professional background check.<br><br>Completion of at least six continuing education unit hours per year or equivalent continuing education as specified by the training organization. | whose curriculum meets the following definition and standards:<br>• Curriculum that covers a doula's role, which includes breastfeeding support, perinatal mood and anxiety disorders, anticipatory care strategies, cultural competency, how to deliver perinatal education and support, how to increase client autonomy during birth, and how to support clients who may need additional care.<br>• Understanding the importance of health-related social needs, including navigation of social services, trauma-informed care, and strategies specific to the community served.<br>• The student must successfully complete the training program and be deemed competent to provide doula services. Certification is attained after evaluation by a birth professional or trainer.<br><br>For doulas whose training came from another source, or from multiple sources, MO HealthNet will determine eligibility for reimbursement as follows:<br>• If there exists any statewide organization composed of doula trainers from three or more independent, well-established doula training organizations located in Missouri whose purpose includes validation of core competencies of trainings, then MO HealthNet may verify that an individual's training and experience satisfies the above-stated criteria through a public roster maintained by such an organization<br>• If no such organization exists, future doula training organizations must prove that their training satisfies the above |

| | | |
|---|---|---|
| | | definition in order to be added to the written policy guide, which will include a list of all approved certification programs. |
| Montana [62] | Pay the fee.<br><br>Submit a completed application.<br><br>Satisfactorily complete competencies that meet the established requirements.<br><br>Not engage in unprofessional conduct.<br><br>Not currently subject to any disciplinary proceedings.<br><br>May be disciplined in accordance with law. | Experience Pathway:<br>• Serves as an unlicensed doula for a period prior to January 1, 2026, may be licensed if:<br>o Provides sufficient evidence to the department of labor and industry that their experience providing doula services is equivalent to the requirements for licensure defined- 2025 69th Legislature 2025 SB 319 by department rule.<br>o To be eligible for licensure under this section, an individual shall demonstrate the evidence to the department on or before December 31, 2027. |
| Nebraska | There are not any licensure requirements or any statutory coverage requirements for Doula services in Nebraska though a pilot program is underway. | |
| Nevada [63, 64] | Current adult and infant CPR certification.<br><br>Must agree to adhere to the Nevada Certification Board's birth doula specific code of ethics.<br><br>Must live or work in Nevada at least 50 percent of the time.<br><br>Must maintain certification from the Nevada Certification Board.<br><br>Enroll as an individual Nevada Medicaid Provider and get an NPI.<br><br>Must pay the associated fees.<br><br>Must recertify every two years by paying the renewal fee, having proof of current adult and infant CPR | All training for initial certification must have been completed within the past five years from an NCB approved foundational birth doula training that includes the core competencies of:<br><br>• Perinatal counseling and support services<br>• Labor support<br>• Infant care<br>• Four hours of NCB approved training in Trauma-Informed Care<br>• Six hours of NCB approved training in Cultural Competence/Cultural Humility<br>• One hour of NCB approved training in the Health Insurance Portability and |

| | | |
|---|---|---|
| | certification, and completing 20 hours of continuing education in the Nevada Birth Doula Competencies. | Accountability Act of 1996 (HIPAA).<br><br>Attendance at a minimum of one birth within the past five years, with a recommendation submitted to NCB by the birthing individual. |
| New Hampshire [65] | Doula certification and lactation service certification is voluntary.<br><br>The doula and lactation consultants certified by the office of professional licensure must be credentialed by an organization accredited by:<br><br>• The American National Standards Institute<br>• The National Commission for Certifying Agencies<br>• Another nationally or internationally recognized accreditation organization identified by the office of professional licensure. | |
| New Jersey [66, 67, 68] | Must be at least 18 years old.<br><br>Must have HIPAA training.<br><br>Must have adult/infant CPR certification.<br><br>A certified doula has received and maintains a certification to perform doula services from an approved training program or organization.<br><br>The Department of Health has a Doula Registry for doulas that:<br><br>• Submit to the department an application for inclusion on the registry, and whose application is approved by the department<br>• Pays any applicable fees established by the department<br>• Passes a criminal history record background check | Doula training programs must be approved by the New Jersey Department of Human Services (NJ-DHS)—in consultation with the NJ Department of Health (NJDOH). There is a list of recognized training programs.<br><br>Approved community doula training programs must include:<br>• Core competency training that includes evidence-based perinatal education, birth plan development, continuous support during labor, comfort measures, and infant feeding<br>• Practical (hands-on) experience, including prenatal, labor, birth and postpartum observation/support<br>• Community-based/cultural competency training that includes delivering person-centered and trauma-informed care, and |

| | | |
|---|---|---|
| | • Annually submits evidence that the applicant is a certified doula<br><br>Enroll as a Medicaid provider.<br><br>Must pass a background check.<br><br>Must have liability insurance. | facilitating access to NJ-specific community-based resources<br>• Relevant readings associated with classroom hours, cultural competency, HIPAA and CPR training, and practical experience |
| New Mexico [69, 70, 71] | Be at least 18 years old at the time the application is submitted.<br><br>Maintain a current adult and infant CPR certification from the American Red Cross or American Heart Association.<br><br>Have a Driver's License or state-issued identification card.<br><br>Live in, or within 100 miles, of New Mexico.<br><br>Provide attestation of having completed HIPAA Training within one year prior to the date of the Doula Certification application.<br><br>Complete one of three Pathways towards Doula Certification with the NM Department of Health.<br><br>Must pass a background check.<br><br>Enroll as a Medicaid provider.<br><br>Must recertify every two years with 24 hours of continuing education completed during that time. | Pathway 1 Training Pathway:<br>• Certified in an identified doula training program.<br><br>Pathway 2 Core Competencies Pathway:<br>• Complete a doula training that meets the requirements for core competencies.<br>• Provide attestation of the completion of services to three doula clients.<br><br>Pathway 3 Experience Pathway:<br>• Provide three letters of recommendation attesting to the competency of the applicant's skills and experience as a doula.<br>• Provide attestation of the completion of services to three doula clients in either a paid or voluntary capacity.<br>• Have at least two years of experience providing doula services without formal training. |
| New York [72, 73] | Must be 18 years or older.<br><br>Have current adult and infant CPR certification.<br><br>Have current liability insurance.<br><br>Review and comply with HIPAA and complete HIPAA training. | Training Pathway:<br>• 24-hour minimum training in all required competencies<br>• Doula support provided at a minimum of three births<br><br>Work Experience Pathway: |

| | | |
|---|---|---|
| | NYS Medicaid Fee-for-Service Doula Directory.<br><br>Enroll as a New York State Medicaid provider and obtain an NPI.<br><br>Must recertify as a New York State Medicaid provider every five years and demonstrate completion of continuing education. | • 30 births or 1000 hours of doula experience within the last 10 years<br>• Testimonials of doula skills in prenatal, labor and postpartum care |
| North Carolina | There are not any licensure requirements or any statutory coverage requirements for Doula services in North Carolina. | |
| North Dakota | There are not any licensure requirements or any statutory coverage requirements for Doula services in North Dakota. | |
| Ohio [74] | Be at least 18 years of age at the time of submitting the doula application.<br><br>Submit an application.<br><br>Pay the required fee.<br><br>Be certified by a doula certification organization that is recognized on an international, national, state, or local level, for training and certifying doulas, or, if not certified, have education and experience considered by the board to be appropriate.<br><br>Must complete a background check.<br><br>Must recertify every other year. | Certification Pathway:<br>• If applying based on certification by a doula certification organization recognized on an international, national, state, or local level, for training and certifying doulas, the certification must be current and must either be:<br>o Provided directly to the board by the doula certifying organization; or<br>o If provided by the applicant, the applicant must provide contact information sufficient for the board to verify the certification.<br>o Must attest that they have completed four hours of training directly related to racial bias, health disparities, and cultural competency either through their doula certification organization or otherwise.<br><br>Education and Experience Pathway:<br>• Complete ten hours of education that meets the requirements of the |

| | | |
|---|---|---|
| | | Administrative Code for doula continuing education.<br>○ At least four of those hours must be training directly related to racial bias, health disparities, and cultural competency.<br>○ The remaining six hours should relate to the doula's practice.<br>• Education may be demonstrated by attestation to having completed education meeting these requirements. At the discretion of the board, the applicant may be required to show proof of completion of the education.<br>• Must have been actively engaged in practice as a doula for three years immediately prior to the date the application is submitted to the board. Alternatively, may attest to having provided doula services to five clients over the three years immediately prior to the date of the application. At the board's discretion, an applicant may be required to provide date spans and a general description of the doula services provided for each of the five clients. |
| Oklahoma [75] | Must be 18 years of age.<br><br>Obtain and maintain a National Provider Identifier (NPI).<br><br>Enroll as a SoonerCare Contracted provider.<br><br>Use the taxonomy number required by the State.<br><br>Possess one of the following certifications from an organization recognized by the Oklahoma Health Care Authority:<br><br>• Birth doula<br>• Postpartum doula<br>• Full-spectrum doula | |

| | | |
|---|---|---|
| | • Community-based doula | |
| Oregon [76, 77] | Enroll as a Medicaid provider.<br><br>Have current CPR certification for children/infants and adults.<br><br>Complete Oral Health training.<br><br>Be state-certified as a Traditional Health Worker (THW).<br><br>Adhere to THW Standards of Professional Conduct.<br><br>Be certified and registered with the OHA, Office of Equity and Inclusion with approved curricula used to train birth doulas.<br><br>Must complete a background check.<br><br>Recertification Requirements:<br><br>• At least 20 hours of continuing education during every three-year renewal period. A minimum of three hours within the 20 hours must be suicide risk assessment, treatment and management appropriate to their scope of work.<br>• A current CPR certification for children/infants and adults | New Applicants:<br>• A minimum of 40 contact hours from an Authority approved training program that includes a minimum of 28 contact hours of in-person education offered by an Authority approved training program, that includes any combination of childbirth education and birth doula training in addition to completing the 12 hours of training topics through an Authority approved training program or through another training program provided by a birth doula certification organization.<br>• Six contact hours in cultural competency training.<br>• Six contact hours in one or more of the following topics as they relate to birth doula care:<br>o One hour of interprofessional collaboration.<br>o One hour of Health Insurance Portability and Accountability Act (HIPAA) compliance.<br>o Four hours of trauma-informed care.<br>• Complete a 1.5 hour OHA-approved oral health training.<br>• Create a community resource list for the geographical areas served.<br>• Document attendance at a minimum of three births.<br>• Document attendance at a minimum of three postpartum visits.<br><br>The Legacy Clause:<br>• A clear copy of government issued identification<br>• An OHA-approved oral health training |

| | | |
|---|---|---|
| | | • Proof of attending 10 births and providing 500 hours of community work supporting birthing persons and families in the capacity of a birth doula within the five years.<br>• Community resource list specific to the region you are providing doula services to.<br>• One letter of recommendation from any previous employer/client for whom THW services were provided within the last five years. Letter must be on professional letterhead, must contain author's signature and contact information. Job duties must be listed as they relate to the worker-type you are applying for.<br><br>Competency Test:<br>• If you have had your certification expired for more than six months you can take the Competency Skills Test to renew your certification by:<br>o Passing the Competency Skills Test<br>o Having proof of 20 CEUs required for worker type with three of the 20 hours coming from suicide prevention training (must be completed in the last 3 years)<br>o Oral health training (must be completed in the last 3 years)<br>o Current CPR certification for children/infants and adults<br><br>Note: All core curriculum for training birth doulas must cover the following topics:<br><br>• Anatomy and physiology of labor, birth, maternal postpartum, neonatal transition, and breastfeeding;<br>• Labor coping strategies, comfort measures, and non- |

| | | |
|---|---|---|
| | | pharmacological techniques for pain management;<br>• The reasons for, procedures of, and risks and benefits of common medical interventions, medications, and Cesarean birth;<br>• Emotional and psychosocial support of birthing persons and their support team<br>• Birth doula scope of practice, standards of practice, and basic ethical principles<br>• The role of the birth doula with members of the birth team<br>• Communication skills, including active listening, cross-cultural communication, and inter-professional communication<br>• Self-advocacy and empowerment techniques<br>• Breastfeeding support measures<br>• Postpartum support measures for the birthing person and baby relationship<br>• Perinatal mental health<br>• Family adjustment and dynamics<br>• Evidence-informed educational and informational strategies<br>• Community resource referrals<br>• Professional conduct, including relationship boundaries and maintaining confidentiality<br>• Self-care |
| Pennsylvania [78, 79] | Must be at least 18 years old.<br><br>Must be certified by the Pennsylvania Certification Board.<br><br>Documentation of current CPR certification for adults and infants.<br><br>Pay the required fee.<br><br>Three client evaluations from families served.<br><br>Must be recertified every three years. | Training Pathway:<br>• Must be educated through an approved doula certifying or training body that meets core competencies<br>o There is no time limit on when the education/training was received and no limit to the amount of online education that may be submitted<br>o Training must be non-repetitive meaning the same training cannot be claimed more than one time even if the training is taken on |

| | | |
|---|---|---|
| | | different dates from different providers<br>• Must have 24 total hours of relevant education/training to the Certified Perinatal Doula knowledge areas.<br>• Must have one hour of training in HIPAA/client confidentiality.<br><br>Experience Pathway:<br>• One year of experience is required for applicants who have not obtained their education through an approved doula certifying body or an approved doula training organization.<br>• Must be currently practicing, and experience must be acquired within two years prior to the submission of the application.<br>• Three client evaluations from families served within the last year. If the applicant does not currently live in Pennsylvania, all client evaluations must be from clients living in Pennsylvania. |
| Rhode Island [80] | Certification is not required to practice as a doula in Rhode Island.<br><br>Certification is for doulas who plan to accept insurance reimbursement and those contracting with Medicaid.<br><br>Enroll as a Medicaid provider.<br><br>Documentation of current CPR certification for adults and infants.<br><br>Documentation of current SafeServ certification for meal preparation.<br><br>Certified by Rhode Island Certification Board.<br><br>Pay the required fees.<br><br>Live or work in Rhode Island at the time of applying for certification. | 20 total hours of relevant education/training to the Certified Perinatal Doula domains:<br><br>• 12 hours must be in birth doula training, antepartum doula training, postpartum doula training and/or childbirth education<br>• At least one training must be a doula training<br>• Two hours must be in breastfeeding or document a valid lactation certification<br>• Two hours must be attendance at a childbirth class or document a valid childbirth education certification<br>• Three hours must be in cultural competency<br>• One hour must be in HIPAA/client confidentiality |

| | | |
|---|---|---|
| | Must be recertified every two years. | • There is no time limit on when the education/training was received and no limit to the amount of online education that may be submitted<br>• Training must be non-repetitive meaning the same training cannot be claimed more than one time even if the training is taken on different dates from different providers |
| South Carolina | There are not any licensure requirements or any statutory coverage requirements for Doula services in South Carolina. | |
| South Dakota [81, 82] | Must be at least 18 years old.<br><br>Must maintain up-to-date certification through a doula certification program approved by South Dakota Medicaid. | |
| Tennessee [83] | Tennessee created a Doula Services Advisory Committee which is currently exploring ways to integrate Doulas into care in Tennessee.<br><br>This Committee has made recommendations but there do not appear to be any licensure requirements or any statutory coverage requirements for Doula services in Tennessee at this time. | |
| Texas [84, 85] | Must be 18 years of age or older.<br><br>Complete standardized HHSC training modules online with certificate of proof.<br><br>Complete HIPAA training.<br><br>Develop a Community Resource Document.<br><br>Be certified by a recognized national certification program, as determined by HHSC. | Doula Training Pathway:<br>• HHSC standardized case management training for CPW through the Online Provider Education Portal<br>  ○ Additional hours of core competency, doula-specific, training for applicants who do not meet the five year experience requirements:<br>  ○ Childbirth education<br>  ○ Lactation support. Or show proof of being a certified lactation counselor (CLC or IBCLC) |

| | | |
|---|---|---|
| | | ○ Nonmedical comfort measures, prenatal support, and labor support techniques<br>○ Chronic and acute health conditions during the perinatal period<br>○ Cultural competency training<br>• Attendance in at least three births with three written professional letters of recommendation<br><br>Doula Experience Pathway:<br>• HHSC standardized case management training for CPW through the Online Provider Education Portal<br>• Five years of experience in the capacity as a doula<br>• Attendance in at least three births in the capacity of a birth doula with three written professional letters of recommendation |
| Utah [86] | Passed legislation asking that the state develop a state plan amendment to cover doula services, but it does not appear that there are licensure requirements yet. | |
| Vermont [87] | Does not require doulas to be certified to practice.<br><br>Must be at least 18 years of age.<br><br>Pay necessary fees.<br><br>The Office of Professional Regulation may discipline a certified community-based perinatal doula for unprofessional conduct.<br><br>Complete and submit an application.<br><br>Pass any criminal history background or registry checks required by the Director.<br><br>May discipline providers for unprofessional conduct. | Must have sufficient and appropriate competencies in community-based perinatal doula services, whether acquired through experience, mentorship, training, formal education, or a combination of these, as determined by the Director. |

| | | |
|---|---|---|
| | Must renew certification every two years. | |
| Virginia [88, 89, 90] | Virginia does not require a doula to be certified by a certifying body approved by the State Board of Health to practice as a doula.<br><br>For certified doulas they must be enrolled as a Medicaid provider.<br><br>Must be at least 18 years old.<br><br>Any person seeking to be a Virginia state-certified doula must be a community-based doula and:<br><br>• Meet the established qualifications and education requirements for the Certification of Doulas<br>• Hold a certification as a certified doula from a certifying body approved by the Virginia Board of Health--Virginia Certification Board (VCB).<br><br>Must recertify every two years and complete a minimum of 15 hours of continuing education from an approved training entity. | Within the last three years must have had 60 total hours specific to the knowledge areas from an approved certifying body approved by the State Board of Health.<br><br>• Two hours must be in Maternal and Infant Health Concepts and Approaches<br>• 10 hours must be in Lactation anticipatory guidance and support<br>• 20 hours must be in Service Coordination and System Navigation<br>• Eight hours must be in Health Promotion and Prevention<br>• Five hours must be in Advocacy, Outreach and Engagement<br>• Two hours must be in Communication<br>• Eight hours must be in Cultural Humility and Responsiveness<br>• Five hours must be in Ethical Responsibilities and Professionalism<br><br>The training and education requirements do not apply to doulas who have already obtained an initial level of certification within the three years prior to January 6, 2022, and are applying to be a state-certified doula through the certifying body approved by the State Board of Health, provided that the applicant provides proof of completion of any unmet training and education requirements within one year of application. |
| Washington [91, 92] | Doula certification is voluntary.<br><br>For individuals that want to bill Medicaid they must submit a completed application as required by the department and possess current certification as a birth doula with the | Training Pathway:<br>• Successfully complete training and education programs approved by the secretary that collectively introduce students to the key principles of the following topics:<br>o Role of a birth doula |

| | | |
|---|---|---|
| | Washington State Department of Health.<br><br>Must be at least 18 years old.<br><br>Satisfactorily complete competencies that meet the established requirements.<br><br>Not engage in unprofessional conduct.<br><br>Not currently subject to any disciplinary proceedings.<br><br>Complete background check.<br><br>Pay needed fees.<br><br>Successfully complete culturally congruent ancestral practices, training, and education as required or complete the requirements under the ancestral pathway competencies.<br><br>Culturally congruent ancestral practices, training, and education:<br>• Demonstrate knowledge of culturally congruent ancestral practices, training, and education that upholds culturally congruent care.<br>• Culturally congruent ancestral training or experience may include, but is not limited to:<br>o History of obstetrics<br>o Trauma-informed care<br>o Social determinants of health<br>o Adverse childhood experiences<br>o Other training and education that enhances the applicant's knowledge of culturally congruent care or culturally congruent ancestral practices, training, and education.<br>• An attestation that they have successfully completed training or have experience in one of the categories; or<br>• A certificate of completion from relevant training that lists the applicant's name. | o Prenatal and birth care<br>o Postpartum care<br>o Communication and interpersonal skills<br>o Doula safety and self-care<br>o Birth justice and advocacy<br><br>Culturally Congruent Ancestral Practices (Experience) Pathway:<br>• Submission of proof of successful completion of culturally congruent ancestral practices, training, and education which the secretary will review to determine whether the training and education meet the competency-based requirements.<br>• Complete birth doula ancestral training that is substantially equivalent to the required training. Documentation of completion must include:<br>o An attestation on forms provided by the department that they have completed training that is substantially equivalent to the required training or<br>o Three written client testimonial letters or letters of recommendation from profession-related leaders or peers using testimonial templates provided by the department. Letters must be written within the last five years. One letter must be from either a licensed provider, a community-based organization, or a practicing doula or midwife.<br><br>Endorsement Pathway:<br>• An initial applicant currently certified to practice as a birth doula in another state, the District of Columbia, or a territory of the United States may be certified by endorsement. An applicant shall |

| | | |
|---|---|---|
| | Complete 10 hours of continuing education every renewal cycle. Eight hours of continuing education and leadership development activities must be obtained through designated activities. A minimum of five hours must directly relate to the practice of a birth doula. Any remaining hours may be in leadership development activities that enhance the practice of the birth doula. A birth doula shall also complete two hours of health equity continuing education every four years. | comply with the requirements for licensure and submit proof of:<br>○ Current certification from another United States jurisdiction, if the applicant is certified in a United States jurisdiction that has substantially equivalent standards to Washington.<br>○ For applicants who have been certified for at least two years in another United States jurisdiction that does not have substantially equivalent standards, the applicant must submit:<br>▪ Current certification from another United States jurisdiction; and<br>▪ Proof of 10 hours of continuing education within the two-year period immediately preceding certification.<br>○ For applicants who have been certified for less than two years in a United States jurisdiction that does not have substantially equivalent standards, the applicant may apply for certification through the application process. |
| Washington DC [93] | Must be at least 18 years of age.<br><br>Possess a high school diploma or the equivalent.<br><br>Possess a current certification by a doula training program or organization, approved by the District of Columbia Department of Health Care Finance (DHCF).<br><br>Enroll as a DHCF provider and receive an NPI and taxonomy number. During enrollment doulas must also provide information on:<br><br>• Certificate of Occupancy (or Lease) or Business License | |

| | | |
|---|---|---|
| | • Disclosure of Ownership<br>• NPI # and Taxonomy<br>• Professional Certification (Interim until DC Health creates a Certification)<br>• Proof of Liability Insurance of at least $1M per occurrence/$3M per aggregate<br>• W-9<br>• Proof of doula certification from the District (once available) | |
| West Virginia | There are not any licensure requirements or any statutory coverage requirements for Doula services in West Virigina. | |
| Wisconsin | There are not any licensure requirements or any statutory coverage requirements for Doula services in Wisconsin. | |
| Wyoming | There are not any licensure requirements or any statutory coverage requirements for Doula services in Wyoming. | |

APPENDIX B: ACOG MEDICAID REIMBURSEMENT CHART

| State | Date Searched | Service Description | CPT Code | Medicaid Rate | Medicare Rate | Comparison |
|---|---|---|---|---|---|---|
| **Alabama** | 3/4/2025 | Vaginal Delivery | 59400 | $1,690 | $2,108.02 | 80.17% |
| | | Cesarean delivery | 59510 | $1,690 | $2,330.72 | 72.51% |
| | | VBAC Delivery | 59610 | $1,690 | $2,196.55 | 76.94% |
| **Alaska** | 3/25/2025 | Vaginal Delivery | 59400 | $3,951.12 | $2,888.61 | 136.78% |
| | | Cesarean delivery | 59510 | $4,366.82 | $3,190.25 | 136.88% |
| | | VBAC Delivery | 59610 | $4,114.64 | $3,006.20 | 136.87% |
| **Arizona** | 3/4/2025 | Vaginal Delivery | 59400 | $3,811.89 | $2,287.13 | 166.67% |
| | | Cesarean delivery | 59510 | $4,204.21 | $2,536.15 | 165.77% |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | VBAC Delivery | 59610 | $3,981.05 | $2,391.06 | 166.50% |
| **Arkansas** | 3/4/2025 | Vaginal Delivery | 59400 | $1,210 | $2,081.97 | 58.12% |
| | | Cesarean delivery | 59510 | $1,230.26 | $2,300.02 | 53.49% |
| | | VBAC Delivery | 59610 | $1,525.41 | $2,167.38 | 70.38% |
| **California** | 3/5/2025 | Vaginal Delivery | 59400 | $2,091.21 | $2,306.54 | 90.66% |
| | | Cesarean delivery | 59510 | $2,297.54 | $2,542.89 | 90.35% |
| | | VBAC Delivery | 59610 | $2,173.65 | $2,395.53 | 90.74% |
| **Colorado** | 3/5/2025 | Vaginal Delivery | 59400 | $2,428.11 | $2,352.91 | 103.20% |
| | | Cesarean delivery | 59510 | $2,676.71 | $2,605.51 | 102.73% |
| | | VBAC Delivery | 59610 | $2,530.12 | $2,455.99 | 103.02% |
| **Connecticut** | 3/21/2025 | Vaginal Delivery | 59400 | $2,612.33 | $2,524.99 | 103.46% |
| | | Cesarean delivery | 59510 | $2,950.61 | $2,809.14 | 105.04% |
| | | VBAC Delivery | 59610 | $2,732.42 | $2,649.58 | 103.13% |
| **DC** | 3/5/2025 | Vaginal Delivery | 59400 | $2,142.16 | $2,638.34 | 81.19% |
| | | Cesarean delivery | 59510 | $2,381.50 | $2,930.07 | 81.28% |
| | | VBAC Delivery | 59610 | $2,245.26 | $2,762.98 | 81.26% |
| **Georgia** | 3/5/2025 | Vaginal Delivery | 59400 | $2,470.87 | $2,298.66 | 107.49% |
| | | Cesarean delivery | 59510 | $2,752.40 | $2,562.01 | 107.43% |
| | | VBAC Delivery | 59610 | $2,595.61 | $2,417.10 | 107.39% |
| **Hawaii** | 4/4/2025 | Vaginal Delivery | 59400 | $2,408.90 | $2,336.77 | 103.09% |
| | | Cesarean delivery | 59510 | $2,656.47 | $2,574.58 | 103.18% |
| | | VBAC Delivery | 59610 | $2,502.15 | $2,425.17 | 103.17% |
| **Idaho** | 3/5/2025 | Vaginal Delivery | 59400 | $1,919.32 | $2,103.42 | 91.25% |
| | | Cesarean delivery | 59510 | $2,118.75 | $2,320.11 | 91.32% |
| | | VBAC Delivery | 59610 | $1,996.03 | $2,185.84 | 91.32% |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Illinois** | 3/6/2025 | Vaginal Delivery | 59400 | $1,840.25 | $2,406.13 | 76.48% |
| | | Cesarean delivery | 59510 | $2,046.31 | $2,689.70 | 76.08% |
| | | VBAC Delivery | 59610 | $1,938.17 | $2,538.55 | 76.35% |
| **Iowa** | 3/6/2025 | Vaginal Delivery | 59400 | $1,364.46 | $2,106.28 | 64.78% |
| | | Cesarean delivery | 59510 | $1,550.85 | $2,322.97 | 66.76% |
| | | VBAC Delivery | 59610 | $1,485.07 | $2,188.50 | 67.86% |
| **Kansas** | 3/6/2025 | Vaginal Delivery | 59400 | $1,751.03 | $2,127.46 | 82.31% |
| | | Cesarean delivery | 59510 | $1,924.96 | $2,349.75 | 81.92% |
| | | VBAC Delivery | 59610 | $1,821.50 | $2,214.17 | 82.27% |
| **Maine** | 3/11/2025 | Vaginal Delivery | 59400 | $1,570.42 | $2,169.09 | 72.40% |
| | | Cesarean delivery | 59510 | $1,737.43 | $2,399.76 | 72.40% |
| | | VBAC Delivery | 59610 | $1,637.54 | $2,261.79 | 72.40% |
| **Massachusetts** | 3/18/2025 | Vaginal Delivery | 59400 | $2,173.45 | $2,360.26 | 92.09% |
| | | Cesarean delivery | 59510 | $2,405.36 | $2,612.26 | 92.08% |
| | | VBAC Delivery | 59610 | $2,281.10 | $2,462.17 | 92.65% |
| **Michigan** | 3/18/2025 | Vaginal Delivery | 59400 | $2,220.73 | $2,337.61 | 95.00% |
| | | Cesarean delivery | 59510 | $2,475.76 | $2,606.06 | 95.00% |
| | | VBAC Delivery | 59610 | $2,335.79 | $2,458.73 | 95.00% |
| **Minnesota** | 3/18/2025 | Vaginal Delivery | 59400 | $1,387.89 | $2,148.52 | 64.60% |
| | | Cesarean delivery | 59510 | $1,387.89 | $2,360.28 | 58.80% |
| | | VBAC Delivery | 59610 | $1,387.89 | $2,222.46 | 62.45% |
| **Missouri** | 3/18/2025 | Vaginal Delivery | 59400 | $1,802.10 | $2,229.52 | 80.83% |
| | | Cesarean delivery | 59510 | $1,987.76 | $2,480.56 | 80.13% |
| | | VBAC Delivery | 59610 | $1,882.18 | $2,339.71 | 80.45% |
| **Montana** | 3/21/2025 | Vaginal Delivery | 59400 | $3,199.23 | $2,348.31 | 136.24% |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | Cesarean delivery | 59510 | $3,556.14 | $2,607.76 | 136.37% |
| | | VBAC Delivery | 59610 | $3,352.74 | $2,459.04 | 136.34% |
| **Nebraska** | 3/21/2025 | Vaginal Delivery | 59400 | $1,853.20 | $2,059.83 | 89.97% |
| | | Cesarean delivery | 59510 | $2,316.50 | $2,265.66 | 102.24% |
| | | VBAC Delivery | 59610 | $2,223.84 | $2,133.74 | 104.22% |
| **Nevada** | 3/21/2025 | Vaginal Delivery | 59400 | $2,251.97 | $2,304.71 | 97.71% |
| | | Cesarean delivery | 59510 | $2,490.53 | $2,554.44 | 97.50% |
| | | VBAC Delivery | 59610 | $2,361.65 | $2,408.15 | 98.07% |
| **New Hampshire** | 3/21/2025 | Vaginal Delivery | 59400 | $2,435.95 | $2,350.61 | 103.63% |
| | | Cesarean delivery | 59510 | $2,690.47 | $2,606.21 | 103.23% |
| | | VBAC Delivery | 59610 | $2,546.58 | $2,457.06 | 103.64% |
| **New Jersey** | 3/21/2025 | Vaginal Delivery | 59400 | $2,426.12 | $2,516.52 | 96.41% |
| | | Cesarean delivery | 59510 | $2,696.50 | $2,794.16 | 96.50% |
| | | VBAC Delivery | 59610 | $2,542.20 | $2,634.75 | 96.49% |
| **New Mexico** | 3/21/2025 | Vaginal Delivery | 59400 | $3,555.08 | $2,334.78 | 152.27% |
| | | Cesarean delivery | 59510 | $3,756.09 | $2,602.98 | 144.30% |
| | | VBAC Delivery | 59610 | $3,742.28 | $2,455.84 | 152.38% |
| **New York** | 3/21/2025 | Vaginal Delivery | 59400 | $2,238.52 | $2,225.77 | 100.57% |
| | | Cesarean delivery | 59510 | $2,486.34 | $2,464.45 | 100.89% |
| | | VBAC Delivery | 59610 | $2,356.27 | $2,323.01 | 101.43% |
| **North Carolina** | 3/21/2025 | Vaginal Delivery | 59400 | $1,549.75 | $2,184.80 | 70.93% |
| | | Cesarean delivery | 59510 | $1,503.26 | $2,417.30 | 62.19% |
| | | VBAC Delivery | 59610 | $1,549.75 | $2,278.35 | 68.02% |
| **North Dakota** | 3/21/2025 | Vaginal Delivery | 59400 | $2,468.16 | $2,198.30 | 112.28% |
| | | Cesarean delivery | 59510 | $2,724.51 | $2,424.34 | 112.38% |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | VBAC Delivery | 59610 | $2,566.42 | $2,283.97 | 112.37% |
| **Oklahoma** | 3/21/2025 | Vaginal Delivery | 59400 | $2,128.12 | $2,203.80 | 96.57% |
| | | Cesarean delivery | 59510 | $2,363.19 | $2,445.01 | 96.65% |
| | | VBAC Delivery | 59610 | $2,227.82 | $2,305.31 | 96.64% |
| **Oregon** | 3/21/2025 | Vaginal Delivery | 59400 | $2,828.10 | $2,227.64 | 126.95% |
| | | Cesarean delivery | 59510 | $3,128.25 | $2,462.00 | 127.06% |
| | | VBAC Delivery | 59610 | $2,947.66 | $2,320.12 | 127.05% |
| **Pennsylvania** | 3/21/2025 | Vaginal Delivery | 59400 | $2,025.00 | $2,270.24 | 89.20% |
| | | Cesarean delivery | 59510 | $2,025.00 | $2,521.64 | 80.30% |
| | | VBAC Delivery | 59610 | $2,025.00 | $2,377.92 | 85.16% |
| **Rhode Island** | 3/21/2025 | Vaginal Delivery | 59400 | $815.00 | $2,368.75 | 34.41% |
| | | Cesarean delivery | 59510 | $815.00 | $2,624.37 | 31.06% |
| | | VBAC Delivery | 59610 | $846.45 | $2,473.94 | 34.21% |
| **South Dakota** | 3/21/2025 | Vaginal Delivery | 59400 | $2,220.16 | $2,154.37 | 103.05% |
| | | Cesarean delivery | 59510 | $2,445.01 | $2,370.63 | 103.14% |
| | | VBAC Delivery | 59610 | $2,302.69 | $2,232.71 | 103.13% |
| **Tennessee** | 3/25/2025 | Vaginal Delivery | 59400 | $4,240.86 | $2,120.43 | 200.00% |
| | | Cesarean delivery | 59510 | $4,684.88 | $2,342.44 | 200.00% |
| | | VBAC Delivery | 59610 | $4,414.67 | $2,207.33 | 200.00% |
| **Utah** | 3/21/2025 | Vaginal Delivery | 59400 | $2,117.06 | $2,276.87 | 92.98% |
| | | Cesarean delivery | 59510 | $2,117.06 | $2,528.97 | 83.71% |
| | | VBAC Delivery | 59610 | $2,219.16 | $2,384.83 | 93.05% |
| **Vermont** | 3/21/2025 | Vaginal Delivery | 59400 | $1,934.29 | $2,192.79 | 88.21% |
| | | Cesarean delivery | 59510 | $2,133.20 | $2,418.50 | 88.20% |
| | | VBAC Delivery | 59610 | $2,009.69 | $2,278.50 | 88.20% |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Virginia** | 3/21/2025 | Vaginal Delivery | 59400 | $2,336.19 | $2,264.81 | 103.15% |
| | | Cesarean delivery | 59510 | $2,597.65 | $2,507.43 | 103.60% |
| | | VBAC Delivery | 59610 | $2,449.16 | $2,363.49 | 103.62% |
| **Washington** | 3/21/2025 | Vaginal Delivery | 59400 | $2,406.07 | $2,333.07 | 103.13% |
| | | Cesarean delivery | 59510 | $2,406.07 | $2,583.06 | 93.15% |
| | | VBAC Delivery | 59610 | $2,512.99 | $2,434.77 | 103.21% |
| **West Virginia** | 3/21/2025 | Vaginal Delivery | 59400 | $2,357.83 | $2,348.84 | 100.38% |
| | | Cesarean delivery | 59510 | $2,638.80 | $2,626.06 | 100.49% |
| | | VBAC Delivery | 59610 | $2,489.58 | $2,478.55 | 100.45% |
| **Wisconsin** | 3/21/2025 | Vaginal Delivery | 59400 | $1,149.32 | $2,101.95 | 54.68% |
| | | Cesarean delivery | 59510 | $1,149.32 | $2,312.03 | 49.71% |
| | | VBAC Delivery | 59610 | $1,222.55 | $2,177.41 | 56.15% |
| **Wyoming** | 3/21/2025 | Vaginal Delivery | 59400 | $2,069.78 | $2,270.54 | 91.16% |
| | | Cesarean delivery | 59510 | $2,308.79 | $2,512.67 | 91.89% |
| | | VBAC Delivery | 59610 | $2,178.68 | $2,368.28 | 91.99% |

*Note: Medicaid reimbursement rates for codes 59400, 59510, and 59610 have been pulled from publicly available state Medicaid fee schedules in 2025. The states that do not use global billing are not included. These rates are the fee-for-service rates and do not reflect managed care rates as those are not publicly available. The rates are compared to the locally adjusted Medicare rates. For states with more than one MAC, the MAC representing the larger portion of the state was chosen (e.g. not individual cities).*

APPENDIX C: AMA POLICY

The following AMA policy is relevant to this Board Report:

Disparities in Maternal Mortality D-420.993

1. Our American Medical Association will ask the Commission to End Health Care Disparities to evaluate the issue of health disparities in maternal mortality and offer recommendations to address existing disparities in the rates of maternal mortality in the United States.
2. Our AMA will work with the CDC, HHS, state and county health departments to decrease maternal mortality rates in the US.

3. Our AMA encourages and promotes to all state and county health departments to develop, implement, and sustain a maternal mortality surveillance system that centers around health equity.
4. Our AMA will work with stakeholders to encourage research on identifying barriers and developing strategies toward the implementation of evidence-based practices to prevent disease conditions that contribute to poor obstetric outcomes, maternal morbidity and maternal mortality in racial and ethnic minorities.

Maternal and Child Health Care H-420.986

The AMA opposes any further decreases in funding levels for maternal and child health programs; encourages more efficient use of existing resources for maternal and child health programs; encourages the federal government to allocate additional resources for increased health planning and program evaluation within Maternal and Child Health Block Grants; and urges increased participation of physicians through advice and involvement in the implementation of block grants.

Medical Care for Indigent and Culturally Displaced Obstetrical Patients and Their Newborns H-420.995

Our AMA (1) reaffirms its long-standing position regarding the major importance of high-quality obstetrical and newborn care by qualified obstetricians, family physicians, and pediatricians and the need to make such care available to all women and newborns in the United States; (2) favors educating the public to the long-term benefit of antepartum care and hospital birth, as well as the hazards of inadequate care; and (3) favors continuing discussion of means for improving maternal and child health services for the medically indigent and the culturally displaced.

Classification and Surveillance of Maternal Mortality H-420.948

1. Our American Medical Association will encourage research efforts to characterize the health needs for pregnant inmates, including efforts that utilize data acquisition directly from pregnant inmates while ensuring appropriate nondiscrimination and privacy safeguards.
2. Our AMA support legislation requiring all correctional facilities, including those that are privately-owned, to collect and publicly report pregnancy-related healthcare statistics with transparency in the data collection process while ensuring appropriate nondiscrimination and privacy safeguards.
3. Our AMA encourages data collection on pregnancy and other reproductive health outcomes of incarcerated people and research efforts to characterize the health needs for pregnant inmates, including efforts that utilize data acquisition directly from pregnant inmates.
4. Our AMA supports legislation requiring all correctional facilities, including those that are privately-owned, to collect and report pregnancy-related healthcare statistics with transparency in the data collection process.
5. Our AMA opposes the separation of infants from incarcerated pregnant individuals post-partum.
6. Our AMA supports solutions, such as community-based programs, which allow infants and incarcerated postpartum individuals to remain together.

Patient Navigation Programs H-373.994

1. Our AMA recognizes the increasing use of patient navigator and patient advocacy services to help improve access to care and help patients manage complex aspects of the health care system. In order to ensure that patient navigator services enhance the delivery of high-quality patient care, our AMA supports the following guidelines for patient navigator programs:
    a. The primary role of a patient navigator should be to foster patient empowerment, and to provide patients with information that enhances their ability to make appropriate health care choices and to receive medical care with an enhanced sense of confidence about risks, benefits, and responsibilities.
    b. Patient navigator programs should establish procedures to ensure direct communication between the navigator and the patient's medical team.
    c. Patient navigators should refrain from any activity that could be construed as clinical in nature, including interpreting test results or medical symptoms, offering second opinions, or making treatment recommendations. Patient navigators should provide a supportive role for patients and, when necessary, help them understand medical information provided by physicians and other members of their medical care team.
    d. Patient navigators should fully disclose relevant training, experience, and credentials, in order to help patients understand the scope of services the navigator is qualified to provide.
    e. Patient navigators should fully disclose potential conflicts of interest to those whom they serve, including employment arrangements.
2. Our AMA will work with the American College of Surgeons and other entities and organizations to ensure that patient navigators are free of bias, do not have any role in directing referrals, do not usurp the physician’s role in and responsibility for patient education or treatment planning, and act under the direction of the physician or physicians primarily responsible for each patient’s care.
3. Policy provisions for patient navigators are also relevant for community health workers and other non-clinical public health workers.

REFERENCES

[1] Chen A. Doula Medicaid Project. National Health Law Program. Published April 17, 2025. Accessed July 23, 2025. https://healthlaw.org/doulamedicaidproject/.
[2] Doula State Certification. Family Planning. Published June 27, 2025. Accessed July 23, 2025. https://www.vdh.virginia.gov/family-planning/doula-state-certification/.
[3] Medicaid and CHIP Payment and Access Commission. Doulas in Medicaid: Case Study Findings. MACPAC; 2023. Accessed July 23, 2025. https://www.macpac.gov/wp-content/uploads/2023/11/Doulas-in-Medicaid-Case-Study-Findings.pdf.
[4] Falconi AM, Ramirez L, Cobb R, Levin C, Nguyen M, Inglis T. Role of Doulas in Improving Maternal Health and Health Equity Among Medicaid Enrollees, 2014–2023. American Journal of Public Health. 2024;114(11):1275-1285. doi: https://doi.org/10.2105/ajph.2024.307805.
[5] Rudowitz R, Burns A, Hinton E, Mohamed M. 10 Things to Know About Medicaid. KFF. Published February 18, 2025. Accessed July 23, 2025. https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid/.
[6] *Id*.
[7] State Plan Amendments (SPA) | Medicaid. Medicaid.gov. Published June 23, 2025. Accessed July 23, 2025. https://www.medicaid.gov/medicaid/prescription-drugs/state-prescription-drug-resources/state-plan-amendments-spa.
[8] Center for Medicaid and CHIP Services. 2024 Medicaid and CHIP Beneficiaries at a Glance: Maternal Health. Centers for Medicare & Medicaid Services. Published May 2024. Accessed July 23, 2025. https://www.medicaid.gov/medicaid/benefits/downloads/2024-maternal-health-at-a-glance.pdf.
[9] Chen A, Robles-Fradet A. NHeLP's Doula Medicaid Project: Current State Efforts at Expanding Access to Doula Care. National Health Law Program. Published June 2025. Accessed July 23, 2025. https://docs.google.com/spreadsheets/d/1vsZTIecerW5t49Gg01pya2fURuZ-L6tDimC2e3QeIeE/edit?gid=1534310451#gid=1534310451.
[10] Medicaid and CHIP Payment and Access Commission, *supra* note 3.
[11] Tsai D. Improving Maternal Health and Extending Postpartum Coverage in Medicaid and the Children's Health Insurance Program (CHIP). Centers for Medicare & Medicaid Services. Published December 7, 2021. Accessed July 23, 2025. https://www.medicaid.gov/federal-policy-guidance/downloads/sho21007.pdf.
[12] Medicaid and CHIP Payment and Access Commission, *supra* note 3.
[13] *Id*.
[14] Knocke K, Chappel A, Sugar S, De Lew N, Sommers B. Doula Care and Maternal Health: An Evidence Review. Assistant Secretary for Planning and Evaluation; 2022. Accessed July 23, 2025. https://aspe.hhs.gov/sites/default/files/documents/dfcd768f1caf6fabf3d281f762e8d068/ASPE-Doula-Issue-Brief-12-13-22.pdf.
[15] AAPC. Doula Birth Worker Services HCPCS Code range T1032-T1033. Codify by AAPC. Published 2025. Accessed July 23, 2025. https://www.aapc.com/codes/hcpcs-codes-range/567/?srsltid=AfmBOoqi5XLS-jMl8SAUyGljg45dlEihEN2zsfYQ7nun_XZrWxuR5SAN.
[16] Services D. Doula Services.; 2022. Accessed July 23, 2025. https://providers.anthem.com/docs/gpp/CA_CAID_DoulaProviderManual.pdf?v=202306231849.
[17] Tsai, *supra* note 11.
[18] Chen A, Rohde K. Doula Medicaid Training and Certification Requirements: Summary of Current State Approaches and Recommendations for Improvement. National Health Law Program. Published March 16, 2023. Accessed July 23, 2025. https://healthlaw.org/doula-medicaid-training-and-certification-requirements-summary-of-current-state-approaches-and-recommendations-for-improvement/.
[19] DONA International . Birth Doula Certification a Doula's Guide . DONA International ; 2023. Accessed July 23, 2025. https://www.dona.org/wp-content/uploads/2023/04/Updated-Birth-Doula-Certification-Overview-04-15-2023.pdf.
[20] CAPPA. Certified Labor Doula (CLD) | CAPPA. CAPPA. Published July 29, 2020. Accessed July 23, 2025. https://cappa.net/training-certification/certified-labor-doula-cld/.
[21] National Doula Certification Board . Certified Professional Doula (CPD) Initial Certification Requirements Step 1 -Educational Validation. Accessed July 23, 2025. https://www.doulaboard.org/wp-content/uploads/2023/07/Certified-Professional-Doula.pdf.
[22] International Doula Institute. Standards of Practice – Birth Doula . Published February 15, 2023. Accessed July 25, 2025. https://internationaldoulainstitute.com/standards-of-practice-birth-doula/.

[23] Herbert K. Private Insurance Coverage of Doula Care: Spring 2025 State of the States. National Health Law Program. Published April 21, 2025. Accessed July 23, 2025. https://healthlaw.org/private-insurance-coverage-of-doula-care-spring-2024-state-of-the-states/.
[24] Knocke K, Chappel A, Sugar S, De Lew N, Sommers B. Doula Care and Maternal Health: An Evidence Review. Assistant Secretary for Planning and Evaluation; 2022. Accessed July 23, 2025. https://aspe.hhs.gov/sites/default/files/documents/dfcd768f1caf6fabf3d281f762e8d068/ASPE-Doula-Issue-Brief-12-13-22.pdf.
[25] NYC Health. Hospital Doula-Friendliness Guidebook.; 2024. Accessed July 25, 2025. https://www.nyc.gov/assets/doh/downloads/pdf/ms/hospital-doula-friendliness-guidebook.pdf.
[26] *Id*.
[27] Skopec L, Pugazhendhi A, Zuckerman S. Updated Medicaid-To-Medicare Fee Index: Medicaid Physician Fees Still Lag Behind Medicare Physician Fees. Health Affairs. 2025;44(5):531-538. https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2024.01530.
[28] McMorrow S, Holahan J, Berenson RA. Commercial Health Insurance Markups over Medicare Prices for Physician Services Vary Widely by Specialty. Urban Institute. Published October 18, 2021. Accessed August 1, 2025. https://www.urban.org/research/publication/commercial-health-insurance-markups-over-medicare-prices-physician-services-vary-widely-specialty.
[29] American Medical Association. Medicare physician payment continues to fall further behind practice cost inflation. Published January 2025. Accessed August 1, 2025. https://fixmedicarenow.org/sites/default/files/2025-01/Medicare%20Gap%20Chart_2025.pdf.
[30] Arrington J. One Big Beautiful Bill Act.; 2025. Accessed July 23, 2025. https://www.congress.gov/bill/119th-congress/house-bill/1.
[31] Arizona Department of Health Services. Article 9: Doula Certification. Accessed July 23, 2025. https://www.azdhs.gov/documents/licensing/special/doulas/doulas-rules.pdf.
[32] Scott J. Arizona State Plan Amendment - 24-0006. Centers for Medicare & Medicaid Services. Published August 23, 2024. Accessed July 24, 2025. https://www.medicaid.gov/medicaid/spa/downloads/AZ-24-0006.pdf.
[33] Bureau of Licensing for Professions and Occupations. Doula Certification Reciprocity Application.; 2025. Accessed July 24, 2025. https://www.azdhs.gov/documents/licensing/special/doulas/doula-reciprocity-application.pdf?v=20230808.
[34] Johnson L., Irvin M. Certified Community-Based Doula Certification Act.; 2025. Accessed July 24, 2025. https://arkleg.state.ar.us/Home/FTPDocument?path=%2FACTS%2F2025R%2FPublic%2FACT965.pdf.
[35] California Department of Health Care Services. Doula Services Frequently Asked Questions. DHCS. Published March 11, 2025. Accessed July 24, 2025. https://www.dhcs.ca.gov/provgovpart/Pages/Doula-Providers-Enrolling-As-A-Doula-FAQ.aspx#:~:text=The%20Department%20of%20Health%20Care,Childbirth%20education.
[36] Medi-Cal. Doula Services. Published March 2025. Accessed July 24, 2025. https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/0075B242-F893-41DB-A418-4129A274E46C/doula.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO.
[37] Colorado Administrative Code. 10 CCR 2505-10-8.734 - Doula Services. Published September 30, 2024. Accessed July 24, 2025. https://www.law.cornell.edu/regulations/colorado/10-CCR-2505-10-8.734.
[38] Colorado Department of Health Care Policy & Financing. Health First Colorado Doula Benefit: Provider Training. Published 2019. Accessed July 24, 2025. https://drive.google.com/file/d/1gOCSLtazqTtwSxTOyxNrZgjuktYwryiN/view.
[39] General Statutes of Connecticut. Chapter 377a Doulas. Published July 1, 2023. Accessed July 24, 2025. https://www.cga.ct.gov/2024/sup/chap_377a.htm.
[40] Delaware Certification Board . Certified Doula for Medicaid Reimbursement. Published 2022. Accessed July 24, 2025. https://www.decertboard.org/doula.
[41] Delaware Certification Board. DCB Doula for Medicaid Reimbursement Application.; 2023. Accessed July 24, 2025. https://www.decertboard.org/sites/default/files/2024-01/DCB_Doula_Application_23_0.pdf.
[42] Chen A. Doula Medicaid Project: February 2024 State Roundup. National Health Law Program. Published February 21, 2024. Accessed July 24, 2025. https://healthlaw.org/doula-medicaid-project-february-2024-state-roundup.
[43] SIU School of Medicine. Pathways & Requirements Illinois Medicaid-Certified Doula Program. Published 2025. Accessed July 24, 2025. https://www.siumed.edu/fcm/pathways-requirements.

[44] Indiana Code. 12-7-2-69.7 Doula. Published 2024. Accessed July 24, 2025. https://law.justia.com/codes/indiana/title-12/article-7/chapter-2/section-12-7-2-69-7/.
[45] Iowa Health & Human Services. Maternal Health Doula Project. Published March 31, 2025. Accessed July 24, 2025. https://hhs.iowa.gov/programs-and-services/family-health/maternal-health/programs/doula.
[46] KanCare. Doula Enrollment Instructions . Accessed July 24, 2025. https://portal.kmap-state-ks.us/Documents/Provider/Forms/Doula/Doula_Attestation_Form_Packet.pdf.
[47] Humana. Humana Healthy Horizons in Kentucky Provider Maternal Health Resources. Published 2025. Accessed July 24, 2025. https://provider.humana.com/medicaid/kentucky-medicaid/maternal-health.
[48] Louisiana Administrative Code. Title 48, § V-17301 - Qualifications for Registration. Published February 1, 2024. Accessed July 24, 2025. https://www.law.cornell.edu/regulations/louisiana/La-Admin-Code-tit-48-SS-V-17301.
[49] Louisiana Administrative Code. Title 48 Public Health General Part I. General Administration Subpart 3. Licensing and Certification. Published May 2025. Accessed July 24, 2025. https://www.doa.la.gov/media/52pfpizc/48v2.pdf.
[50] Miller D. Requires Medicaid Coverage for Certain Doula Services. Vol H.B. 454.; 2025. Accessed July 24, 2025. https://www.legis.la.gov/legis/BillInfo.aspx?s=25rs&b=HB454&sbi=y.
[51] State of Maine. H.P. 1008 - L.D. 1523 Resolve, to Develop MaineCare Coverage for Doula Services. Published June 19, 2025. Accessed July 24, 2025. https://legislature.maine.gov/legis/bills/getPDF.asp?paper=HP1008&item=3&snum=132.
[52] Maryland Code of Regulations. Md. Code Regs. 10.09.39.01 - Definitions. Published February 21, 2022. Accessed July 24, 2025. https://www.law.cornell.edu/regulations/maryland/COMAR-10-09-39-01.
[53] Scott J. Delaware State Plan Amendment 24-0001. Centers for Medicare & Medicaid Services. Published June 20, 2024. Accessed July 24, 2025. https://www.medicaid.gov/medicaid/spa/downloads/DE-24-0001.pdf.
[54] Title 10 Maryland Department of Health Subtitle 09 Medical Care Programs. Accessed July 24, 2025. https://health.maryland.gov/regs/SiteAssets/Lists/Proposed%20Regulations/NewForm/10.09.39%20Text%20-%20Draft.pdf.
[55] Maryland Code of Regulations. 10.09.36.03 - Conditions for Participation. Published September 18, 2023. Accessed July 24, 2025. https://www.law.cornell.edu/regulations/maryland/COMAR-10-09-36-03.
[56] Massachusetts Regulations. 130 CMR, § 463.404 - Provider Eligibility. Published November 8, 2024. Accessed July 24, 2025. https://www.law.cornell.edu/regulations/massachusetts/130-CMR-463-404.
[57] Michigan Medicaid Policy. Medicaid Coverage of Doula Services. Published January 1, 2023. Accessed July 24, 2025. https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Assistance-Programs/Medicaid-BPHASA/2022-Bulletins/Final-Bulletin-MMP-22-47-Doula.pdf.
[58] Michigan Department of Health and Human Services. Michigan Department of Health and Human Services Doula Initiative Doula Provider Frequently Asked Questions Guidance.; 2023. Accessed July 24, 2025. https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Maternal-and-Infant-Health/Doula-Provider-FAQ-Guidance_Final.pdf.
[59] Minnesota Statutes. 148.995 Definitions. Published 2024. Accessed July 24, 2025. https://www.revisor.mn.gov/statutes/cite/148.995.
[60] Minnesota Department of Health. Minnesota Doula Registry. Published December 17, 2024. Accessed July 24, 2025. https://www.health.state.mn.us/facilities/providers/doula/index.html.
[61] Missouri Code of State Regulations. 13 CSR 70-25.160 - Doula Services. Published April 30, 2025. Accessed July 24, 2025. https://www.law.cornell.edu/regulations/missouri/13-CSR-70-25-160.
[62] Neumann C. Generally Revise Health Care Laws Related to Doulas. MT SB 319.; 2025. Accessed July 24, 2025. https://www.billtrack50.com/billdetail/1753924.
[63] Nevada Certification Board. Birth Doula Certification Requirements. Published March 14, 2025. Accessed July 24, 2025. https://nevadacertboard.org/certs/doula/requirements/.
[64] Nevada Certification Board. Birth Doula Competencies, Scope of Work, and Service Provision for NCB Certified Doulas.; 2022. Accessed July 24, 2025. https://nevadacertboard.org/wp-content/uploads/2022/09/Birth-Doula-Competencies-508.pdf.
[65] Whitley B. Relative to Doula and Lactation Service Provider Certification. Vol NH SB 337.; 2024. Accessed July 24, 2025. https://www.billtrack50.com/billdetail/1655188.
[66] Teresa Ruiz M. Doula Care.; 2021. Accessed July 24, 2025. https://www.njleg.state.nj.us/bill-search/2020/S4229/bill-text?f=S4500&n=4229_I1.
[67] NJMIHIA. Approved Trainings for Enrollment as a NJ FamilyCare Community Doula.; 2025. Accessed July 24, 2025. https://www.nj.gov/humanservices/dmahs/info/NJFC_Approved_Doula_Trainings.pdf.

[68] New Jersey Department of Human Services. Steps for Individual Doulas to Enroll in FFS NJ FamilyCare (Medicaid).; 2021. Accessed July 24, 2025. https://www.nj.gov/humanservices/dmahs/info/NJFC_Doula_Steps.pdf.
[69] NMHealth. Doula Program. Published 2025. Accessed July 24, 2025. https://www.nmhealth.org/about/phd/fhb/mch/doula/.
[70] NMHealth. Becoming a Certified Doula New Mexico Department of Health Doula Certification Toolkit. Published June 2025. Accessed July 24, 2025. https://www.nmhealth.org/publication/view/guide/9154/.
[71] NMHealth. Frequently Asked Questions (FAQs). Accessed July 24, 2025. https://www.nmhealth.org/publication/view/help/9088/.
[72] New York State Department of Health. Non-Patient-Specific Standing Order for the Provision of Doula Services for Pregnant, Birthing and Postpartum Persons. Published June 10, 2025. Accessed July 24, 2025. https://www.health.ny.gov/health_care/medicaid/program/doula/doula_standing_order.htm.
[73] New York State Department of Health. Pathway Options to Enroll as a NYS Medicaid Doula Services Provider.; 2024. Accessed July 24, 2025. https://www.health.ny.gov/health_care/medicaid/program/doula/docs/visualize_enrollment_pathways.pdf.
[74] Ohio Administrative Code. 4723-24-02 - Doula certification. Published September 30, 2024. Accessed July 24, 2025. https://www.law.cornell.edu/regulations/ohio/Ohio-Admin-Code-4723-24-02.
[75] Oklahoma Health Care Authority. 317:30-5-1216. Eligible providers. Published 2024. Accessed July 24, 2025. https://oklahoma.gov/ohca/policies-and-rules/xpolicy/medical-providers-fee-for-service/individual-providers-and-specialties/doula/doula-providers.html.
[76] Oregon Health Authority. Birth Doulas. Accessed July 24, 2025. https://www.oregon.gov/oha/ei/pages/thw_birthdoulas.aspx.
[77] Oregon Health Authority. 950-060-0150 Birth Doula Certification Curriculum Standards. Accessed July 24, 2025. https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=301070.
[78] Pennsylvania Certification Board. Certified Perinatal Doula Application . Published January 2024. Accessed July 24, 2025. https://www.pacertboard.org/sites/default/files/2025-06/PCB_Doula_App_24.pdf.
[79] Hughes R. Pennsylvania State Plan Amendment 25-0003. Centers for Medicare & Medicaid Services . Published April 2, 2025. Accessed July 24, 2025. https://www.medicaid.gov/medicaid/spa/downloads/PA-25-0003.pdf.
[80] Rhode Island Certification Board. Certified Perinatal Doula (CPD). Published 2022. Accessed July 24, 2025. https://www.ricertboard.org/certified-perinatal-doula-cpd.
[81] South Dakota Department of Social Services. South Dakota Medicaid Billing and Policy Manual Doula Services.; 2025. Accessed July 24, 2025. https://dss.sd.gov/docs/medicaid/providers/billingmanuals/Professional/Doula_Services.pdf.
[82] Scott J. South Dakota State Plan Amendment 24-0017. Centers for Medicare & Medicaid Services. Published January 15, 2025. Accessed July 24, 2025. https://dss.sd.gov/docs/medicaid/medicaidstateplan/Approved/Doula_Services.pdf.
[83] TN Department of Health. Doula Services Advisory Committee. Published 2023. Accessed July 24, 2025. https://www.tn.gov/health/health-program-areas/fhw/get-involved-with-fhw/taskforces-and-committees/doula-services.html.
[84] Texas Doula Association. HB 1575 Information. Published 2023. Accessed July 24, 2025. https://www.txdoulas.org/our-work-1.
[85] Scott J. Texas State Plan Amendment - 24-0006. Centers for Medicare & Medicaid Services. Published November 22, 2024. Accessed July 24, 2025. https://www.medicaid.gov/medicaid/spa/downloads/TX-24-0006.pdf.
[86] Escamilla L, Clancy T. Utah State Legislature S.B. 284 Medicaid Doula Services. Published May 11, 2025. Accessed July 24, 2025. https://le.utah.gov/~2025/bills/static/SB0284.html.
[87] Vermont Legislature. VT S0053 An act relating to certification of community-based perinatal doulas and Medicaid coverage for doula services. Published June 11, 2025. Accessed July 24, 2025. https://www.billtrack50.com/billdetail/1822405#:~:text=%C2%A7%204176.,%C2%A7%204177.
[88] Administrative Code of Virginia. 12VAC5-403-70. Certification not required. Published January 6, 2022. Accessed July 24, 2025. https://law.lis.virginia.gov/admincode/title12/agency5/chapter403/section70/.
[89] Virginia Department of Health. State-Doula Certification Program. Published June 27, 2025. Accessed July 24, 2025. https://www.vdh.virginia.gov/family-planning/doula-state-certification/.
[90] Virginia Certification Board. State-Certified Doula (SCD). Published 2022. Accessed July 24, 2025. https://www.vacertboard.org/doula.

[91] Washington State Legislature. Chapter 18.47 RCW Birth Doulas. Published October 1, 2023. Accessed July 24, 2025. https://app.leg.wa.gov/RCW/default.aspx?cite=18.47&full=true.
[92] Washington State Legislature. Chapter 246-835 WAC Birth Doula. Published December 26, 2024. Accessed July 24, 2025. https://app.leg.wa.gov/WAC/default.aspx?cite=246-835&full=true.
[93] Byrd M. Provider Qualifications and Enrollment, Rates and Reimbursement Standards. Government of the District of Columbia Department of Health Care Finance; 2022. Accessed July 24, 2025. https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/publication/attachments/Transmittal-22-34-Doula-Benefit-Provider-Qualifications-and-Enrollment-Rates-and-Reimbursement-Standards.pdf.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 13-I-25

Subject: Antidiscrimination Protections for LGBTQ+ Youth in Foster Care

Presented by: David H. Aizuss, MD

Referred to: Reference Committee B

---

During the 2025 American Medical Association (AMA) Annual Meeting, the House of Delegates (HOD) referred for report, Board of Trustees Report 17-A-25, "Antidiscrimination Protections for LGBTQ+ Youth in Foster Care." The report recommended that Resolve 2 of Resolution 224-A-24[1] be adopted and the remainder of the report be filed. The resolve recommended:

> RESOLVED, that our AMA support efforts by the Department of Health and Human Services and other appropriate stakeholders to establish a reporting mechanism for the collection of anonymized and aggregated sexual orientation and gender identity data in the Adoption and Foster Care Analysis and Reporting System (AFCARS) only when strong privacy protections exist.

The report further explored considerations for integrating sexual orientation and gender identity (SOGI) data into AFCARS, emphasizing the need for strong privacy protections in response to Resolve 2 of Resolution 224-A-24. BOT Report 17-A-25 received broad support from delegates through both online testimony and in-person discussion within the Reference Committee. However, some delegates expressed concern that the AMA should reassess the potential safety risks associated with collecting SOGI data from LGBTQ+ youth in foster care, particularly in light of the current political climate. When BOT Report 17-A-25 was originally drafted, the current presidential administration had been newly sworn into office. While several federal protections for gender identity and gender-affirming care were still in place, some policies were rescinded via executive orders. This updated report seeks to reevaluate those risks in the context of the post-2024 policy landscape, including the revocation of key protections, while still acknowledging and incorporating relevant pre-2024 considerations.

DISCUSSION

In recent years, the medical community has increasingly recognized the importance of collecting SOGI data as a means of advancing equitable care and closing health disparity gaps. For LGBTQ+ youth in foster care, who are both overrepresented in the system and more likely to face trauma and instability, this data can be a lifeline. It allows health care professionals to better understand their needs, tailor care, and advocate for resources that can improve health outcomes and placement success.

Yet in today's volatile political climate, marked by efforts at the federal level and within many states to ban gender-affirming care and penalize both health care professionals and caregivers, the

[1] https://www.ama-assn.org/system/files/a24-resolutions.pdf#page=29

collection of SOGI data carries new risks. These include threats to patient privacy, legal vulnerability, and the potential misuse of data in ways that could cause harm to the very youth that are supposed to be supported.

*Emerging Risks: Privacy, Politics, and Policy Gaps*

The legal and political landscape surrounding LGBTQ+ health and wellbeing, specifically gender-affirming care has shifted dramatically in recent years and most notably, within the past several months. As of mid-2025, more than half of U.S. states have enacted or proposed legislation restricting or outright prohibiting access to gender-affirming care for minors.[2] In several of these jurisdictions, physicians, mental health professionals, and even parents or guardians have faced the threat of prosecution, loss of licensure, or other legal consequences for supporting a child's gender identity.[3]

These state-level developments are occurring alongside significant changes at the federal level. In February 2025, the U.S. Department of Health and Human Services (HHS) rescinded earlier guidance that had strengthened the interpretation of Health Insurance Portability and Accountability Act (HIPAA) protections for gender-affirming care.[4] This reversal has created uncertainty around the confidentiality of SOGI data, particularly how such data may be interpreted, accessed, or weaponized by government authorities in states with hostile policies toward transgender individuals. It raises legitimate concerns for health care professionals and patients alike about the safety of disclosing or documenting sensitive identity-related information.

The regulatory environment has been further complicated by a series of executive actions issued following the change in presidential administration in January 2025. Within the first two weeks of the new administration, four executive orders were signed that significantly impact the rights, protections, and daily realities of transgender individuals. These executive orders represent a coordinated federal approach to rolling back prior protections and reshaping how gender identity is recognized or dismissed across institutions.

- **Executive Order 14168 – Defending Women from Gender Ideology Extremism and Restoring Biological Truth to the Federal Government**
  Issued January 20, 2025, this order mandates that all references to "gender identity" be removed from federal policies and documents, instead defining "sex" strictly according to biological assignment at birth. This redefinition could have broad implications across federal agencies, including health care, education, housing, and civil rights enforcement.
- **Executive Order 14183 – Prioritizing Military Excellence and Readiness**
  Signed January 27, 2025, this order reinstates a ban on transgender individuals serving in the U.S. military, reversing inclusive policies established under previous administrations.
- **Executive Order 14187 – Protecting Children From Chemical and Surgical Mutilation**
  Signed January 28, 2025, this directive seeks to limit access to gender-affirming care for individuals under the age of 19, restrict federal funding to health care

[2] https://www.hrc.org/resources/attacks-on-gender-affirming-care-by-state-map
[3] https://www.hrw.org/report/2025/06/03/theyre-ruining-peoples-lives/bans-gender-affirming-care-transgender-youth-us
[4] https://www.hhs.gov/sites/default/files/ocr-rescission-february-20-2025-notice-guidance.pdf

professionals offering such care, and explore avenues to reduce insurance coverage for these services under federal programs.

- **Executive Order 14190 – Ending Radical Indoctrination in K-12 Schooling** Signed January 29, 2025, this order directs federal agencies to recommend the withdrawal of funding from educational institutions that support "gender ideology," potentially impacting Title IX protections, school-based health services, and inclusive policies for transgender and gender-diverse students.

While several aspects of these executive orders are being challenged in federal court, and some provisions have been temporarily blocked, the political intent and cultural impact are already evident.[5] Health care professionals in multiple states have reported increased barriers to care for transgender patients, including heightened scrutiny, patient hesitancy, and administrative confusion over what care can legally be provided or documented.[6]

These challenges are compounded by growing concerns over the misuse of electronic health records and SOGI data. In states such as Missouri[7] and Florida,[8] state officials have reportedly sought access to patient health records to identify individuals receiving gender-affirming care, particularly minors. The potential for this type of surveillance raises profound ethical and legal concerns, especially within foster care systems where youth may already lack consistent advocacy and privacy protections. As electronic health records (EHR) become more interoperable across health care professionals and state lines, the likelihood that sensitive data might be shared, intentionally or unintentionally, only increases.

It is important to recognize that federal privacy laws like HIPAA set a floor, not a ceiling. States may introduce laws that either enhance or undermine these protections. For example, while HIPAA provides general safeguards around protected health information, it does not explicitly prohibit disclosure in all cases, particularly when law enforcement or state authorities claim a legal right to access records.[9] Likewise, Title IX's application to transgender rights has been subject to shifting interpretations under different administrations, and its protection is not uniformly enforced across states.

However, it is important to reiterate that most foster youth data systems are outside of health care, and are thus not governed by HIPAA. This distinction underscores a critical gap: youth in foster care often have their data shared between educational, child welfare, and legal systems, which lack the robust data security standards found in clinical settings. Therefore, even if health systems adopt best practices, the downstream data environment remains fragmented and legally vulnerable. Data

[5] https://healthlgbtq.org/advocacy_brief/overview-2025-executive-actions-impacting-lgbtq-health/#:~:text=Since%20taking%20office%20in%20January,serve%20people%20fairly%20and%20safely

[6] https://www.hrw.org/report/2025/06/03/theyre-ruining-peoples-lives/bans-gender-affirming-care-transgender-youth-us

[7] https://missouriindependent.com/2024/07/08/judge-rules-missouri-ag-has-no-right-to-medical-records-of-transgender-minors-at-wash-u/#:~:text=By:%20Annelise%20Hanshaw%20%2D%20July%208,AG%20investigation%20of%20transgender%20care

[8] https://www.hrc.org/press-releases/federal-court-blocks-first-state-law-restricting-health-care-for-transgender-adults-state-of-florida-loses-federal-challenge-as-court-blocks-law-targeting-adults-and-adolescents#:~:text=A%20federal%20district%20court%20has,individuals%20just%20for%20being%20transgender

[9] https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html#:~:text=Covered%20entities%20may%20disclose%20protected,requests;%20(2)%20to%20identify

fed into these systems involve nonprofit and government agencies involved in foster care, with only occasional overlap with health care professionals and health care organizations.

In this environment, LGBTQ+ youth in foster care are at a particularly precarious intersection of visibility and vulnerability. On one hand, collecting SOGI data can affirm their identities, improve placement outcomes, and tailor mental and behavioral health support. On the other, this same data, if improperly secured or accessed in a hostile jurisdiction, could expose them to discrimination, stigma, or even separation from affirming caregivers, contributing to mental health crises.[10]

Navigating this climate demands caution, clarity, and ongoing legal awareness. The benefits of SOGI data collection remain substantial, but so do the risks and both must be weighed thoughtfully as we consider how best to support vulnerable youth while upholding our ethical obligations to do no harm.

*Looking Ahead with Care and Caution*

In an ideal policy environment, collecting SOGI data would be a clear and uncontroversial step toward achieving health equity. When conducted thoughtfully, such data collection empowers clinicians to deliver more personalized, affirming, and effective care, especially for LGBTQ+ youth who are disproportionately represented in foster care and face elevated risks of trauma, discrimination, and poor health outcomes.

However, the current political and legal landscape demands a more measured approach. Without robust, enforceable safeguards at the federal level, the collection of SOGI data, however well-intentioned, may inadvertently expose LGBTQ+ youth and the professionals who support them to serious risks, including legal threats, privacy breaches, or punitive action from hostile jurisdictions. Given this landscape, interim protective actions should include stronger de-identification protocols, tiered data access permissions, and the implementation of consent pathways even when not required by law. Institutional review boards (IRBs), health systems, and state agencies must be proactive in reviewing the implications of data collection policies, particularly in politically hostile environments.

Physicians hold a dual responsibility: to advance equitable care while actively protecting the safety and dignity of vulnerable populations. This means ensuring that data collection practices do not outpace the infrastructure, legal protections, and ethical frameworks necessary to support them. Where protections are lacking or inconsistent across states, caution must guide the physician's actions.

Moving forward, physicians should prioritize trauma-informed, consent-based, and context-aware approaches to SOGI data collection, especially for minors in systems of care. Advocacy for clearer national standards, stronger privacy laws, and enhanced training must continue alongside clinical efforts.

Ultimately, the health and well-being of LGBTQ+ youth in foster care depend not just on what is known, but on how responsible action is taken given that knowledge. Now more than ever, leadership in medicine requires not only clinical skill, but also moral clarity, legal awareness, and a steadfast commitment to protecting those most at risk.

[10] https://www.finance.senate.gov/chairmans-news/state-attorneys-general-misused-medicaid-authority-to-persecute-teens-seeking-gender-affirming-care-finance-inquiry-finds-politicized-requests-for-patient-information-caused-spike-in-teen-crisis-mental-health-calls

RECOMMENDATION

The Board of Trustees recommends that the following be adopted in lieu of BOT Report 17-A-25 and the remainder of the report be filed:

That our AMA support advocacy efforts by youth, families, foster care organizations, foster care workers, health care professionals, and public health authorities to strengthen youth-centered privacy protections for sexual orientation and gender identity (SOGI) data in foster care. (New HOD Policy)

Fiscal Note: To be determined

REPORT OF THE BOARD OF TRUSTEES

B of T Report 15-I-25

| | |
|---|---|
| Subject: | Protecting Evidence-Based Medicine, Public Health Infrastructure and Biomedical Research Report |
| Presented by: | David H. Aizuss, MD, Chair |
| Referred to: | Reference Committee B |

---

At the 2025 Annual Meeting, the American Medical Association (AMA) House of Delegates (HOD) adopted Policy D-440.905, "Protecting Evidence-based Medicine, Public Health Infrastructure and Biomedical Research," and asks our AMA to do the following:

> To affirm that protecting science, clinical integrity, and the patient-physician relationship is central to the organization's mission.
>
> To assertively and publicly lead the House of Medicine in collective, sustained advocacy for federal and state policies, proposals, and actions that safeguard public health infrastructure, advance biomedical research, improve vaccine confidence, and maintain the integrity of evidence-based medicine and decision-making processes
>
> To report back at the 2025 Interim Meeting of the AMA House of Delegates on the actions taken to implement this policy.

Reference Committee B heard extensive and strong testimony in support of Policy D-440.905 and this report is being submitted to the HOD as information as directed in the policy. (Note: Because of approval deadlines, this report was prepared in August of 2025.)

Since the January 2025 inauguration, the Trump Administration has taken a number of unprecedented actions to reduce funding for biomedical research, eliminate programs promoting public health and health equity, and shift policies regarding the regulation of vaccines. In addition to actions already taken by the Administration, they have proposed a significant reorganization of the Department of Health and Human Services (HHS) which, if approved by Congress, would reduce the Department's total discretionary funding by over $31 billion in Fiscal Year (FY) 2026 compared to FY 2025 and result in the elimination of several HHS programs. The Administration has already engaged in an unprecedented reduction in force of HHS employees across all agencies, resulting in the termination or incentivized retirement of tens of thousands of federal employees as of the drafting of this report. The proposed changes seek to redirect HHS to focus on Trump Administration priorities, such as chronic disease reduction efforts and eliminating work on diversity, equity, and inclusion programs and gender-focused research and care.

© 2025 American Medical Association. All rights reserved.

*Biomedical Research*

Reductions in support for biomedical research at the National Institutes of Health (NIH) have been a significant focus of the Trump Administration, with the Administration terminating $1.8 billion in grants within its first 40 days. The Administration has focused on eliminating funding for grants which it deems to not align with the Administration's priorities. About 30 percent of NIH funding for the National Institute on Minority Health and Health Disparities (NIMHD) was terminated, as were a number of previously awarded grants for gender-focused research.

In another unprecedented early move, the Administration moved forward with a new policy to cap indirect research expenses at 15 percent of the total grant award. This cap is expected to have a dramatic impact on medical research (especially higher-cost medical research), as it constrains resources necessary to carry out research projects. The indirect expenses cap has the potential to impact the number of research institutions that are able to carry out research projects, leaving only large, well-funded institutions capable of funding research.

The Trump Administration has also proposed a significant reorganization of the NIH that would reduce the number of institutes and centers that comprise the NIH from 27 to eight by eliminating some institutes and centers (including NIMHD) and consolidating others. The Administration is also proposing to cut $18 billion from NIH's appropriated funds—a 44 percent reduction in funding from FY 2025 levels. However, the ultimate decision regarding NIH funding levels and programmatic reorganization lies with Congressional appropriators, who, as of the date of this report, are just beginning the Congressional appropriations process. There are some early signals that Congress will reject significant funding cuts for scientific research, but the final status of NIH appropriations and potential reorganization will remain unknown until the conclusion of the FY 2026 appropriations process.

*Evidence-Based Medicine*

The Trump Administration has taken a number of actions that call into question the current evidence base underlying the practice of medicine. Other Administration actions directly contradict the current evidence base. To date, this has been most evident with HHS Secretary Robert F. Kennedy, Jr.'s approach to vaccine review and recommendations. At the onset of the current measles outbreak, Secretary Kennedy appeared to suggest alternative options to the measles vaccine, including treatment with Vitamin A supplementation, which lacks evidence demonstrating its utility as a treatment for measles. Shortly after his installation as Commissioner of the U.S. Food and Drug Administration (FDA), Dr. Marty Makary, along with the then newly appointed FDA Chief Medical and Scientific Officer Dr. Vinay Prasad,* announced a significant policy change regarding FDA's approach to review of COVID-19 vaccines. Announced in the New England Journal of Medicine (NEJM), the policy change would require any new COVID-19 vaccine for those under 65 or without additional risk factors to undergo a placebo-controlled randomized clinical trial. This policy change was made without the traditional opportunity for public review and comment and raised significant concern among the scientific and medical communities. Soon after this change in approach to reviewing COVID-19 vaccines was announced, Secretary Kennedy announced that COVID-19 vaccines were being removed from the Centers for Disease Control and Prevention's (CDC) recommended immunization schedule for healthy children and pregnant women, leading several top CDC officials to resign.

* On July 29, 2025, Dr. Prasad stepped down from all roles at the FDA and was replaced in his role as director of the FDA's Center for Biologics Evaluation and Research by Dr. George Tidmarsh (in an acting capacity).

Outside of FDA, the Administration has taken further actions that have raised concern about its impact on vaccine hesitancy, including the abrupt removal of the full membership of the CDC's Advisory Committee on Immunization Practices (ACIP) prior to their scheduled June 2025 meeting. In defense of the removal, the Secretary claimed that the ACIP members had significant conflicts of interest with pharmaceutical companies and were therefore biased in their assessments and recommendations. The members were quickly replaced by Secretary Kennedy without the traditional process of public nomination, and the new ACIP members include several individuals who have been the subject of some controversy over their positions on vaccination and who bring their own conflicts of interest to the panel. Historically, anyone joining ACIP must disclose any possible conflicts of interest and is subject to strict rules about their relationships with industry during their time on the committee. In an effort to further increase transparency, HHS launched a public tool sharing conflicts reported by ACIP members—however, as of the drafting of this report, the tool has yet to be updated with all of new members' disclosures. While the scheduled ACIP meetings proceeded as planned, the agenda ultimately included controversial topics previously thought to be settled science, such as the inclusion of thimerosal in influenza vaccination and mRNA vaccine technologies. In addition, meetings of ACIP Vaccine Work Groups have been paused and, on July 31, 2025, Secretary Kennedy notified several representatives of ACIP liaison organizations (such as the AMA, the American Academy of Pediatrics, the Infectious Diseases Society of America, the American Academy of Family Physicians, the American Nurses Association, and the Association of Immunization Managers) that they would no longer be permitted to serve on ACIP's Work Groups. The liaisons play a crucial role in ensuring that evidence-based science is applied as work group recommendations are developed and presented to ACIP voting members. On August 5, 2025, Secretary Kennedy cancelled $500 million in HHS contracts for mRNA vaccine development and announced the beginning of a coordinated wind-down of mRNA vaccine development activities under the Biomedical Advanced Research and Development Authority.

Regarding the evidence base at large, the "Make Our Children Healthy Again Assessment" (also known as the "MAHA report") issued on May 22, 2025, by Secretary Kennedy's MAHA Commission stated that the current evidence base for medical practice has been too strongly influenced by pharmaceutical companies and therefore is not clinically valid. This criticism was focused strongly on several well-respected, peer-reviewed medical journals, as well as specialty practice guidelines. While not accusatory of physicians directly, the report suggests that physicians can ultimately harm patients by relying on a faulty and biased evidence base.

Finally, in an act that has implications for all of HHS and its sub-agencies, on March 3, 2025, Secretary Kennedy rescinded longstanding agency policy (commonly known as the "Richardson Waiver") regarding voluntary adherence to Administrative Procedure Act (APA) rulemaking processes. The APA exempts certain agency actions—those relating to "agency management or personnel or to public property, loans, grants, benefits, or contracts"—from standard notice and comment rulemaking requirements, but under the Richardson Waiver (which had been HHS policy since 1971) HHS followed notice and comment processes when taking those actions anyway. The repeal of the Richardson Waiver will not impact processes for actions that are subject to the APA's rulemaking requirements under the terms of the statute, but it may change the processes HHS follows for actions such as grantmaking decisions and methodologies, changing eligibility standards for benefit programs administered by HHS (subject to statutory limitations), and awarding contracts.

*Public Health Infrastructure*

Immediately following his inauguration, President Trump moved quickly to begin dismantling

many programs, communications efforts, and research projects within the CDC, raising the alarm within the public health, scientific, and medical communities. As part of its significant reduction in force efforts, the Administration has terminated approximately 2,400 employees at CDC alone, along with several thousand employees across other HHS agencies impacting public health. On July 29, 2025, the United States Senate voted to confirm Susan Monarez as director of the CDC. As with many other health care agencies, the Administration has proposed a significant reorganization to CDC, including additional funding reductions and program eliminations. This reorganization proposal includes the creation of a new agency, the Administration for a Healthy America (AHA). The Administration is proposing to combine several functions of the CDC, Health Resources and Services Administration, Agency for Healthcare Quality and Research (AHRQ), and other agencies into the new AHA, with a focus on primary care and chronic disease reduction. The new AHA would also incorporate health workforce, environmental health, mental health, and maternal health programs, among others. However, this proposal also recommends eliminating a significant number of programs within each of these agencies, raising concerns about adequate resources and staffing for a significant number of federal health care efforts.

The Administration has also taken actions, or proposed actions, relating to funding for HIV/AIDS initiatives. The Administration initially included $400 million in cuts to the President's Emergency Plan for AIDS Relief (PEPFAR), a global HIV/AIDS relief program, as part of a $9 billion rescissions package under consideration by Congress. However, the PEPFAR cuts were dropped from the bill before final passage by Congress. On the domestic front, the Administration's proposed budget for FY 2026 would largely maintain funding at FY 2025 levels for HIV care, treatment, and pre-exposure prophylaxis programs, but would eliminate HIV prevention and surveillance efforts at the CDC. As with the proposals relating to funding and structural reorganization at the NIH, the final decision on whether to adopt the Administration's proposals with respect to CDC's HIV/AIDS prevention and surveillance efforts lies with Congress. There are indications that Congress will ultimately preserve CDC prevention and surveillance funding—on July 31, 2025, the Senate Committee on Appropriations, in a broadly bipartisan vote, approved an FY 2026 HHS funding bill that essentially maintains funding for the CDC's National Center for HIV, Viral Hepatitis, Sexually Transmitted Diseases, and Tuberculosis Prevention at FY 2025 levels.

*AMA Advocacy Actions through August 6, 2025*

The AMA has been engaged in advocacy to affirm our commitment to biomedical research, evidence-based medicine, and public health since President Trump's inauguration in January 2025. Advocacy has been aimed at both the Administration directly and at Congress. An outline of specific advocacy actions as of August 6, 2025, are outlined below. The AMA will continue to strongly advocate as a leader of the Federation of Medicine throughout the duration of this Administration.

- March 5, 2025 Letter to NIH on Indirect Expense Cap: The AMA joined numerous other physician and health care organizations in opposing the 15 percent cap on indirect research costs imposed by NIH on grantees. The letter highlighted the severe detrimental impact this cap would have on biomedical research and the United States' standing as a global leader in biomedical innovation.
- May 29, 2025 Letter to Secretary Kennedy on COVID-19 Vaccine Review: The AMA wrote to Secretary Kennedy expressing serious concern with the announced policy changes regarding review of COVID-19 vaccines and requirement for placebo-controlled randomized clinical trials (RCT) for new vaccines. The AMA noted that the announcement lacked transparency and opportunity for public input, while also highlighting the ethical

- concerns regarding RCTs when existing vaccines are available. Additionally, we highlighted the concerns about maintaining access to vaccines for those who want them—an early promise of Secretary Kennedy.
- June 13, 2025 Letter to Senator Cassidy on ACIP: The AMA wrote to Senator Cassidy requesting the Senator inquire as to the circumstance of the termination of the sitting members of ACIP.
- June 18, 2025 Letter to Secretary Kennedy on ACIP: The AMA led a Federation sign-on letter to Secretary Kennedy opposing his removal of all sitting members of ACIP. The letter called for the previously appointed members to be reinstated and for the appointment process to follow its long-standing tradition of a transparent public nomination process.
- June 25, 2025 Open Letter to the Public on Fall Respiratory Season: The AMA joined over 70 medical specialty groups in an open letter to the public urging the public to vaccinate for the fall respiratory season. The letter also highlighted concerns about the Administration's approach to vaccine recommendations.
- July 9, 2025 Friends of ARHQ Sign-On Letter in Support of USPSTF: The AMA joined Friends of ARHQ in writing to Congress to support the work of the United States Preventive Services Task Force (USPSTF) and urging Congress to protect USPSTF from political interference.
- July 27, 2025 Letter to Secretary Kennedy on USPSTF: The AMA wrote to Secretary Kennedy expressing deep concern regarding recent reporting that the Secretary intends to remove all of the members of the USPSTF. The letter highlights the essential role of the USPSTF in making evidence-based recommendations for clinical prevention of disease and the role these recommendations play in terms of health insurance coverage of preventive services.

Beyond the formal letters listed above, the AMA spoke out against reported changes Secretary Kennedy is considering making to the USPSTF. The AMA's media statement and interviews have emphasized the critical role this organization has in developing best practices for physicians to provide evidence-based care. National media including Reuters, NPR, CBS News, PBS News, and other outlets featured the AMA's concerns. Additional coverage is likely if further actions are taken by government. Media coverage of the USPSTF statement generated 285 media stories, 986 million media impressions and an estimated $9.1 million in publicity value (estimated traditional and online media across print publications, radio, television, news services, news websites, and blogs).

Since June, the AMA's leadership on vaccine advocacy has drawn widespread media attention. National coverage surged following Secretary Kennedy's controversial dismissal of CDC vaccine experts, prompting calls from senators and medical organizations for a formal review of ACIP. AMA's concerns and expertise are featured prominently in major outlets like CNN and USA Today. The AMA's letter to the American people on the importance of vaccines to battle influenza, respiratory syncytial virus, and COVID-19 was picked up by outlets like Medscape. Following Secretary Kennedy's July 31 exclusion of liaison organizations from ACIP Working Groups the AMA joined seven other medical association in a joint statement protesting the move. Media coverage of AMA's ACIP statements generated 2,551 media stories, 7.9 billion media impressions, and an estimated $72 million in publicity value.

AMA social media supported the AMA's advocacy responses by quickly producing text-based images featuring key quotes from official releases and amplifying related content across channels. For the July 27, 2025, USPSTF announcement, the AMA published a text image alongside the release, then amplified a video on July 28 and an AMA News story on July 29. In response to ACIP developments, the AMA supported the June 9 announcement of changes with a text image

and release. For the ACIP liaison announcement, the AMA shared a text image and statement on August 1, followed by amplifying the AMA News story on August 2 and a video on August 3. In response to H.R. 1 (the "One Big Beautiful Bill Act"), the AMA posted a sounding-the-alarm carousel and video on July 2, and followed up with a text image and statement on July 3. Given the significant influence Congress will have over protecting the funding to, and structure of, federal research and public health agencies, the AMA has engaged in substantial advocacy with Congress to ensure federal agencies, advisory committees, and task forces remain independent, non-partisan, and protected from political interference to the most significant extent possible. The AMA is also advocating to protect critical programs from elimination and to ensure continued bipartisan support for biomedical research functions at NIH.

Over the past five years, the AMA has partnered with CDC on an annual flu campaign to encourage the American public to get vaccinated against the flu, with a focus on Black and Hispanic populations. However, with the CDC unable to participate this year, the AMA will be the sole sponsor of the campaign. The campaign has been very successful. Over the past five years, the campaign has had over 350 million digital and broadcast impressions, $50 million in donated media, and 1.27 million site sessions on GetMyFlushot.org. Those aware of the campaign are significantly more likely to agree that getting vaccinated helps protect their loved ones and is the most effective way of preventing the flu. They were also significantly more likely (58 percent versus 45 percent) to receive a flu vaccine compared to those who did not see any of the campaign's public service announcements. Furthermore, a recent study published in JAMA Network Open found an increase in vaccination rates among Black and Hispanic older adults from 2019 to 2022. The annual flu campaign is tangible evidence of AMA support for, and effectiveness in promoting, flu vaccination.

*State Activity*

Over the past several years, states have increasingly considered legislation that undermines evidence-based medicine, weakens public health infrastructure, and interferes with the patient-physician relationship. These measures have included efforts to curtail the authority of public health authorities, discourage vaccinations, and restrict access to abortion care and gender-affirming care for minors.

State legislative activity slowed during the period between adoption of Policy D-440.905 in June and the writing of this report in July. At the time of writing, 42 of the 50 state legislatures had adjourned for the year, and, of the eight state legislatures still in session, six had finalized their FY2026 state budgets and two had passed deadlines for introducing new legislation. Nevertheless, significant legislation impacting public health and medical practice was enacted earlier in 2025. States including Idaho, Kansas, North Dakota, and Tennessee enacted laws restricting the authority of public health departments and numerous states passed laws governing vaccines, including legislation to establish liability of vaccine manufacturers in Texas; to expand nonmedical exemptions for mandated vaccines in North Dakota, Texas, Utah, and West Virginia; and to prohibit adolescents from consenting to vaccines in Alabama. However, positive legislation improving vaccine access was enacted in Colorado, Maine, Maryland, and Louisiana.

Notably, this year the United States experienced its largest measles outbreak in 30 years, with three deaths and 1,319 confirmed cases across 40 jurisdictions, due in part to declining vaccination rates. Measles has been officially "eliminated" from the United States since 2000 but this status may be at risk if the current outbreak is not contained. CDC data show national kindergarten immunization rates have dropped from roughly 95 percent pre-pandemic to just under 93 percent in 2023-24, while non-medical exemptions rates reached all-time highs. In Texas, for example, exemption

requests surged sharply, with 153,000 requests in the 2023-2024 school year, nearly double the number in 2019. Relaxation of vaccine mandates and promotion efforts—such as the Louisiana Department of Health's decision to scale back vaccine campaigns—poses significant risks for preventable disease resurgence.

Meanwhile, in the area of reproductive health, Arkansas and Wyoming enacted laws restricting access to abortion medication, while Colorado, New York, Vermont, and Washington passed legislation protecting such access. In addition, bills amending exceptions for medical emergencies were enacted in Tennessee and Texas, insurance coverage of abortion care was expanded in Colorado and the District of Columbia, and shield law protections were strengthened in Colorado, the District of Columbia, Maine, North Carolina, Vermont, and Washington. On gender-affirming care, Kansas enacted the "Help Not Harm Act," banning care for minors effective July 1, 2025, while New Hampshire expanded the scope of its existing restriction.

The AMA, through the Advocacy Resource Center (ARC), continues to prioritize state advocacy to defend the patient-physician relationship and public health. The AMA works in close partnership with state medical associations, national medical specialty associations, and public health coalitions to safeguard access to vaccines, abortion, and gender-affirming care. The ARC provides direct advocacy support to Federation members through letters and written testimony, legislative analysis, and strategy support. Often this work is conducted behind-the-scenes with Federation staff. The ARC also facilitates collaboration through regular coalition calls, webinars, and in-person convenings that bring together Federation members, subject matter experts, and allied organizations to share information and collaborate on strategy. For example, to address troubling vaccine legislation introduced in several states earlier this year, the ARC convened over 60 staff members from state and specialty medical associations for a virtual strategy session to share information and collaborate on strategies. Such strategy calls are held on a weekly basis during legislative sessions on a wide range of topics. Additionally, AMA initiatives stemming from the work of the Task Force to Protect the Patient-Physician Relationship—public opinion research to refine messaging on abortion laws, research on workforce impact of criminalizing medical care, and more—has been disseminated to Federation organizations to inform state advocacy efforts. The AMA's sustained engagement with state partners ensures that the AMA remains at the forefront of defending science-based public health policy at the state level, even amid heightened challenges to vaccine confidence, misinformation, and the erosion of public health infrastructure.

## CONCLUSION

Through the efforts described in this report, the AMA continues to assertively and publicly advance the goals of Policy D-440.905 by supporting the integrity of evidence-based medicine and resisting encroachments that threaten biomedical research and public health infrastructure. Due to the amount of time between the drafting of this report and the interim HOD meeting, this report is not representative of the full breadth of federal and state activity, or the AMA's advocacy efforts, with respect to evidence-based medicine, biomedical research, and public health infrastructure. In particular, additional congressional action on appropriations is expected, which could significantly impact funding levels and program eliminations.

## RECOMMENDATION

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

1. The third item of Policy D-440.905 be rescinded as having been accomplished by this report.

Fiscal note: Less than $500.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 16-I-25

Subject: Preservation of Medicaid

Presented by: David H. Aizuss, MD, Chair

Referred to: Reference Committee B

This report is presented for the information of the House of Delegates (HOD). At the 2025 American Medical Association (AMA) Annual Meeting of the HOD, the HOD adopted Policy H-290-951, "Preservation of Medicaid." The Policy calls for the following:

1. Our AMA elevate Medicaid to an urgent and top legislative advocacy priority alongside Medicare payment reform, specifically advocating for maintaining and expanding Medicaid coverage, access, federal funding, and eligibility, and request report back on the Board of Trustees' actions at I-25.

2. Our AMA strongly opposes federal and state efforts to restrict eligibility, coverage, access, and funding for Medicaid and the Children's Health Insurance Program (CHIP).

(Note: This report was prepared in August based on approval deadlines, so more recent developments may not be reflected in it.)

## AMA ACTIVITIES ON THE PRESERVATION OF MEDICAID

### *Addressing Threats and Preserving Medicaid*

Medicaid provides coverage to millions of Americans and serves as a critical safety net for children, pregnant and postpartum women, seniors, people with disabilities and serious health conditions, and low-income people who do not have access to, or cannot afford, private health insurance coverage.

As the largest insurer for children, pregnant individuals, people with disabilities, and low-income seniors, Medicaid is not merely a funding mechanism—it is a lifeline. The AMA recognizes that efforts to restrict Medicaid are not abstract policy choices but decisions that fundamentally impact access to life-saving care. Medicaid plays an outsized role in reducing racial and geographic health disparities. Black, Latino, Indigenous, and rural populations are more likely to rely on Medicaid, and as such, face disproportionate harm when coverage is restricted or burdens are increased.

The AMA began sustained Medicaid advocacy in early January 2025, participating in a working coalition of national organizations including the Federation of American Hospitals, the American Hospital Association, Families USA, the American Health Care Association, America's Health Insurance Plans, and the Blue Cross Blue Shield Association. Weekly meetings were held to coordinate strategy and share intelligence. AMA also remained active in the Modern Medicaid Alliance. In February, AMA lobbyists began outreach to targeted Republican Congressional offices representing high Medicaid populations, expansion states, and members who had previously expressed concern about Medicaid cuts. In need of their votes, these targeted Members had

© 2025 American Medical Association. All rights reserved.

significant influence with House and Senate Republican leadership. Although no formal legislative language had yet been released, these initial conversations laid the groundwork for engagement once text emerged. Simultaneously, advocacy staff activated grassroots coordination with state medical societies, distributing draft letters, messaging materials, and call-to-action templates. At the National Advocacy Conference, the AMA worked closely with state medical association delegations sharing intelligence, state-level implementation challenges, and other relevant background information for use in raising Medicaid concerns in targeted Hill meetings.

As Congress moved toward drafting legislative text, AMA intensified its engagement with House and Senate leadership and key committee staff throughout late February and March. AMA's concerns about significant disruptions to Medicaid were clearly conveyed well before legislative text was finalized. When the House bill was released in early May, AMA issued a formal letter opposing the proposed Medicaid provisions, which aimed to reduce federal spending not by directly cutting eligibility or funding, but by increasing administrative burdens on patients and shifting costs to states. A second letter reiterated our opposition before final House consideration. While the final version of H.R. 1, the One Big Beautiful Bill Act (OBBBA), was far from ideal, it is notable that it did not include per capita caps, Federal Medical Assistance Percentage (FMAP) reductions, or elimination of the Medicaid expansion eligibility pathway. That outcome reflects, in part, the sustained and strategic advocacy efforts of AMA staff over several months.

Following House passage, AMA launched a grassroots campaign calling on the Senate to eliminate or revise the most harmful Medicaid provisions. Through the Physicians Grassroots Network , the Patients Access Network, and Federation channels, thousands of physicians and advocates contacted lawmakers. On June 20, AMA sent an additional letter to Senate leadership outlining opposition to provisions that would increase red tape, reduce patient access, and shift additional financial burdens to states. After Senate passage on July 2, AMA lobbyists reached out again to key House Republicans who had expressed concern with the bill's Medicaid policies, urging last-minute changes before final passage. Although the final bill was enacted over AMA's objections, our advocacy team led a sustained six-month campaign combining coalition coordination, targeted Hill engagement, grassroots mobilization, and strategic communications. This ensured AMA's position was heard at every stage and helped prevent even more damaging proposals from becoming law.

*Summary of Medicaid Provisions Included in H.R. 1, OBBBA*

On July 4, the OBBBA, that included many changes to Medicaid and CHIP, was signed into law. These changes include:

- Repealing regulatory requirements that streamline eligibility and enrollment processes for Medicaid and CHIP.
- Requiring more frequent eligibility checks for Medicaid expansion enrollees and also requiring states to regularly verify contact information, check for dual enrollment across states, and check enrollment against death files for all Medicaid enrollees.
- Mandating that certain categories of enrollees satisfy a community engagement requirement (i.e., "work requirement") as a condition of Medicaid eligibility.
- Reducing retroactive coverage requirements from three months to two months or, in the case of expansion enrollees, one month.
- Establishing new cost-sharing requirements for Medicaid expansion enrollees with incomes above the federal poverty line.
- Prohibiting all states from establishing new provider taxes; existing provider tax arrangements may continue as long as they are not altered. This takes effect on the date of enactment, July 4,

2025. Provider taxes—fees collected from health care providers by states—are used to draw down federal Medicaid matching funds. While often a routine financing tool, certain provider tax structures have drawn scrutiny from CMS and may be subject to reform, potentially jeopardizing state Medicaid budgets.

- For expansion states only, phasing down the permissible rate of existing provider taxes (excluding taxes on nursing facilities and intermediate care facilities) from six percent of net patient revenue to 3.5 percent by 0.5 percentage points per year. The phase-down begins October 1, 2027, and the reduction will be fully phased-in on October 1, 2031.
- Reducing federal contributions to states with identified improper and overpayments.
- Capping state directed payments, separate payments to providers for achieving state-defined policy goals, such as improving quality of care or enhancing access.
- Notably, H.R. 1 does not impose per capita caps, decrease FMAP rates, or eliminate the Medicaid expansion eligibility pathway.

Many of the proposed changes are not direct cuts to Medicaid funding or eligibility. Rather, they largely accomplish reductions in federal spending through policies that (1) increase administrative burdens on enrollees (such as more frequent eligibility redeterminations or work requirements) that will cause disenrollments or (2) shift costs to the states (such as limiting the use of provider taxes) by limiting how states can draw down federal matching funds.

Nevertheless, the changes included in H.R. 1 are significant. According to the Kaiser Family Foundation, the Congressional Budget Office (CBO) estimates that, relative to its estimates of insurance coverage prior to the law being enacted, the law will increase the number of people without health insurance in 2034 by 10 million, because of changes to Medicaid (7.5 million), the ACA Marketplaces (2.1 million), and other policies and interactions among different provisions (0.4 million). These legislative changes come at a time when enhanced premium tax credits for ACA Marketplace enrollees are set to expire later this year. When combining the impact of the reconciliation law with that of expected expiration of the ACA's enhanced premium tax credits, CBO estimates show that the number of uninsured people will increase by more than 14 million in 2034. The estimate does not account for the effect of the Trump administration's ACA Marketplace Integrity and Affordability rule finalized earlier this year, so the overall change in the number of uninsured people could be even larger.

In a separate proposed rule, CMS proposed guardrails to close "loopholes" which would effectively end certain types of provider taxes in seven states. This proposed rule overlaps significantly with a provision that was included in the final version of the OBBBA. In comments, the AMA asked CMS to consider the rule altogether in light of the passage of the OBBBA, and to consider, as an alternative to eliminating the provider tax arrangements targeted by the rule, creating guardrails that would address CMS' core concerns by ensuring funds are spent on state Medicaid program improvements, rather than terminating this critical funding source altogether.

The AMA will continue to advocate for policies that promote coverage stability and protect access to care for Medicaid patients. In parallel, the AMA will help physicians support patients in maintaining eligibility under new administrative requirements. We will also seek opportunities to shape OBBBA implementation to mitigate its most harmful provisions.

*AMA Public Statements on Medicaid in 2025*

Letters to Congress:

- Letter to Senate regarding H.R. 1 (OBBBA). Included several pages of concerns about Medicaid changes (June 20, 2025).

- Letter to House leadership regarding H.R. 1 (OBBBA). Included several pages of concerns about Medicaid changes (May 20, 2025).
- Letter to House Energy & Commerce Committee regarding H.R. 1 (OBBBA). Included several pages of concerns about Medicaid changes (May 13, 2025).

Letters to CMS:

- Comment letter opposing proposed rule, titled "Medicaid Program; Preserving Medicaid Funding for Vulnerable Populations—Closing a Health Care-Related Tax Loophole" (July 11, 2025).

Other AMA public statements:

- Social media posts:
  - X post on July 3, 2025 (following passage of H.R. 1), criticizing the bill and the Medicaid and CHIP cuts in particular.
  - X thread on July 2, 2025 (before final passage of H.R. 1 by the House), specifically criticizing the Medicaid and CHIP cuts and student loan provisions.
  - Video posted to Instagram of Dr. Mukkamala making statement about H.R. 1 on July 2, 2025.
- Statement by Dr. Mukkamala on July 3, 2025, following final passage of H.R. 1.
- Statement by Dr. Mukkamala on July 1, 2025, following Senate passage of H.R. 1.

CONCLUSION

In an effort to preserve Medicaid, the AMA provided early and consistent input to Congressional leaders and coalition partners during the development of H.R. 1. We clearly opposed provisions that would increase administrative burdens, reduce access through procedural disenrollments, or unduly shift financial responsibility to states. While the final legislation contains highly concerning policies, it notably excludes the most damaging proposals—such as per capita caps, FMAP reductions, or elimination of the Medicaid expansion pathway. That outcome reflects the sustained advocacy efforts of AMA staff and the broader Federation.

In recognition that our House has designated Medicaid as an "urgent and top legislative advocacy priority," the Board of Trustees will work to mitigate the impacts of H.R.1. To mitigate the impacts in the short term, we will work at the state level to support the adoption of legislation that fills funding gaps created by H.R. 1 and preserves access to care for patients. Simultaneously, we will work on establishing and disseminating tools to help physicians and patients navigate eligibility and enrollment in Medicaid. Overall, we will continue working to preserve and strengthen Medicaid for the patients and communities who rely on it.

RECOMMENDATION

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

The first item of Policy H-290-951, "Preservation of Medicaid" be amended by deletion as follows.

1. Our American Medical Association elevates Medicaid to an urgent and top legislative advocacy priority alongside Medicare payment reform, specifically advocating for maintaining and expanding Medicaid coverage, access, federal funding, and eligibility~~, and request report back on the Board of Trustees' actions at I-25~~. (Modify Current Policy)

Fiscal note: Less than $500.

James L. Madara, MD
CEO, EXECUTIVE VICE PRESIDENT
james.madara@ama-assn.org

May 13, 2025

The Honorable Brett Guthrie
Chairman
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Frank Pallone
Ranking Member
Committee on Energy and Commerce
348 Cannon House Office Building
Washington, DC 20515

Dear Chairman Guthrie and Ranking Member Pallone:

On behalf of the physician and medical student members of the American Medical Association (AMA), I am writing to share our perspective on the Committee on Energy and Commerce Budget Reconciliation text.

The AMA strongly supports section 44304 of the Committee's recommendations, which provides a positive modification to the conversion factor under the Medicare physician fee schedule. Physician practices have faced a 33 percent loss in purchasing power since 2001, severely straining their sustainability. Congress has adopted several temporary physician payment updates to help address steep pay cuts that took effect starting in 2021, but each of these updates led to a steep cliff as the payment update expired and reverted to the reduced payment rate as if there had been no legislative provision at all. Section 44304 provides the first Medicare physician payment update that is permanently built into baseline Medicare rates since the passage of the Medicare and CHIP Reauthorization Act (MACRA) in 2015. As recommended by the Medicare Payment Advisory Commission, it links the Medicare update to inflation in medical practice costs as measured by the Medicare Economic Index (MEI). The proposed 2026 update, 75 percent of MEI, is significantly higher than any of the annual physician payment updates in MACRA. It has been decades since Medicare physician payment updates were linked to the MEI and the AMA strongly supports it.

Under current law, the update for most physician practices will lead to rates being below their 2024 levels at the end of the budget window in 2035. It is absolutely vital that this issue be addressed. It should come as no surprise that physician ownership of their practices has collapsed dramatically over the past quarter century. In 2001, 61 percent of physicians were owners. By 2016, fewer than half of physicians had ownership stakes in their practices, and since 2018 more physicians are employees than owners. Physicians should not be forced to leave community-based practice because it is not financially sustainable, and addressing this erosion is essential to strengthening the Medicare program and protecting patient access to care.

We further view these provisions as a foundational step toward comprehensive Medicare physician payment reform in the 119th Congress. Ensuring regular, adequate payment updates is vital to maintaining practice stability, advancing value-based care models, and safeguarding access to care for Medicare beneficiaries—particularly in rural and underserved communities. Medical practices in the most rural locations treat four times as many Medicare patients as metropolitan practices. The AMA remains

committed to working with Congress to achieve lasting reforms so patients and physicians have the Medicare program they deserve.

The AMA is very pleased to see the inclusion of language requiring additional levels of transparency from pharmacy benefit managers, as well as efforts to constrain pharmacy benefit managers (PBM) compensation in ways that serve to increase costs to patients. The AMA has consistently expressed concern regarding the opaque way PBMs operate and the impact PBM business practices have on access to medically necessary drugs for patients. We have also been deeply concerned about the impacts of the business practices of both prescription drug manufacturers and PBMs on costs to both patients and the health care system at large. As such, we strongly support efforts to mandate greater transparency regarding the business practices of PBMs. This lack of transparency has made it difficult to understand exactly how PBMs operate and the nature of their contracting with manufacturers and health plans and in turn has made it difficult to determine appropriate legislative or regulatory action to limit their continued ability to manipulate the system for their own financial gain.

The AMA would also like to share our views on proposed changes to the Medicaid and Children's Health Insurance Program (CHIP) programs included in the reconciliation legislation. As physicians, we know that Medicaid is a vital component of America's health care infrastructure, providing health insurance coverage to millions of patients and serving as a critical safety net for children, pregnant and postpartum women, seniors, and people with disabilities and serious health conditions. Medicaid coverage is associated with improved long-term health, lower rates of mortality, better health outcomes, fewer hospitalizations, better educational outcomes, and greater financial security.[1] Medicaid is an indispensable source of coverage for maternal health services, covering over 40 percent of all births in the United States, including almost 50 percent of births in rural areas.[2] In many communities Medicaid is a major source of health insurance coverage or, in some cases, the primary payer.[3] For the physician practices and other health care providers who serve these communities, Medicaid payments are a crucial source of funding without which they might be unable to continue to operate, jeopardizing access to care in those communities and in rural areas in particular. For all these reasons, the AMA has a strong interest in ensuring that Medicaid remains a reliable source of health insurance coverage for low-income Americans and other vulnerable patients.

The AMA commends the Committee on the inclusion of section 44302, which streamlines the enrollment process for eligible out-of-state providers under Medicaid and CHIP and will increase the ability of children enrolled in Medicaid and CHIP to receive the care they need from the appropriate providers, even if those providers are located in a different state. However, after reviewing the proposed changes to the Medicaid and CHIP programs, we note the potential for unintended consequences that could affect patients, rural and underserved communities, and the providers who serve them. Medicaid and CHIP—like any large health insurance program[4]—lose money to waste, fraud, and abuse, and the AMA is supportive of legislative efforts to address these program integrity issues in a targeted fashion. However,

---

[1] Benjamin D. Sommers, Katherine Baicker & Arnold M. Epstein, "Mortality and Access to Care among Adults after State Medicaid Expansions." 367 NEJM 11, 1025-34 (Sep. 2012); Henry J. Kaiser Family Foundation, "What is Medicaid's Impact on Access to Care, Health Outcomes, and Quality of Care? Setting the Record Straight in the Evidence" (Aug. 2013); Alisa Chester & Joan Alker, Georgetown University Health Policy Institute Center for Children and Families, "Medicaid at 50: A Look at the Long-Term Benefits of Childhood Medicaid" (Jul. 2015).

[2] https://www.aha.org/fact-sheets/2025-02-07-fact-sheet-medicaid.

[3] https://ccf.georgetown.edu/2025/01/15/medicaids-role-in-small-towns-and-rural-areas/.

[4] https://www.nhcaa.org/tools-insights/about-health-care-fraud/the-challenge-of-health-care-fraud/.

changes that would result in reductions in Medicaid and CHIP funding, procedural changes that may lead to coverage disruptions for otherwise eligible patients, or new obstacles to physicians and other providers participating in Medicaid and CHIP would go against the long-standing policy of the AMA that any Medicaid reform should avoid jeopardizing patient access to health care.

With respect to changes that could result in the denial or loss of coverage under Medicaid or CHIP for eligible patients, the AMA is particularly concerned with sections 44101, 44102, 44108, and 44141. These provisions create additional administrative burdens for patients and could result in more patients being denied or losing coverage under Medicaid or CHIP for failing to comply with administrative requirements, despite meeting all substantive criteria for eligibility.

The AMA understands that robust processes are necessary for program integrity, but we recommend minimizing administrative complexity to help eligible patients enroll and maintain coverage under Medicaid and CHIP. Administrative hurdles in these two safety net programs are a proven barrier to eligible individuals enrolling for coverage, especially given that of the estimated 25.3 million uninsured Americans in 2023, 6.3 million were eligible for Medicaid or CHIP but not enrolled, often due to administrative barriers.[5] The proposed changes may increase the risk of wrongful denials or disenrollments, disrupting patients' access to care and potentially affecting the continuity of care physicians strive to provide. To limit patient churn and help ensure continuity of care, AMA policy supports 12-month continuous eligibility in Medicaid and CHIP.

With respect to the community engagement requirements established under section 44141, the AMA appreciates the policy's goal of lifting people out of poverty by incentivizing stable employment. However, as physicians, we are particularly concerned about the potential for coverage losses and disruptions in continuity of care. Work requirements have in some instances contributed to fluctuations in coverage in and out of the program. Experience from state-level programs suggests that work requirements can be administratively complex and have not consistently achieved improved employment outcomes.[6] This experience supports AMA policy that opposes work requirements due to serious concerns about the impact that such proposals may have on access to health care for patients who are otherwise eligible for coverage under Medicaid.

The group most affected by the new work requirements is the Medicaid expansion population. Over 90 percent of adults enrolled in Medicaid through the expansion pathway either already work or meet the criteria for exemption from the requirement, such as being the parent of a dependent child.[7] Evidence from work requirement programs implemented in multiple states shows that the administrative burdens of demonstrating compliance with work requirements can result in coverage interruptions even among

[5] https://www.kff.org/affordable-care-act/state-indicator/distribution-of-eligibility-for-aca-coverage-among-the-remaining-uninsured; https://www.kff.org/uninsured/issue-brief/a-closer-look-at-the-remaining-uninsured-population-eligible-for-medicaid-and-chip/.

[6] https://www.urban.org/urban-wire/new-evidence-confirms-arkansas-medicaid-work-requirement-did-not-boost-employment.

[7] https://www.urban.org/research/publication/state-state-estimates-medicaid-expansion-coverage-losses-under-federal-work; https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work-an-update/.

individuals who are working or otherwise exempt.[8] While the implementation challenges associated with work requirements and the resulting losses in coverage for working beneficiaries are universal, they are even more pronounced in rural areas.[9]

Adding complexity to the Medicaid expansion pathway by increasing administrative burdens for expansion patients could have substantial consequences. The expansion option provides an essential pathway to health insurance coverage for millions of low-income Americans (in 2025, the income eligibility threshold for the expansion pathway was $21,597 for a single-person household). Since it was first implemented in 2014, Medicaid expansion has been adopted by 40 states (including seven states that adopted expansion pursuant to a voter referendum) and the District of Columbia[10] and has filled a gap in the health care system by providing coverage to patients without access to employer sponsored insurance or the ability to pay for private insurance. The popularity of Medicaid expansion continues to grow, with new states reinforcing their commitment as recently as March 2025, when Montana voted to make its Medicaid expansion permanent.[11]

Medicaid expansion has been shown to have significant positive benefits for low-income patients, with many studies demonstrating improvements in expansion states in health care coverage, access, utilization, and mortality.[12] Medicaid expansion has played an important role in fighting America's opioid epidemic, providing much-needed treatment and coverage of lifesaving medications for opioid use disorder to millions of beneficiaries with substance use disorders and creating significant savings through decreased hospital and emergency department utilization.[13] Medicaid expansion has also contributed to substantial improvements in maternal health outcomes in the United States, with research indicating that Medicaid expansion is associated with a 17 percent decrease in hospitalization rates in postpartum women.[14] The expansion has also been an important source of coverage for individuals with chronic health conditions, with 44 percent of expansion enrollees suffering from at least one chronic condition.[15]

For all these reasons, we would urge the Committee to reconsider the proposed changes that create additional administrative barriers for all Medicaid and CHIP patients. To the extent additional program integrity measures are necessary, we would recommend that the Committee consider adding safeguards to ensure that such measures do not result in eligible patients losing coverage under Medicaid and CHIP.

Another change that we note could impact timely access to care for some patients is the modification to retroactive coverage requirements contained in section 44122. Under current law, states are required to

---

[8] https://www.cbpp.org/blog/georgias-medicaid-experiment-is-the-latest-to-show-work-requirements-restrict-health-care; https://familiesusa.org/wp-content/uploads/2025/03/Medicaid-Work-Reporting-Requirements-Fact-Sheet.pdf; Benjamin Sommers, Anna Goldman, Robert Blendon, et al., Medicaid Work Requirements—Results from the First Year in Arkansas, 381 New England Journal of Medicine 11, 1073-82.

[9] https://healthlaw.org/wp-content/uploads/2025/04/ParkerNewton_MedicaidWorkRequirementsUndermineRuralHealthcare_04042025.pdf.

[10] https://www.kff.org/status-of-state-medicaid-expansion-decisions/.

[11] https://www.mtpr.org/montana-news/2025-03-28/governor-signs-medicaid-expansion-renewal-into-law.

[12] https://www.commonwealthfund.org/publications/issue-briefs/2023/sep/impact-medicaid-coverage-gap-comparing-states-have-and-have-not; Sarah Miller, Norman Johnson, Laura R Wherry, "Medicaid and Mortality: New Evidence From Linked Survey and Administrative Data," The Quarterly Journal of Economics, Volume 136, Issue 3, August 2021, Pages 1783–1829.

[13] https://ccf.georgetown.edu/2025/02/19/how-medicaid-helps-people-with-substance-use-disorders.

[14] https://www.healthaffairs.org/doi/epdf/10.1377/hlthaff.2022.00819.

[15] https://www.kff.org/medicaid/issue-brief/5-key-facts-about-medicaid-expansion/.

provide retroactive Medicaid and CHIP coverage for the three months preceding the month in which an eligible patient submits their application for assistance under the program. The proposed change would reduce this requirement to one month of retroactive coverage. To ensure that patients receive the care they need when they need it, AMA policy supports retroactive coverage for low-income patients to the time at which an eligible patient seeks medical care.

The proposed changes to Medicaid and CHIP also include additional provider screening requirements. While current regulations require states to verify provider eligibility upon enrollment or reenrollment, section 44105 would expand this exponentially to require provider eligibility databases to be checked every month, by every state, for every provider. Such a requirement would necessitate increased staffing, resources, and expenditures at a time when efficiency in Medicaid is at a premium. The AMA favors these eligibility checks to be conducted upon provider enrollment and reenrollment, so as to avoid inefficiencies and undue administrative burden which could ultimately threaten patient access to Medicaid services.

In a similar vein, section 44106 adds a requirement to screen providers against the Social Security Administration's Death Master File (DMF). We believe being listed in the DMF could be an important data point to flag further inquiry into the provider's eligibility. However, we are also aware that false positives (names of living individuals) are erroneously added to the DMF at an average rate of 5,500 per month. The AMA recommends that any use of the DMF to determine provider eligibility would use the occurrence of a provider's name in the DMF as a trigger for further inquiry before pursuing any action adverse to that provider's participation in Medicare or Medicaid. Otherwise, should a provider be automatically barred from participation based on a false positive, that provider would suddenly be cut off from access to the program and more importantly, from their patients. Resolving the false positive by confirming the living provider's eligibility status could require an extended amount of time given the scale of these programs and state staffing levels. Such a delay would unnecessarily disrupt patient care, place strain on small provider practices, particularly those with limited administrative capacity, and could ultimately force some physician practices to close, exacerbating the problem of patient access to their provider or to any care under these programs.

Again, while the AMA generally supports program integrity initiatives in Medicaid and CHIP, we would recommend that the Committee include safeguards to ensure that physician practices and other providers are not erroneously barred from participating in these programs. These safeguards could include giving providers notice and an opportunity to appeal before they are adversely affected. Preventing providers who are without fault from participating in Medicaid and CHIP threatens beneficiary access to care and, in some cases, the continued viability of providers.

Another matter that raises concern is the new cost sharing requirements included in section 44142. While the new cost sharing requirements would only apply to Medicaid expansion patients with incomes that are greater than 100 percent of the federal poverty level ($15,650 for a household of one in 2025), even modest cost sharing requirements can deter patients from accessing medical care. There is an extensive body of research showing that copayments can make it harder for low-income people to afford needed medical services and force them to make difficult choices between needed health care and other basic necessities, such as food and rent.[16] This is especially the case for individuals with chronic conditions who may require more frequent medical care and thus be charged more copayments. As physicians, we

[16] https://www.kff.org/medicaid/issue-brief/understanding-the-impact-of-medicaid-premiums-cost-sharing-updated-evidence-from-the-literature-and-section-1115-waivers/.

fear that the proposed cost sharing provisions could pose barriers to Medicaid beneficiaries' ability to access medically necessary services in a timely fashion, including adhering to physician-prescribed therapies, which could lead to delays in treatment, increases in emergency room visits and hospitalizations, and other expensive forms of care.

The AMA appreciates the Committee's ongoing efforts to strengthen the nation's health care system and urges careful consideration of the potential impact of proposed changes on physicians and the patients they serve. We stand ready to work collaboratively with Congress to advance policies that promote access to high-quality, affordable care, ensure the sustainability of physician practices, and protect the integrity of vital safety net programs like Medicare, Medicaid, and CHIP.

Sincerely,

James L. Madara, MD

James L. Madara, MD
CEO, EXECUTIVE VICE PRESIDENT
james.madara@ama-assn.org

May 20, 2025

The Honorable Mike Johnson
Speaker
United States House of Representatives
H-232, The Capitol
Washington, DC 20515

The Honorable Hakeem Jeffries
House Democratic Leader
United States House of Representatives
H-204, The Capitol
Washington, DC 20515

Dear Speaker Johnson and Leader Jeffries:

On behalf of the physician and medical student members of the American Medical Association (AMA), I am writing to share our comments on numerous parts of the combined legislation accompanying the Concurrent Resolution on the Budget for Fiscal Year 2025, specifically House Concurrent Resolution 14. Since the House of Representatives is considering this comprehensive piece of legislation under a condensed legislative calendar, this letter intentionally focuses on the policy issues that are central to the AMA's advocacy platform. More specifically, my colleagues and I are pleased to offer our expertise and perspective on provisions within the legislative proposal pertaining to Medicare physician payment, Pharmacy Benefit Manager (PBM) transparency, Medicaid and the Children's Health Insurance Program (CHIP), artificial intelligence (AI), the Affordable Care Act (ACA) marketplaces, and federal support of medical student loans.

**Medicare**

The AMA strongly supports section 44304 which provides a positive modification to the conversion factor under the Medicare physician fee schedule. Since 2001, Medicare physician payment updates have fallen 33 percent below inflation in the costs of running a medical practice as measured by the Medicare Economic Index (MEI), severely straining practice sustainability. Congress has adopted several temporary physician payment updates to help address steep cuts that took effect starting in 2021, but each of these updates led to a severe cliff as the payment update expired and reverted to the reduced payment rate as if there had been no legislative provision at all. Section 44304 provides the first Medicare physician payment update that is permanently built into baseline Medicare rates since the passage of the Medicare Access and CHIP Reauthorization Act (MACRA) in 2015.

As recommended by the Medicare Payment Advisory Commission, section 44304 links the Medicare update to the MEI. The proposed 2026 update, 75 percent of the MEI, currently estimated to provide a 2026 payment update of 2.25 percent, is significantly higher than any of the annual physician payment updates in MACRA. It has been decades since Medicare physician payment updates were linked to inflation and the AMA strongly supports it. Importantly, this payment increase will be permanently built into the rates that Medicare pays for patient care delivered by medical practices instead of expiring at the end of the year like so many previous temporary updates. As a result, the AMA estimates that the cumulative growth in Medicare payment updates for physician practices from 2025 to 2035 will be 4.3 percent under section 44304 compared to 2.5 percent under current law, reflecting a nearly two percentage point increase.

Under current law, reductions in the conversion factor over the last five years to account for budget neutrality adjustments have led to payment rates falling to levels that make private practice unsustainable for many physicians. It is absolutely vital that this issue be addressed. It should come as no surprise that physician ownership of their practices has decreased dramatically over the past quarter century. In 2001, 61 percent of physicians were owners. By 2016, fewer than half of physicians had ownership stakes in their practices, and since 2018 more physicians are employees than owners. Physicians should not be forced to leave community-based practice because it is not financially sustainable, and addressing this erosion is essential to strengthening the Medicare program and protecting patient access to care.

We further view these provisions as a foundational step toward comprehensive Medicare physician payment reform in the 119th Congress. Ensuring regular, adequate payment updates is vital to maintaining practice stability, advancing value-based care models, and safeguarding access to care for Medicare beneficiaries, particularly in rural and underserved communities. Medical practices in the most rural locations treat four times as many Medicare patients as metropolitan practices. The AMA remains committed to working with Congress to achieve lasting reforms that give patients and physicians the Medicare program they need and deserve.

**PBM Transparency**

The AMA is also pleased to see the inclusion of language requiring additional levels of transparency from PBMs, as well as efforts to constrain PBM compensation practices that serve to increase costs to patients. The AMA has consistently expressed concern regarding the opaque way PBMs operate and the impact PBM business practices have on access to medically necessary drugs for patients. We have also been deeply concerned about the impact of the business practices of both prescription drug manufacturers and PBMs on costs to both patients and the health care system at large. As such, we strongly support efforts to mandate greater transparency regarding the business practices of PBMs. This lack of transparency has made it difficult to understand exactly how PBMs operate and the nature of their contracting with manufacturers and health plans and in turn has made it difficult to determine appropriate legislative or regulatory action to limit their continued ability to manipulate the system for their own financial gain.

**Medicaid and CHIP**

The AMA would also like to share our views on proposed changes to the Medicaid and CHIP programs included in the reconciliation legislation. As physicians, we know that Medicaid is a vital component of America's health care infrastructure, providing health insurance coverage to millions of patients and serving as a critical safety net for children, pregnant and postpartum women, seniors, and people with disabilities and serious health conditions. Medicaid coverage is associated with improved long-term health, lower rates of mortality, better health outcomes, fewer hospitalizations, better educational outcomes, and greater financial security.[1] Medicaid is an indispensable source of coverage for maternal health services, covering over 40 percent of all births in the United States, including almost 50 percent of births in rural areas.[2] In many communities Medicaid is a major source of health insurance coverage or, in

[1] Benjamin D. Sommers, Katherine Baicker & Arnold M. Epstein, "Mortality and Access to Care among Adults after State Medicaid Expansions." 367 NEJM 11, 1025-34 (Sep. 2012); Henry J. Kaiser Family Foundation, "What is Medicaid's Impact on Access to Care, Health Outcomes, and Quality of Care? Setting the Record Straight in the Evidence" (Aug. 2013); Alisa Chester & Joan Alker, Georgetown University Health Policy Institute Center for Children and Families, "Medicaid at 50: A Look at the Long-Term Benefits of Childhood Medicaid" (Jul. 2015).
[2] https://www.aha.org/fact-sheets/2025-02-07-fact-sheet-medicaid.

some cases, the primary payer.[3] For the physician practices and other health care providers who serve these communities, Medicaid payments are a crucial source of funding without which they might be unable to continue to operate, jeopardizing access to care in those communities and in rural areas in particular. For all these reasons, the AMA has a strong interest in ensuring that Medicaid remains a reliable source of health insurance coverage for low-income Americans and other vulnerable patients.

The AMA commends the inclusion in the Energy and Commerce title of section 44302, which streamlines the enrollment process for eligible out-of-state providers under Medicaid and CHIP and will increase the ability of children enrolled in Medicaid and CHIP to receive the care they need from the appropriate providers, even if those providers are located in a different state. However, after reviewing the proposed changes to the Medicaid and CHIP programs, we note the potential for unintended consequences that could affect patients, rural and underserved communities, and the providers who serve them. Like any large health insurance program, Medicaid and CHIP lose money to waste, fraud, and abuse.[4] The AMA is supportive of legislative efforts to address these program integrity issues in a targeted fashion. However, changes that would result in reductions in Medicaid and CHIP funding, procedural changes that may lead to coverage disruptions for otherwise eligible patients, or new obstacles to physicians and other providers participating in Medicaid and CHIP would go against the long-standing policy of the AMA that Medicaid reforms should avoid jeopardizing patient access to health care.

Regarding changes that could result in the denial or loss of coverage under Medicaid or CHIP for eligible patients, the AMA is particularly concerned with sections 44101, 44102, 44108, and 44141. These provisions could create additional administrative burdens for patients. The AMA understands that robust processes are necessary for program integrity, but we recommend minimizing administrative complexity to help eligible patients enroll and maintain coverage under Medicaid and CHIP. Administrative hurdles in these two safety net programs are a proven barrier to eligible individuals enrolling for coverage, especially given that of the estimated 25.3 million uninsured Americans in 2023, 6.3 million were eligible for Medicaid or CHIP but not enrolled, often due to administrative barriers.[5] The proposed changes may increase the risk of wrongful denials or disenrollments, disrupting patients' access to care and potentially affecting the continuity of care physicians strive to provide. To limit patient churn and help ensure continuity of care, the AMA has policy that supports 12 months of continuous eligibility in Medicaid and CHIP.

With respect to the community engagement requirements established under section 44141, the AMA appreciates the policy's goal of lifting people out of poverty by incentivizing stable employment. However, as physicians, we are particularly concerned about the potential for coverage losses and disruptions in continuity of care. Work requirements have in some instances contributed to fluctuations in coverage in and out of the program. Experience from state-level programs suggests that work requirements can be administratively complex and that they have not consistently achieved improved employment outcomes.[6] It should be noted that over 90 percent of adults enrolled in Medicaid through the expansion pathway either already work or meet the criteria for an exemption from the requirement, such

[3] https://ccf.georgetown.edu/2025/01/15/medicaids-role-in-small-towns-and-rural-areas/.
[4] https://www.nhcaa.org/tools-insights/about-health-care-fraud/the-challenge-of-health-care-fraud/.
[5] https://www.kff.org/affordable-care-act/state-indicator/distribution-of-eligibility-for-aca-coverage-among-the-remaining-uninsured; https://www.kff.org/uninsured/issue-brief/a-closer-look-at-the-remaining-uninsured-population-eligible-for-medicaid-and-chip/.
[6] https://www.urban.org/urban-wire/new-evidence-confirms-arkansas-medicaid-work-requirement-did-not-boost-employment.

as being the parent of a dependent child.[7] While the implementation challenges associated with work requirements and the resulting losses in coverage for working beneficiaries are universal, they are even more pronounced in rural areas.[8] This experience supports AMA policy that opposes work requirements due to serious concerns about the impact that such proposals may have on access to health care for patients who are otherwise eligible for coverage under Medicaid.

Adding complexity to the Medicaid expansion pathway by increasing administrative burdens for expansion patients could have substantial consequences. The expansion option provides an essential pathway to health insurance coverage for millions of low-income Americans (in 2025, the income eligibility threshold for the expansion pathway was $21,597 for a single-person household). Since it was first implemented in 2014, Medicaid expansion has been adopted by 40 states (including seven states that adopted expansion pursuant to a voter referendum) and the District of Columbia[9] and has filled a gap in the health care system by providing coverage to patients without access to employer sponsored insurance or the ability to pay for private insurance. The popularity of Medicaid expansion continues to grow, with new states reinforcing their commitment as recently as March 2025, when Montana voted to make its Medicaid expansion permanent.[10]

Medicaid expansion has been shown to have significant positive benefits for low-income patients, with many studies demonstrating improvements in health care coverage, access, utilization, and mortality.[11] Medicaid expansion has played an important role in fighting America's opioid epidemic, providing much-needed treatment and coverage of lifesaving medications for opioid use disorder to millions of beneficiaries with substance use disorders and creating significant savings through decreased hospital and emergency department utilization.[12] Medicaid expansion has also contributed to substantial improvements in maternal health outcomes in the United States, with research indicating that Medicaid expansion is associated with a 17 percent decrease in hospitalization rates in postpartum women.[13] The expansion has also been an important source of coverage for individuals with chronic health conditions, with 44 percent of expansion enrollees suffering from at least one chronic condition.[14]

For these reasons, we would urge the House to reconsider the proposed changes that create additional administrative barriers for all Medicaid and CHIP patients. To the extent additional program integrity measures are necessary, we would recommend that the House consider adding safeguards to ensure that such measures do not result in putting at risk eligible patients' coverage under Medicaid and CHIP.

---

[7] https://www.urban.org/research/publication/state-state-estimates-medicaid-expansion-coverage-losses-under-federal-work; https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work-an-update/.

[8] https://healthlaw.org/wp-content/uploads/2025/04/ParkerNewton_MedicaidWorkRequirementsUndermineRuralHealthcare_04042025.pdf.

[9] https://www.kff.org/status-of-state-medicaid-expansion-decisions/.

[10] https://www.mtpr.org/montana-news/2025-03-28/governor-signs-medicaid-expansion-renewal-into-law.

[11] https://www.commonwealthfund.org/publications/issue-briefs/2023/sep/impact-medicaid-coverage-gap-comparing-states-have-and-have-not; Sarah Miller, Norman Johnson, Laura R Wherry, "Medicaid and Mortality: New Evidence From Linked Survey and Administrative Data," The Quarterly Journal of Economics, Volume 136, Issue 3, August 2021, Pages 1783–1829.

[12] https://ccf.georgetown.edu/2025/02/19/how-medicaid-helps-people-with-substance-use-disorders.

[13] https://www.healthaffairs.org/doi/epdf/10.1377/hlthaff.2022.00819.

[14] https://www.kff.org/medicaid/issue-brief/5-key-facts-about-medicaid-expansion/.

Another change that we note could impact timely access to care for some patients is the modification to retroactive coverage requirements contained in section 44122. Under current law, states are required to provide retroactive Medicaid and CHIP coverage for the three months preceding the month in which an eligible patient submits their application for assistance under the program. The proposed change would reduce this requirement to one month of retroactive coverage. To ensure that patients receive the care they need when they need it, AMA policy supports retroactive coverage for low-income patients to the time at which an eligible patient seeks medical care.

The proposed changes to Medicaid and CHIP also include additional provider screening requirements. While current regulations require states to verify provider eligibility upon enrollment or reenrollment, section 44105 would expand this to require provider eligibility databases to be checked every month, by every state, for every provider. Such a requirement would necessitate increased staffing, resources, and expenditures at a time when efficiency in Medicaid is at a premium. The AMA supports these eligibility checks being conducted upon provider enrollment and reenrollment, so as to avoid inefficiencies and undue administrative burdens which could ultimately reduce patient access to Medicaid services.

In a similar vein, section 44106 adds a requirement to screen providers against the Social Security Administration's Death Master File (DMF). We agree that being listed in the DMF is an important data point to flag for further inquiry into the provider's eligibility. However, we are also aware that false positives (names of living individuals) are erroneously added to the DMF at an average rate of 5,500 per month. The AMA recommends that any use of the DMF to determine provider eligibility would use the occurrence of a provider's name in the DMF as a trigger for further inquiry before pursuing any action adverse to that provider's participation in Medicare or Medicaid. Otherwise, should a provider be automatically barred from participation based on a false positive, that provider would suddenly be cut off from access to the program and more importantly, from their patients. Resolving the false positive by confirming the living provider's eligibility status could require an extended amount of time given the scale of these programs and is highly contingent on state staffing levels. Such a delay could unnecessarily disrupt patient care, place strain on small provider practices, particularly those with limited administrative capacity, and could ultimately force some physician practices to close, exacerbating the problem of patient access to their provider or to any care under these programs.

Again, while the AMA generally supports program integrity initiatives in Medicaid and CHIP, we would recommend that Congress include safeguards to ensure that physician practices and other providers are not erroneously barred from participating in these programs. These safeguards could include giving providers notice and an opportunity to appeal before they are adversely affected. Preventing providers who are without fault from participating in Medicaid and CHIP threatens beneficiary access to care and, in some cases, the continued viability of providers.

Another matter that raises concern is the new cost-sharing requirements included in section 44142. While these requirements would only apply to Medicaid expansion patients with incomes that are greater than 100 percent of the federal poverty level ($15,650 for a household of one in 2025), even modest cost-sharing requirements can deter patients from accessing medical care. There is an extensive body of research showing that copayments can make it harder for low-income people to afford needed medical services and force them to make difficult choices between needed health care and other necessities, such as food and rent.[15] This is especially the case for individuals with chronic conditions who may require

[15] https://www.kff.org/medicaid/issue-brief/understanding-the-impact-of-medicaid-premiums-cost-sharing-updated-evidence-from-the-literature-and-section-1115-waivers/.

more frequent medical care and thus be charged more copayments. As physicians, we fear that the proposed cost-sharing provisions could pose barriers to Medicaid beneficiaries' ability to access medically necessary services in a timely fashion, including adhering to physician-prescribed therapies, which could lead to delays in treatment, increases in emergency room visits and hospitalizations, and other expensive forms of care.

**Artificial Intelligence**

The AMA has serious concerns about the inclusion of provisions in section 43201 that would prohibit state-level regulation of AI without additional federal action to create guardrails around the design, development, and deployment of AI. This lack of clear and consistent legislative and regulatory requirements is especially notable as applied to health care AI, including any AI that may be used in federal programs and may impact patient data privacy and patient access to care.

The AMA shares Congress' concerns that a patchwork of state legislation regulating AI would be problematic and confusing for developers, physicians, and patients alike. However, to ensure the safety and protection of our patients, additional federal action to ensure quality, performance, and transparency of AI must be in place. Without additional consumer protections, clear guidelines to assure AI quality, strong consumer data privacy protections, and further action to limit bias within AI systems, Americans will undoubtedly suffer harm. In the absence of any federal action to further these critical protections, states have taken action to fill critical gaps by mandating transparency and stepping up efforts to ensure their residents are covered by strong consumer protection laws that serve to limit unintended consequences from poorly performing AI systems.

In the health care space specifically, use of unregulated AI by federal departments and agencies could ultimately result in inappropriate dissemination and use of protected personal health information and denials of critical health care by federal payers—issues we have already seen come to fruition that have caused real harm to real patients. Stakeholders across industry, physicians, and patient organizations have consistently agreed that additional federal action to create clear and consistent guardrails that seek to ensure patient safety and data privacy are a critical need that remains unaddressed.

While the AMA remains a strong supporter of developing innovative AI tools that reduce physician burden and improve health outcomes for our patients, we also recognize the distinct and serious risks that health care AI poses to patient safety. These risks must be mitigated to the greatest extent possible. This legislation, as currently drafted, may fall short of achieving that goal. It sets a precedent for AI regulation that lacks sufficient clarity, contributes to ongoing confusion, and may fail to provide adequate assurances of performance and safety. We urge a reconsideration of this approach and encourage close collaboration with stakeholders to ensure the right balance between enabling innovation and upholding our shared responsibility to do no harm.

The AMA has significant concerns about section 112204, under which a total of $25 million will be transferred from the Federal Hospital Insurance Trust Fund and Federal Supplementary Medical Insurance Trust Fund to the Centers for Medicare & Medicaid Services to enter into contracts with AI tool vendors to help identify and reduce improper payments made under Medicare Parts A and B. While supportive of rooting out improper payments, delegating Medicare integrity functions to opaque, black-box algorithms would strip physicians of due-process visibility, invite biased or erroneous claw-backs, and erode clinical autonomy. The legislation is also silent regarding any appeals processes available to physicians or physician practices subjected to errors committed by the AI technology. The AMA is

concerned about the precedent of using AI technology for this purpose and the lack of statutory protections for physicians. Congress should instead require transparent, evidence-based audit standards with meaningful physician oversight and appeal rights before allowing any AI-driven payment policing.

**ACA Marketplace**

The AMA believes there are opportunities to enhance program integrity and protect taxpayer dollars with regard to the ACA Exchanges. We are concerned, however, that several provisions within sections 44201, 112201,112202, and 112203 codifying provisions of the proposed ACA "Marketplace Integrity and Affordability Rule"[16] will effectively reduce marketplace coverage for middle and low-income Americans. The Trump administration previously estimated that the various reforms included in this package will cumulatively reduce projected enrollment by up to two million individuals, and result in $11-14 billion in fewer advanced premium tax credits (APTC) available to help Americans afford their health insurance every year.[17] We are also concerned by the cumulative effect of these policies happening at once, shortening the enrollment window at the same time income verification processes and timelines are being ramped up, for example. These estimates also do not account for the scheduled expiration of enhanced tax credits at the end of 2025, which would result in an additional $26.1 billion reduction in 2026 alone.[18]

The AMA has significant concerns with provisions in section 44201 that would permanently limit the annual ACA marketplace open enrollment period to 45 days, rather than the previous 75-day timeline. A primary reason for the longer open enrollment period is to give consumers more time to make plan decisions, particularly when their subsidy has changed compared to the previous year. Individuals that are automatically reenrolled may not be aware of subsidy changes or impacts on their premiums until January, so this extended timeframe provides a valuable opportunity for consumers to make more informed decisions about switching plans and should be maintained to prevent coverage disruptions. Further, by shortening the standard annual enrollment period, the Agency is likely deterring healthy individuals from enrolling, which runs counter to the goal of stabilizing the risk pool.

The AMA is also concerned about the potential impacts of sections 44201 and 112202 as they relate to special enrollment periods based on income. We are concerned that the language in the bill could be interpreted to disallow special enrollment periods that are triggered by a change to an individual's income, such as the special enrollment period for individuals who become newly eligible for premium tax credits following a change in income. While the AMA appreciates the need to address potential adverse selection concerns associated with continuous special enrollment periods that allow an individual to enroll in any month provided that their income is below a certain threshold, we also believe it is essential that individuals retain the ability to enroll in a health plan if they experience a change in circumstances, including a change in income, that impacts their health insurance coverage or their eligibility for premium tax credits or cost-sharing reductions. AMA policy would oppose the limitations placed on special enrollment periods by sections 44201 and 112202 if they would prohibit any special enrollment period that allows individuals to enroll in, or change, health plans following a change to their income or coverage status.

---

[16] https://www.cms.gov/files/document/MarketplacePIRule2025.pdf.
[17] https://www.healthaffairs.org/content/forefront/house-republican-budget-reconciliation-legislation-unpacking-coverage-provisions.
[18] https://www.commonwealthfund.org/publications/issue-briefs/2025/mar/cost-eliminating-enhanced-premium-tax-credits.

If carefully designed, reasonable income verification measures have the potential to strengthen program integrity and ensure enrollees meet income-based and other eligibility requirements. However, we are strongly concerned that provisions within sections 44201 and 112201 may be both burdensome on individual enrollees and difficult for states to administer and may ultimately negatively impact enrollment of eligible individuals, particularly healthy individuals, in marketplace plans, thus also negatively impacting risk pools. For example, automatic enrollment with verification from federal data sources is an effective way to protect the integrity of eligibility requirements and promote coverage for eligible individuals while reducing enrollment burden, yet this would be eliminated under section 112201. Many states already have robust verification processes in place. Adding additional verification criteria and moving up the timeline to require verification prior to enrollment may lead to coverage disruptions, interfering with enrollees' abilities to see their physicians. The AMA also strongly supports flexibility for state exchanges to design their own pre-enrollment verification processes, which these provisions would interfere with.

In sections 44201 and 112203, which bar premium tax credits for individuals that fail to reconcile their previous tax returns, the AMA urges a grace period for enrollees to retroactively reconcile and apply for coverage and have their coverage be retroactively effective to the beginning of the coverage year. This grace period would balance the need to ensure income is verified while averting coverage disruptions for eligible enrollees. Failure to reconcile income status likely reflects a lack of understanding of the need to file taxes based solely on the receipt of APTC, reiterating the strong need to provide educational resources and enrollment support, including through care navigators, particularly during the initial transition period.

Section 44201 would allow issuers to redirect premium payments for the current payment year to instead repay past-due premiums from any previous plan year before coverage can be effectuated for a new benefit year. We have several concerns with this policy. Typically, once insurance premiums go unpaid for a certain period of time, coverage is terminated, and any outstanding claims made during the non-payment window may not be covered. Once coverage is terminated, the enrollee would be responsible for paying for his or her own medical bills moving forward. Therefore, if enrollees are required to pay for any outstanding premiums for any plan year, they are likely paying insurance companies for coverage from which they will not actually benefit. There are also several unanswered questions about how this policy will work logistically, including how services in previous plan years during which coverage was interrupted would be treated, as well as how incomplete payments for premiums would impact coverage for services moving forward. The fact that this policy would extend to unpaid premiums during any period of time in the distant past adds further complication and concern. At a minimum, the lookback period should be limited to 12 months as it was during a prior Trump administration rule and issuers should be required to disclose this policy to enrollees prior to making any payments for new policy premiums. Not disclosing how their money will be spent creates a potentially serious breach of contractual obligations to enrollees.

Section 112203 would remove the current cap on paying back excess advance premium tax credits received during the coverage year based on an enrollee's income. Moving forward, enrollees would owe the full past due amount, regardless of income. The AMA is concerned that this change might be particularly difficult for low-income enrollees to comply with and may result in additional coverage losses.

The AMA is concerned by provisions in section 44201 to widen required de minimis ranges and loosen restrictions on silver-level plans, which would negatively impact patients' ability to afford their coverage

and access health care services. Under the new growth rate methodology, the growth rate for 2026 would be approximately 7.2 percentage points higher than under the previous methodology, which would have several important implications for enrollee cost-sharing, including higher maximum annual cost-sharing limits, higher required contributions (and therefore decreased APTCs), and higher employer shared responsibility payment amounts. Higher out-of-pocket expenses disproportionately impact those with more complex health needs, including those with chronic disease. Broader ranges also confuse enrollees and make it more difficult for enrollees to compare coverage options within the same metal tier levels. Regarding easing silver level plan restrictions, we are concerned about the negative impact on APTCs, which are calculated using the difference between the second lowest cost silver plan premium and the applicable percentage of the enrollee's income. If these provisions are enacted, it will be incumbent on the U.S. Department of Health and Human Services to provide clear information to enrollees about the differences in out-of-pocket costs across plan options and to closely monitor plan premiums to ensure that these proposals are indeed correlating to lower premiums that offset the higher out of pocket costs. If not, patients are simply paying more for the same coverage.

Finally, the AMA is concerned by provisions in 44201 and 112102 that would eliminate marketplace eligibility for lawfully present immigrants including deferred action for childhood arrivals (DACA) recipients, and in the case of section 112102, asylum seekers, and green card holders. The AMA appreciates the need to protect taxpayer dollars. With this in mind, we believe there is an economic argument to be made to maintain ACA coverage and subsidies for immigrants who are in the U.S. legally, as these groups often have minimal alternative health insurance options and would otherwise be uninsured and it is well-established that expanding access to coverage improves population health and is likely to result in reduced costs for the American taxpayer since individuals without insurance are less likely to receive preventive or routine health screenings and may delay necessary medical care, often resulting in higher health care costs down the road. Legal immigrants such as green card holders and DACA recipients also play a critical role in local economies. For example,[19] more than 200,000 DACA recipients serve as frontline workers and studies show that individuals with health coverage are likely to miss fewer days of work.[20] Allowing legal immigrants to enroll in exchange coverage would provide stability for these individuals to seek out lawful education and employment opportunities. Furthermore, many of these classes of individuals including DACA recipients are relatively young and healthy,[21] and thus would have a positive impact on ACA risk pools. Therefore, the AMA opposes the proposal to restrict the definition of "lawfully present" to exclude immigrants who are in this country legally.

**Student Loans**

The AMA believes that the cost of medical education should never be a barrier to the pursuit of a career in medicine. As such, we greatly appreciate the provision in section 30022 that would defer the accrual of student loan interest during the first four years of residency in a somewhat similar manner to the Resident Education Deferred Interest Act (H.R. 2028/S. 942)[22] and believe this provision should be extended to cover the entire residency period of a physician. However, we are extremely concerned about the negative

[19] https://cmsny.org/daca-essential-workers-covid.
[20] https://pmc.ncbi.nlm.nih.gov/articles/PMC2690190.
[21] https://www.kff.org/racial-equity-and-health-policy/fact-sheet/key-facts-on-deferred-action-for-childhood-arrivals-daca/.
[22] https://searchlf.ama-assn.org/letter/documentDownload?uri=/unstructured/binary/letter/LETTERS/lfra.zip/2025-4-2-Letter-to-Babin-and-Houlahan-re-HR-2028-REDI-Act-v3.pdf.

ramifications of the overall implementation of this bill and ask that at a minimum, carveouts are provided for medical school education to ensure that we can continue to educate our next generation of physicians.

Medical education remains the most expensive post-secondary education in the United States with about 71 percent of medical students graduating with a mean of over $212,000 in educational debt.[23] This is in part due to the fact that the median cost of graduating from a public in-state medical school is $286,454, while the cost of graduating from a private institution is $390,848.[24] As a result, the cost of attending medical school was the number one reason why qualified applicants chose not to apply.[25]

Unfortunately, section 30002 would base the amount of student loans offered on the median cost of attendance for students enrolled in the same program of study nationally. And section 30011 would eliminate subsidized loans and Federal Direct Graduate (GRAD) PLUS loans, limit parents' ability to borrow loans on behalf of their children, and cap the amount of Federal Direct Unsubsidized loans that a student can borrow for professional school to $150,000 not including any amount borrowed to help fund an undergraduate degree.

Currently, Direct Unsubsidized Loans and GRAD PLUS loans are the most common loan types taken out by medical students.[26] Therefore, the combined effect of the elimination of GRAD PLUS loans along with a borrowing cap for Direct Unsubsidized Loans that is $62,000 below the mean amount needed to graduate from medical school will severely limit the number of individuals that can afford a medical degree and likely exacerbate the looming shortage of 86,000 physicians.[27] Moreover, limiting the amount of Direct Unsubsidized Loans that an individual can take based on the median cost of attending medical school will likely require students, especially those from low income backgrounds, to scramble to find multiple funding streams to support their medical education since a significant portion of medical schools will cost more to attend than the national median.

We appreciate the importance of working to create an affordable and sustainable higher education system. However, we worry that the bill, as currently drafted, would make medical school unaffordable for most students, even if they are the most qualified candidates applying. As such, we urge you to maintain subsidized and GRAD Plus loans, allow parents to have better borrowing terms to help fund their children's higher education, and not cap the amount that an individual can borrow to pay for medical school.

Section 30024 would make it so that time spent in residency would not count as a public service job, thereby making residents ineligible for the Public Service Loan Forgiveness (PSLF) program. The PSLF program has increasingly gained popularity since its creation, and in 2024 over 88 percent of medical student graduates with student debt noted in their graduation questionnaire that they intended to participate in the PSLF program.[28] Additionally, studies have shown that more future primary care physicians intend to use PSLF than programs that were historically designed to promote primary care, a

[23] https://store.aamc.org/downloadable/download/sample/sample_id/633/.
[24] *Id.*
[25] https://www.researchgate.net/publication/324523861_Doctors_of_debt_Cutting_or_capping_the_Public_Service_Loan_Forgiveness_Program_PSLF_hurts_physicians_in_training.
[26] https://students-residents.aamc.org/media/9941/download.
[27] https://www.aamc.org/news/press-releases/new-aamc-report-shows-continuing-projected-physician-shortage.
[28] https://www.aamc.org/data-reports/students-residents/report/graduation-questionnaire-gq.

stated bipartisan concern of many members of Congress.[29] These studies show that the PSLF program has the ability to incentivize physicians to work for qualifying employers, which ultimately equates to more physicians practicing for 10 or more years in underserved communities. However, if time as a resident does not count towards loan forgiveness, significantly fewer physicians will participate in this program and in turn access to much needed medical care for patients in rural and underserved communities will be diminished.

Moreover, non-physician practitioners (NPPs), including nurse practitioners and physician assistants, are currently able to count their training time toward loan forgiveness under PSLF.[30] Proposing to exclude physicians from the same eligibility raises concerns about fairness especially given that physicians often enter residency with significantly more education and training than NPPs and, as they progress through their residency, ultimately take on larger workloads and more complicated tasks than their NPP counterparts. Instead, all resident physicians should have access to PSLF during their training years since regardless of whether they are working in a public, private, or nonprofit setting, they are working for low wages to better public health.

Section 30021 would end current repayment plans and replace them with a standard plan and a Repayment Assistance Plan. We applaud the provisions under the Repayment Assistance Plan that would allow those borrowers that are making full- and on-time payments to avoid interest accrual and reduce their principal loan balance by $50 or less for each qualifying payment that is made. However, since this section would do away with the current income driven repayment (IDR) plans, it could cause significant hardship for medical students since over 77 percent of physicians were participating in IDR plans in 2020.[31]

Moreover, under the Repayment Assistance Plan a borrower would have to remain in repayment for 30 years, instead of 25 years, before they could receive forgiveness, and repayment amounts would be based on the borrower's adjusted gross income maxing out at 10 percent for individuals that make more than $100,000 per year. Since year one residents earn a mean salary of about $66,700, they would be paying six percent of their adjusted gross income just to student loans, which is a significant amount for anyone in that salary range.[32] Even those physicians who do eventually go on to earn $100,000 or more will be paying 10 percent of their adjusted gross income for 30 years or until they pay off their balance. This is a significant payment and would likely place substantial stress on, and impede, residents and young physicians from meeting important financial goals like saving for retirement, buying a house, marrying, and more.[33] Furthermore, research finds that students with larger student loan balances, such as those with medical degrees, tend to default less frequently,[34] and the Congressional Budget Office found that only about five percent of individuals who financed a graduate degree (including professional degrees) using federal student loans were in default after six years.[35] Given the high success rate of student loan

[29] https://pubmed.ncbi.nlm.nih.gov/27295187/.
[30] https://www.aapa.org/news-central/2024/12/how-physician-associates-can-qualify-for-student-loan-forgiveness/#:~:text=Public%20Service%20Loan%20Forgiveness%20for%20PAs&text=For%20example%2C%20a%20full%2Dtime,student%20loan%20debt%20management%20strategy.
[31] https://www.degruyterbrill.com/document/doi/10.7556/jaoa.2020.058/html.
[32] https://www.aamc.org/data-reports/students-residents/report/aamc-survey-resident/fellow-stipends-and-benefits.
[33] https://www.tandfonline.com/doi/full/10.3402/meo.v19.25603.
[34] https://upcea.edu/wp-content/uploads/2018/03/Exploring-the-Determinants-of-Student-Loan-Default-Rates.pdf#:~:text=2%20As%20student%20loan%20debt,at%20managing%20financial%20risk%2C%20for.
[35] https://www.cbo.gov/system/files/2024-09/58963-student-loan.pdf.

repayment for physicians, we would urge you to continue to allow physicians to access the current repayment plans along with the new repayment plans so that they can choose a plan that will be best suited for them.

Physicians are the backbone of the entire medical system and central to one of the most important federally promised benefits, Medicare. Physicians serve as the gatekeepers of Medicare not only by determining medical necessity and authorizing care, but also by safeguarding the system against fraud, waste, and abuse. By law, Medicare only reimburses for items and services that are "reasonable and necessary for the diagnosis or treatment of illness or injury" which requires physician certification or documentation.[36] This requirement is even more explicit in key areas of the Medicare statute, such as home health care[37] and hospice services,[38] both of which condition coverage based on physician certification. Therefore, without a robust physician workforce, Medicare could not meet its statutory obligation to provide appropriate, medically necessary care to its beneficiaries, and beyond that medical care cannot be provided to our country at large without an adequate supply of physicians. Unfortunately, this bill may deter individuals from applying to medical school, make medical school unaffordable for all but the wealthiest, make student loan repayment harder for some, and deter physicians from serving in health professional shortage areas. As such, we ask that carveouts be provided for medical school education in recognition of the unique role that physicians play in society and in alignment with the heavy educational burden that they undertake to care for those most in need.

**Conclusion**

The AMA appreciates the House's careful consideration of the potential impact of proposed changes on physicians and the patients they serve. We stand ready to work collaboratively with Congress to advance policies that promote access to high-quality, affordable care, ensure the sustainability of physician practices, and protect the integrity of vital safety net programs like Medicare, Medicaid, and CHIP.

Sincerely,

James L. Madara, MD

cc: The Honorable Brett Guthrie
The Honorable Frank Pallone
The Honorable Jason Smith
The Honorable Richie Neal
The Honorable Tim Walberg
The Honorable Bobby Scott
The Honorable Jodey Arrington
The Honorable Brendan Boyle
The Honorable Virginia Foxx
The Honorable Jim McGovern

[36] 42 U.S.C. § 1395y(a)(1)(A) https://www.law.cornell.edu/uscode/text/42/1395y.
[37] 42 U.S.C. § 1395f(a)(2)(C) https://www.law.cornell.edu/uscode/text/42/1395f.
[38] 42 U.S.C. § 1395f(a)(7) https://www.law.cornell.edu/uscode/text/42/1395f.

AMA
AMERICAN MEDICAL ASSOCIATION

James L. Madara, MD
CEO, EXECUTIVE VICE PRESIDENT
james.madara@ama-assn.org

June 20, 2025

The Honorable John Thune
U.S. Senate
511 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Charles Schumer
U.S. Senate
322 Hart Senate Office Building
Washington, DC 20510

Dear Majority Leader Thune and Leader Schumer:

On behalf of the physician and medical student members of the American Medical Association (AMA), I am writing to share our comments on numerous parts of H.R. 1, the "One Big Beautiful Bill Act," the reconciliation legislation passed by the House of Representatives on May 22, 2025, and now under consideration in the Senate. As the Senate contemplates changes to the House-passed bill, my colleagues and I would like to offer our perspective. While H.R. 1 touches on many areas of interest to the AMA, this letter will focus on the subjects we believe are most important to the physicians, medical students, and patients that we represent: Medicaid and the Children's Health Insurance Program (CHIP), access to health insurance coverage through the Affordable Care Act (ACA) marketplaces, federal support of medical student loans, artificial intelligence (AI), and Medicare physician payment reform.

**Medicaid and CHIP**

The AMA would like to share our views on proposed changes to the Medicaid and CHIP programs included in H.R. 1. As physicians, we know that Medicaid is a vital component of America's health care infrastructure, providing health insurance coverage to millions of patients and serving as a critical safety net for children, pregnant and postpartum women, seniors, and people with disabilities and serious health conditions. Medicaid coverage is associated with improved long-term health, lower rates of mortality, better health outcomes, fewer hospitalizations, better educational outcomes, and greater financial security.[1] Medicaid is an indispensable source of coverage for maternal health services, covering over 40 percent of all births in the United States, including almost 50 percent of births in rural areas.[2] In many communities Medicaid is a major source of health insurance coverage or, in some cases, the primary payer.[3] For the physician practices and other health care providers who serve these communities, Medicaid payments are a crucial source of funding without which they might be

[1] Benjamin D. Sommers, Katherine Baicker & Arnold M. Epstein, "Mortality and Access to Care among Adults after State Medicaid Expansions." 367 NEJM 11, 1025-34 (Sep. 2012); Henry J. Kaiser Family Foundation, "What is Medicaid's Impact on Access to Care, Health Outcomes, and Quality of Care? Setting the Record Straight in the Evidence" (Aug. 2013); Alisa Chester & Joan Alker, Georgetown University Health Policy Institute Center for Children and Families, "Medicaid at 50: A Look at the Long-Term Benefits of Childhood Medicaid" (Jul. 2015).

[2] https://www.aha.org/fact-sheets/2025-02-07-fact-sheet-medicaid.

[3] https://ccf.georgetown.edu/2025/01/15/medicaids-role-in-small-towns-and-rural-areas/.

unable to continue to operate, jeopardizing access to care in those communities and in rural areas in particular. For all these reasons, preserving patient access to care under Medicaid is a top priority of the AMA, and the AMA strongly supports policies that maintain and expand coverage, access, federal funding, and eligibility criteria under Medicaid and CHIP.

Like any large health insurance program, Medicaid and CHIP lose money to waste, fraud, and abuse.[4] The AMA is supportive of legislative efforts to address these program integrity issues in a targeted fashion. However, changes that would result in reductions in Medicaid and CHIP funding, procedural changes that may lead to coverage disruptions for otherwise eligible patients, or new obstacles to physicians and other providers participating in Medicaid and CHIP would go against the long-standing policy of the AMA that Medicaid reforms should avoid jeopardizing patient access to health care. After reviewing the changes to the Medicaid and CHIP programs proposed by both the House of Representatives and the Senate, we note that they would create new administrative requirements for patients to enroll in, and maintain coverage under, these programs, and would shift billions of dollars in program costs to the states. We fear these changes would lead to unintended consequences that could affect patients who are eligible for Medicaid and CHIP benefits, rural and underserved communities, and the providers who serve them.

Many of the changes included in both the House and Senate provisions of H.R. 1 relate to the administrative processes involved in determining eligibility for benefits under Medicaid and CHIP. The AMA understands that robust processes are necessary for program integrity, but we recommend minimizing administrative complexity to help eligible patients enroll and maintain coverage under Medicaid and CHIP. Administrative hurdles in these two safety net programs are a proven barrier to eligible individuals enrolling for coverage, especially given that of the estimated 25.3 million uninsured Americans in 2023, 6.3 million were eligible for Medicaid or CHIP but not enrolled, often due to administrative barriers.[5] While there are many new administrative requirements in H.R. 1 that could result in the wrongful denial or loss of coverage under Medicaid or CHIP for eligible patients, of particular concern to the AMA are the sections that would: impose community engagement requirements as a condition of coverage; terminate regulations that are intended to streamline eligibility determinations for Medicaid, CHIP, and the Medicare Savings Program (which is administered by state Medicaid programs); increase the frequency of eligibility redeterminations for Medicaid expansion enrollees; and shorten retroactive coverage periods.

Several of the new administrative provisions are designed to apply either exclusively or with greater force to the Medicaid expansion group. Adding complexity to the Medicaid expansion pathway by increasing administrative burdens for expansion patients could have substantial consequences. The expansion option provides an essential pathway to health insurance coverage for millions of low-income Americans (in 2025, the income eligibility threshold for the expansion pathway was $21,597 for a single-person household). Since it was first implemented in 2014, Medicaid expansion has been adopted by 40 states (including seven states that adopted expansion pursuant to a voter referendum) and the District of Columbia[6] and has filled a gap in the health

[4] https://www.nhcaa.org/tools-insights/about-health-care-fraud/the-challenge-of-health-care-fraud/.
[5] https://www.kff.org/affordable-care-act/state-indicator/distribution-of-eligibility-for-aca-coverage-among-the-remaining-uninsured; https://www.kff.org/uninsured/issue-brief/a-closer-look-at-the-remaining-uninsured-population-eligible-for-medicaid-and-chip/.
[6] https://www.kff.org/status-of-state-medicaid-expansion-decisions/.

care system by providing coverage to patients without access to employer sponsored insurance or the ability to pay for private insurance. The popularity of Medicaid expansion continues to grow, with new states reinforcing their commitment as recently as March 2025, when Montana voted to make its Medicaid expansion permanent.[7]

Medicaid expansion has been shown to have significant positive benefits for low-income patients, with many studies demonstrating improvements in health care coverage, access, utilization, and mortality.[8] Medicaid expansion has played an important role in fighting America's opioid epidemic, providing much-needed treatment and coverage of lifesaving medications for opioid use disorder to millions of beneficiaries with substance use disorders and creating significant savings through decreased hospital and emergency department utilization.[9] Medicaid expansion has also contributed to substantial improvements in maternal health outcomes in the United States, with research indicating that Medicaid expansion is associated with a 17 percent decrease in hospitalization rates in postpartum women.[10] The expansion has also been an important source of coverage for individuals with chronic health conditions, with 44 percent of expansion enrollees suffering from at least one chronic condition.[11]

With respect to the community engagement requirements (established under Section 44141 of H.R. 1 as passed by the House of Representatives and under Section 71107 of the language released by the Senate Finance Committee on June 16, 2025), the AMA appreciates the policy's goal of lifting people out of poverty by incentivizing stable employment. However, as physicians, we are particularly concerned about the potential for coverage losses and disruptions in continuity of care. Work requirements have in some instances contributed to fluctuations in coverage in and out of the program. Experience from state-level programs suggests that work requirements can be administratively complex and that they have not consistently achieved improved employment outcomes.[12] It should be noted that over 90 percent of adults enrolled in Medicaid through the expansion pathway either already work or meet the criteria for an exemption from the requirement, such as being the parent of a dependent child.[13] While the implementation challenges associated with work requirements and the resulting losses in coverage for working beneficiaries are universal, they are even more pronounced in rural areas.[14] This experience supports AMA policy that opposes work requirements due to serious concerns about the impact

---

[7] https://www.mtpr.org/montana-news/2025-03-28/governor-signs-medicaid-expansion-renewal-into-law.
[8] https://www.commonwealthfund.org/publications/issue-briefs/2023/sep/impact-medicaid-coverage-gap-comparing-states-have-and-have-not; Sarah Miller, Norman Johnson, Laura R Wherry, "Medicaid and Mortality: New Evidence From Linked Survey and Administrative Data," The Quarterly Journal of Economics, Volume 136, Issue 3, August 2021, Pages 1783–1829.
[9] https://ccf.georgetown.edu/2025/02/19/how-medicaid-helps-people-with-substance-use-disorders.
[10] https://www.healthaffairs.org/doi/epdf/10.1377/hlthaff.2022.00819.
[11] https://www.kff.org/medicaid/issue-brief/5-key-facts-about-medicaid-expansion/.
[12] https://www.urban.org/urban-wire/new-evidence-confirms-arkansas-medicaid-work-requirement-did-not-boost-employment.
[13] https://www.urban.org/research/publication/state-state-estimates-medicaid-expansion-coverage-losses-under-federal-work; https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work-an-update/.
[14] https://healthlaw.org/wp-content/uploads/2025/04/ParkerNewton_MedicaidWorkRequirementsUndermineRuralHealthcare_04042025.pdf.

that such proposals may have on access to health care for patients who are otherwise eligible for coverage under Medicaid.

Both the House and Senate versions of H.R. 1 would require states to redetermine the eligibility of Medicaid expansion enrollees every six months (as opposed to every 12 months under current law). This doubles both the administrative burdens expansion enrollees face when reenrolling in Medicaid and the opportunities for an eligible patient to lose coverage due to an administrative error. As physicians, we prize continuity of care for our patients, and the AMA has policy supporting 12 months of continuous coverage across Medicaid and CHIP. Therefore, we strongly recommend that the Senate reconsider including this policy in its version of H.R. 1.

Another change that could impact timely access to care for some patients is the modification to retroactive coverage requirements (contained in Section 44122 of the House-passed version and Section 71114 of the Senate Finance Committee language). Under current law, states are required to provide retroactive Medicaid and CHIP coverage for the three months preceding the month in which an eligible patient submits their application for assistance under the program if the patient would have been eligible during the retroactive period. The proposed change would reduce this requirement to one month of retroactive coverage (in the Senate Finance Committee's language new enrollees who are not in the Medicaid expansion category will receive two months of retroactive coverage). To ensure that patients receive the care they need when they need it, AMA policy supports retroactive coverage for low-income patients to the time at which an eligible patient seeks medical care.

In addition to the provisions that establish new administrative requirements, the House and Senate versions of H.R. 1 include policies that shift a substantial portion of total Medicaid costs to the states. Chief among these are the policies that limit states' ability to finance the state share of Medicaid spending using revenue from health care provider taxes. Provider tax arrangements are a legitimate mechanism that states have used to finance their Medicaid programs since the mid-1980s and are governed by federal statute and regulations.[15] These arrangements are widely used (49 states and the District of Columbia use provider taxes to finance their Medicaid programs in 2025)[16] and accounted for as much as 17 percent of the total state share of Medicaid spending in 2024.[17] While Congress has made adjustments to the rules governing provider tax arrangements in the past, the changes currently under consideration are much more drastic. The House-passed version of H.R. 1 would freeze existing provider taxes at current levels, prohibit new provider taxes entirely, and effectively terminate certain existing provider tax arrangements. The Senate Finance Committee's language goes even further and, in addition to all of the policies included in the House language, would lower a safe harbor threshold for permissible provider taxes from six percent of the net patient service revenues received by the taxpayer to 3.5 percent (for expansion states only). Taken together, these changes are expected to reduce the federal share of Medicaid spending by well over $100 billion,[18] leaving states with difficult decisions on how to make up the difference. AMA policy supports the use of provider taxes as a means of financing Medicaid, and we are concerned that excessive restrictions on this source of funding, which states have

[15] https://www.congress.gov/crs-product/RS22843.
[16] *Id*.
[17] https://www.macpac.gov/wp-content/uploads/2024/06/MACPAC_June-2024-Chapter-1-Improving-the-Transparency-of-Medicaid-and-CHIP-Financing-1.pdf.
[18] https://www.cbo.gov/publication/61461.

relied upon for decades, will force states to reduce Medicaid benefits and provider reimbursement, threatening patient access to care and the continued financial viability of providers, particularly in rural and low-income areas. At the very least, the AMA would urge the Senate to revise its language to omit the change to the safe harbor threshold, include clarifying language to ensure that states are able to modify existing provider tax arrangements to comply with new requirements, and provide for a five-year transition period to allow states to make alternative plans for financing their programs.

Finally, another matter that raises concern is the new cost-sharing requirements included in Section 44142 of the House-passed version of H.R. 1 and Section 71125 of the Senate Finance Committee's language. While these requirements would only apply to Medicaid expansion patients with incomes that are greater than 100 percent of the federal poverty level ($15,650 for a household of one in 2025), even modest cost-sharing requirements can deter patients from accessing medical care. There is an extensive body of research showing that copayments can make it harder for low-income people to afford needed medical services and force them to make difficult choices between needed health care and other necessities, such as food and rent.[19] This is especially the case for individuals with chronic conditions who may require more frequent medical care and thus be charged more copayments. As physicians, we fear that the proposed cost-sharing provisions could pose barriers to Medicaid beneficiaries' ability to access medically necessary services in a timely fashion, including adhering to physician-prescribed therapies, which could lead to delays in treatment, increases in emergency room visits and hospitalizations, and other expensive forms of care.

**ACA Marketplace**

The AMA believes there are opportunities to enhance program integrity and protect taxpayer dollars with regard to the ACA Exchanges. However, while the AMA commends the Senate Health, Education, Labor and Pensions Committee for omitting from its language provisions that would codify the proposed ACA "Marketplace Integrity and Affordability Rule," we remain concerned that several provisions included in both the House and Senate versions of H.R. 1 will effectively reduce marketplace coverage for middle and low-income Americans. Furthermore, neither the House nor the Senate's versions of H.R. 1 address the scheduled expiration of enhanced tax credits at the end of 2025, which would result in an additional $26.1 billion reduction in 2026 alone,[20] and could lead to an additional 4.1 million uninsured people in 2034.[21]

Of particular concern to the AMA is Section 71303 of the Senate Finance Committee language, which effectively ends automatic reenrollment in ACA marketplace plans for individuals receiving premium tax credits. If carefully designed, reasonable income verification measures have the potential to strengthen program integrity and ensure enrollees meet income-based and other eligibility requirements. However, we are strongly concerned that provisions within Section 71303 may be both burdensome on individual enrollees and difficult for states to administer and may ultimately negatively impact enrollment of eligible individuals, particularly healthy

[19] https://www.kff.org/medicaid/issue-brief/understanding-the-impact-of-medicaid-premiums-cost-sharing-updated-evidence-from-the-literature-and-section-1115-waivers/.
[20] https://www.commonwealthfund.org/publications/issue-briefs/2025/mar/cost-eliminating-enhanced-premium-tax-credits.
[21] https://www.cbo.gov/system/files/2025-06/Wyden-Pallone-Neal_Letter_6-4-25.pdf.

individuals, in marketplace plans, thus also negatively impacting risk pools. For example, automatic enrollment with verification from federal data sources is an effective way to protect the integrity of eligibility requirements and promote coverage for eligible individuals while reducing enrollment burden, yet this would be eliminated under Section 71303. Many states already have robust verification processes in place. Adding additional verification criteria and moving up the timeline to require verification prior to enrollment may lead to coverage disruptions, interfering with enrollees' abilities to see their physicians. The AMA also strongly supports flexibility for state exchanges to design their own pre-enrollment verification processes, which Section 71303 would interfere with.

The AMA is also concerned about the potential impacts of Section 71304 of the Senate Finance Committee's language as it relates to special enrollment periods based on income. We are concerned that Section 71304 could be interpreted to disallow premium tax credits or cost-sharing reductions for patients who enroll during special enrollment periods that are triggered by a change in income, such as the special enrollment period for individuals who become newly eligible for premium tax credits following a change in income. While the AMA appreciates the need to address potential adverse selection concerns associated with continuous special enrollment periods that allow an individual to enroll (and receive premium tax credits and cost-sharing reductions, if eligible) in any month provided that their income is below a certain threshold, we also believe it is essential that individuals retain the ability to enroll in a health plan if they experience a change in circumstances, including a change in income, that impacts their health insurance coverage or their eligibility for premium tax credits or cost-sharing reductions. AMA policy would oppose the limitations placed on special enrollment periods by Section 71304 if they would prevent patients from receiving premium tax credits or cost-sharing reductions simply because they enroll in, or change, health plans during a special enrollment period triggered by a change to their income or coverage status. The AMA urges the Senate to add language to Section 71304 clarifying that patients would remain eligible for premium tax credits and cost-sharing reductions under these circumstances.

Section 71305 of the Senate Finance Committee language would remove the current cap on paying back excess advance premium tax credits received during the coverage year based on an enrollee's income. Moving forward, enrollees would owe the full past due amount, regardless of income. The AMA is concerned that this change might be particularly difficult for low-income enrollees to comply with and may result in additional coverage losses. While the AMA appreciates that the Senate refined the House's language by adding a narrow exception for certain low-income individuals who receive excess tax credits despite acting in good faith, we believe further safeguards are necessary to ensure that low-income patients are not harmed, and would urge the Senate to broaden this exception and apply the current law repayment cap to any individual with income below 400 percent of the poverty line who acts in good faith.

Finally, the AMA is concerned by provisions in Section 71302 of the Senate Finance Committee language that would eliminate premium tax credit eligibility for many categories of lawfully present immigrants, including refugees, asylees, deferred action for childhood arrivals (DACA) recipients, and individuals with Temporary Protected Status. The AMA appreciates the need to protect taxpayer dollars. With this in mind, we believe there is an economic argument to be made to maintain ACA subsidies for all immigrants who are in the United States legally, as these groups often have minimal alternative health insurance options and would otherwise be uninsured. It is well-established that expanding access to coverage improves population health

and is likely to result in reduced costs for the American taxpayer since individuals without insurance are less likely to receive preventive or routine health screenings and may delay necessary medical care, often resulting in higher health care costs down the road. Legal immigrants such as DACA recipients also play a critical role in local economies. More than 200,000 DACA recipients serve as frontline workers for example,[22] and studies show that individuals with health coverage are likely to miss fewer days of work.[23] Allowing legal immigrants to enroll in exchange coverage would provide stability for these individuals to seek out lawful education and employment opportunities. Furthermore, many of these classes of individuals including DACA recipients are relatively young and healthy,[24] and thus would have a positive impact on ACA risk pools. Therefore, the AMA opposes the proposal to restrict eligibility for premium tax credits for immigrants who are in this country legally.

**Student Loans**

The AMA believes that the cost of medical education should never be a barrier to the pursuit of a career in medicine. As a result, we are extremely concerned about the negative ramifications of the overall implementation of this bill and ask that at a minimum, carve outs are provided for medical school education to ensure that we can continue to educate our next generation of physicians.

Medical education remains the most expensive post-secondary education in the United States with about 71 percent of medical students graduating with a mean of over $212,000 in educational debt.[25] This is in part due to the fact that the median cost of graduating from a public in-state medical school is $286,454, while the cost of graduating from a private institution is $390,848.[26] As a result, the cost of attending medical school was the number one reason why qualified applicants chose not to apply.[27]

Unfortunately, Section 81001 would eliminate the ability for medical students to receive subsidized loans and Federal Direct Parent Loan for Undergraduate Students (PLUS) Loans, limit parents' ability to borrow loans on behalf of their children, and cap the amount of Federal Direct Unsubsidized Stafford Loans that a student can borrow for professional school to $200,000, including any amount borrowed for graduate school, but not including any amount borrowed to help fund an undergraduate degree.

Currently, Direct Unsubsidized Loans and Federal Direct PLUS Loans are the most common loan types taken out by medical students.[28] In general Federal Direct PLUS Loans are heavily utilized by medical students because they currently allow students to borrow up to the cost of attendance, have a fixed interest rate for the life of the loan, allow for benefits such as residency forbearance

---

[22] https://cmsny.org/daca-essential-workers-covid.
[23] https://pmc.ncbi.nlm.nih.gov/articles/PMC2690190.
[24] https://www.kff.org/racial-equity-and-health-policy/fact-sheet/key-facts-on-deferred-action-for-childhood-arrivals-daca/.
[25] https://store.aamc.org/downloadable/download/sample/sample_id/633/.
[26] *Id*.
[27] https://www.researchgate.net/publication/324523861_Doctors_of_debt_Cutting_or_capping_the_Public_Service_Loan_Forgiveness_Program_PSLF_hurts_physicians_in_training.
[28] https://students-residents.aamc.org/media/9941/download.

and deferment, and have income-driven repayment options.[29] Though we do appreciate the inclusion in Section 70119 of the discharge of all student loans upon death or disability, the combined effect of the elimination of Federal Direct PLUS Loans along with a borrowing cap for Direct Unsubsidized Loans that is below the mean amount needed to graduate from medical school will severely limit the number of individuals that can afford a medical degree and likely exacerbate the looming shortage of 86,000 physicians.[30] Moreover, limiting the amount of Direct Unsubsidized Loans that an individual can take will likely require students, especially those from low income backgrounds, to scramble to find multiple funding streams to support their medical education.

We appreciate the importance of working to create an affordable and sustainable higher education system. However, we worry that the bill, as currently drafted, would make medical school unaffordable for most students, even if they are the most qualified candidates applying. As such, we urge you to maintain subsidized and Federal Direct PLUS Loans, allow parents to have better borrowing terms to help fund their children's higher education, and not cap the amount that an individual can borrow to pay for medical school.

Section 82004 would make it so that time spent in residency would not count as a public service job, thereby making residents ineligible for the Public Service Loan Forgiveness (PSLF) program. The PSLF program has increasingly gained popularity since its creation, and in 2024 over 88 percent of medical student graduates with student debt noted in their graduation questionnaire that they intended to participate in the PSLF program.[31] Additionally, studies have shown that more future primary care physicians intend to use PSLF than programs that were historically designed to promote primary care, such as the National Health Service Corps.[32] These studies show that the PSLF program has the ability to incentivize physicians to work for qualifying employers, which ultimately equates to more physicians practicing for 10 or more years in underserved communities. However, if time as a resident does not count towards loan forgiveness, significantly fewer physicians will participate in this program and in turn access to much needed medical care for patients will be diminished.

Moreover, non-physician practitioners (NPPs), including nurse practitioners and physician assistants, are currently able to count their training time toward loan forgiveness under PSLF.[33] Proposing to exclude physicians from the same eligibility raises concerns about fairness especially given that physicians often enter residency with significantly more education and training than NPPs and, as they progress through their residency, ultimately take on larger workloads and more complicated tasks than their NPP counterparts. Instead, all resident physicians should have access to PSLF during their training years since regardless of whether they are working in a public, private, or nonprofit setting, they are working for low wages to better public health.

---

[29] https://www.aamc.org/media/82881/download?attachment.
[30] https://www.aamc.org/news/press-releases/new-aamc-report-shows-continuing-projected-physician-shortage.
[31] https://www.aamc.org/data-reports/students-residents/report/graduation-questionnaire-gq.
[32] https://pubmed.ncbi.nlm.nih.gov/27295187/.
[33] https://www.aapa.org/news-central/2024/12/how-physician-associates-can-qualify-for-student-loan-forgiveness/#:~:text=Public%20Service%20Loan%20Forgiveness%20for%20PAs&text=For%20example%2C%20a%20full%2Dtime,student%20loan%20debt%20management%20strategy.

Section 82001 would end current repayment plans and replace them with a standard plan and a Repayment Assistance Plan. We applaud the provisions under the Repayment Assistance Plan that would allow those borrowers that are making full- and on-time payments to avoid interest accrual and reduce their principal loan balance by $50 or less for each qualifying payment that is made. However, since this section would do away with the current income driven repayment (IDR) plans, it could cause significant hardship for medical students since over 77 percent of physicians were participating in IDR plans in 2020.[34]

Moreover, under the Repayment Assistance Plan a borrower would have to remain in repayment for 30 years, instead of 25 years, before they could receive forgiveness, and repayment amounts would be based on the borrower's adjusted gross income maxing out at 10 percent for individuals that make more than $100,000 per year. Since year one residents have a median stipend of about $65,000, they would be paying six percent of their adjusted gross income just to student loans, which is a significant amount for anyone in that salary range.[35] Even those physicians who do eventually go on to earn $100,000 or more will be paying 10 percent of their adjusted gross income for 30 years or until they pay off their balance. This is a significant payment and would likely place substantial stress on, and impede, residents and young physicians from meeting important financial goals like saving for retirement, buying a house, marrying, and more.[36]

Furthermore, research has found that students with larger student loan balances, such as those with medical degrees, tend to default less frequently,[37] and the Congressional Budget Office found that only about five percent of individuals who financed a graduate degree (including professional degrees) using federal student loans were in default after six years.[38] This is in part due to the fact that the earning potential of physicians provides the financial means to effectively manage and repay their student loan obligations and results in default rates from medial school graduates being exceedingly low.[39] Given the high success rate of student loan repayment for physicians, and the resulting financial benefit to the government from the higher interest rates repaid, we would urge you to continue to allow physicians to access the current repayment plans along with the new repayment plans so that they can choose a plan that will be best suited for them.

Additionally, the AMA encourages the inclusion of Section 30022 of H. Con Res. 14 in the Senate text. Section 30022 would defer the accrual of student loan interest during the first four years of residency in a somewhat similar manner to the Resident Education Deferred Interest Act (REDI)(H.R. 2028/S. 942)[40] and we believe this provision should be included and extended to

---

[34] https://www.degruyterbrill.com/document/doi/10.7556/jaoa.2020.058/html.
[35] https://www.aamc.org/data-reports/students-residents/report/aamc-survey-resident/fellow-stipends-and-benefits.
[36] https://www.tandfonline.com/doi/full/10.3402/meo.v19.25603.
[37] https://upcea.edu/wp-content/uploads/2018/03/Exploring-the-Determinants-of-Student-Loan-Default-Rates.pdf#:~:text=2%20As%20student%20loan%20debt,at%20managing%20financial%20risk%2C%20for.
[38] https://www.cbo.gov/system/files/2024-09/58963-student-loan.pdf.
[39] https://www.aamc.org/media/11461/download.
[40] https://searchlf.ama-assn.org/letter/documentDownload?uri=/unstructured/binary/letter/LETTERS/lfra.zip/2025-4-2-Letter-to-Rosen-and-Boozman-re-S-942-REDI-Act-v3.pdf.

cover the entire residency period of a physician. Section 30022 would be especially beneficial for physicians that either cannot afford to pay six percent of their income during residency or choose to utilize residency forbearance during their training years.

Physicians are the backbone of the entire medical system and central to one of the most important federally promised benefits, Medicare. Physicians serve as the gatekeepers of Medicare not only by determining medical necessity and authorizing care, but also by safeguarding the system against fraud, waste, and abuse. By law, Medicare only reimburses for items and services that are "reasonable and necessary for the diagnosis or treatment of illness or injury" which requires physician certification or documentation.[41] This requirement is even more explicit in key areas of the Medicare statute, such as home health care[42] and hospice services,[43] both of which condition coverage based on physician certification. Therefore, without a robust physician workforce, Medicare could not meet its statutory obligation to provide appropriate, medically necessary care to its beneficiaries, and beyond that medical care cannot be provided to our country at large without an adequate supply of physicians. Unfortunately, this bill may deter individuals from applying to medical school, make medical school unaffordable for all but the wealthiest, make student loan repayment harder for some, and deter physicians from serving in health professional shortage areas. As such, we ask that carveouts be provided for medical school education in recognition of the unique role that physicians play in society and in alignment with the heavy educational burden that they undertake to care for those most in need.

**Artificial Intelligence**

The AMA has serious concerns about the inclusion of provisions in Section 0012 of the Senate Committee on Commerce, Science, and Transportation language that would prohibit state-level regulation of AI without additional federal action to create guardrails around the design, development, and deployment of AI. This lack of clear and consistent legislative and regulatory requirements is especially notable as applied to health care AI, including any AI that may be used in federal programs and may impact patient data privacy and patient access to care.

The AMA shares Congress' concerns that a patchwork of state legislation regulating AI would be problematic and confusing for developers, physicians, and patients alike. However, to ensure the safety and protection of our patients, additional federal action to ensure quality, performance, and transparency of AI must be in place. Without additional consumer protections, clear guidelines to assure AI quality, strong consumer data privacy protections, and further action to limit bias within AI systems, Americans will undoubtedly suffer harm. In the absence of any federal action to further these critical protections, states have taken action to fill critical gaps by mandating transparency and stepping up efforts to ensure their residents are covered by strong consumer protection laws that serve to limit unintended consequences from poorly performing AI systems.

In the health care space specifically, use of unregulated AI by federal departments and agencies could ultimately result in inappropriate dissemination and use of protected personal health information and denials of critical health care by federal payers—issues we have already seen come to fruition that have caused real harm to real patients. Stakeholders across industry,

[41] 42 U.S.C. § 1395y(a)(1)(A) https://www.law.cornell.edu/uscode/text/42/1395y.
[42] 42 U.S.C. § 1395f(a)(2)(C) https://www.law.cornell.edu/uscode/text/42/1395f.
[43] 42 U.S.C. § 1395f(a)(7) https://www.law.cornell.edu/uscode/text/42/1395f.

physicians, and patient organizations have consistently agreed that additional federal action to create clear and consistent guardrails that seek to ensure patient safety and data privacy are a critical need that remains unaddressed.

While the AMA remains a strong supporter of developing innovative AI tools that reduce physicians' burden and improve health outcomes for our patients, we also recognize the distinct and serious risks that health care AI poses to patient safety. These risks must be mitigated to the greatest extent possible. This legislation, as currently drafted, may fall short of achieving that goal. It sets a precedent for AI regulation that lacks sufficient clarity, contributes to ongoing confusion, and may fail to provide adequate assurances of performance and safety. We urge a reconsideration of this approach and encourage close collaboration with stakeholders to ensure the right balance between enabling innovation and upholding our shared responsibility to do no harm.

The AMA has significant concerns about Section 112204 of the House-passed language, under which a total of $25 million will be transferred from the Federal Hospital Insurance Trust Fund and Federal Supplementary Medical Insurance Trust Fund to the Centers for Medicare & Medicaid Services to enter into contracts with AI tool vendors to help identify and reduce improper payments made under Medicare Parts A and B. While supportive of rooting out improper payments, delegating Medicare integrity functions to opaque, black-box algorithms would strip physicians of due-process visibility, invite biased or erroneous claw-backs, and erode clinical autonomy. The legislation is also silent regarding any appeal processes available to physicians or physician practices subjected to errors committed by the AI technology. The AMA is concerned about the precedent of using AI technology for this purpose and the lack of statutory protections for physicians. Congress should instead require transparent, evidence-based audit standards with meaningful physician oversight and appeal rights before allowing any AI-driven payment policing. The AMA urges the Senate to continue to omit this provision in its version of H.R. 1.

**Medicare**

The AMA is disappointed and has serious concerns that the Senate Finance Committee omitted Section 44304 of the House-passed bill which has provisions that would permanently link annual physician fee schedule updates to the Medicare Economic Index (MEI). Physicians are already dealing with a 2.83 percent cut to Medicare payment in 2025 and, since 2001, payment updates have fallen behind practice cost inflation by 33 percent. Each short-term fix enacted since 2021 has expired with a steep cliff, as payment updates reverted to reduced payment rates as if there had been no legislative provision at all. Removing Section 44304 leaves that destructive cycle in place.

Section 44304 provides the first permanent payment adjustment built into baseline Medicare rates since the passage of the Medicare Access and CHIP Reauthorization Act (MACRA) in 2015. It follows the Medicare Payment Advisory Commission's recommendation to tie Medicare payment updates to the MEI. The provision sets the 2026 payment update at 75 percent of the MEI, an estimated 2.25 percent higher than any annual update granted under MACRA. Because the increase becomes part of the baseline rather than a temporary patch, the AMA calculates that cumulative physician payment growth from 2025 through 2035 would reach 4.3 percent, compared to only 2.5 percent under current law. That difference is important especially for small

community practices that already operate on thin margins and serve large numbers of Medicare patients in rural and underserved areas.

Additionally, under current law, ongoing budget-neutrality adjustments have continuously reduced the Medicare conversion factor year after year, making private practice unsustainable for many physicians. In 2001, 61 percent of physicians owned their practices; by 2016 fewer than half did, and since 2018 most physicians have been employees. Restoring Section 44304 would help stop that trend, support participation in value-based care models, and stabilize access for seniors who depend on local physicians for routine and complex treatment.

Section 44304 also lays a foundation for comprehensive physician payment reform in the 119th Congress. Regular, adequate updates are important to practice stability and patient access, especially in most rural communities, where medical practices treat four times as many Medicare patients as their metropolitan counterparts. By linking updates to the MEI and embedding them in the fee schedule, Congress would give physicians and patients a stronger, more predictable Medicare program.

The Senate still has time to correct its course. Reinstating Section 44304 before the reconciliation bill advances would shore up practice sustainability, protect patient access, and end the cycle of temporary fixes and payment cliffs. Physicians and their patients cannot afford yet another year of instability caused by the erosion in Medicare payments.

**Conclusion**

The AMA appreciates the Senate's careful consideration of the potential impact of proposed changes on physicians and the patients they serve. We stand ready to work collaboratively with Congress to advance policies that promote access to high-quality, affordable care, ensure the sustainability of physician practices, and protect the integrity of vital safety net programs like Medicare, Medicaid, and CHIP.

Sincerely,

James L. Madara, MD

AMA
AMERICAN MEDICAL ASSOCIATION

John Whyte, MD, MPH
CEO, EXECUTIVE VICE PRESIDENT

john.whyte@ama-assn.org

July 11, 2025

The Honorable Mehmet C. Oz, MD, MBA
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

**Re: Medicaid Program; Preserving Medicaid Funding for Vulnerable Populations—Closing a Health Care-Related Tax Loophole Proposed Rule [RIN 0938–AV58]**

Dear Administrator Oz:

On behalf of the physician and medical student members of the American Medical Association (AMA), I thank the Centers for Medicare & Medicaid Services (CMS) for the opportunity to respond to the proposed rule, titled "Medicaid Program; Preserving Medicaid Funding for Vulnerable Populations—Closing a Health Care-Related Tax Loophole" [RIN 0938–AV58]. In the rule, CMS would establish new criteria to limit certain forms of Medicaid provider taxes that impose higher tax rates on Medicaid providers by ensuring rates imposed on any taxpayer or tax rate group are not higher than another within the same permissible class, either outright or via a lower volume or percentage of Medicaid taxable units. CMS estimates that seven states would be impacted. The rule would also prevent additional states from creating similar taxes in the future. The rule would be effective immediately for states that implemented such taxes in the last two years. Other states would have two years to come into compliance.

**The AMA supports the use of provider taxes and opposes federal proposals that would restrict or eliminate states' ability to assess provider taxes on hospitals, nursing homes, and managed care organizations to protect patient access to care.** Provider taxes are a legitimate financing mechanism used by states in partnership with the federal government to fund essential health services and have kept rural hospitals, maternity wards, nursing homes, and physician practices open in rural and underserved areas across this country. If these provider tax reforms are enacted, it will create significant gaps in state budgets, forcing states to raise taxes or reduce benefits, coverage, or provider payments, or a combination thereof, leading to real impacts on Medicaid enrollees and communities across the country. Emergency department overcrowding will be exacerbated. As the uncompensated care burdens grow from patients losing coverage, many rural hospitals, nursing homes, and community physician practices could be forced to close, leaving entire vulnerable communities without access to critical health care services. Given hospitals and health systems are often among the largest employers in local communities, particularly rural areas, closures could incite broader economic instability.

Provider taxes are often used by states to increase payment rates to physicians and other health care professionals. Far too often, Medicaid payment rates lag behind private insurance and Medicare. While physicians have a strong sense of responsibility to provide care for Medicaid beneficiaries, physician practices cannot remain economically viable if they lose money on the care they provide. Without adequate payment rates, participating physicians will remain sparse in many areas of the country, and without an adequate supply of participating physicians, Medicaid patients may have coverage but not real

access to care. Too often beneficiaries must wait for unreasonable periods of time to receive the needed care, travel long distances to find Medicaid participating physicians, or go without care altogether. Lack of access to participating physicians puts beneficiaries at risk of harm or even death. Numerous studies have found adequate provider payment rates result in higher acceptance rates of Medicaid patients, greater access to and use of primary care, better patient outcomes, and significantly reduced health disparities.[1]

The AMA is deeply concerned that, according to CMS estimates, the changes proposed in this rule will amount to an estimated $33.2 billion reduction in federal Medicaid spending from 2026 through 2030. Several assumptions made in the rule, such as assuming all states will expand existing taxes to all payers, make this likely an underestimation. Furthermore, while a handful of states may be impacted now, the moratorium would prevent additional states from adopting similar taxes in the future, broadening the impact and severely hamstringing states' abilities to expand Medicaid services or respond to health crises or increases in Medicaid enrollment during economic downturns. The funding cuts that will result from this proposed rule will disproportionately impact the traditional Medicaid population of children, veterans, seniors, people with disabilities, and pregnant women.

Importantly, this proposed rule comes on the heels of more than $860 billion in reduced federal Medicaid spending over the next decade as a result of the One Big Beautiful Bill Act (OBBBA) according to the most recent estimate by the nonpartisan Congressional Budget Office, doubling down on the economic pressure states will face. Furthermore, the OBBBA also includes provisions related to provider taxes that overlap in key ways with the proposals in this rule. In particular, section 71117 of the OBBBA imposes limitations on provider taxes that are substantially similar to the limitations in the proposed rule, though there are important differences between the new law and the proposed rule (including whether affected states will be given a transition period to bring their taxes into compliance with new requirements, and how long such transition period will be). **Given these recent developments, the AMA calls on CMS to reevaluate this proposed rule in light of the changes in this legislation and reconsider whether this rule is still necessary.**

The rule asserts that the proposed changes are necessary in part because Medicaid dollars are not being spent judiciously. The AMA fundamentally disagrees with this premise. Administrative costs for Medicaid plans account for just 3.9 percent of total Medicaid spending in 2023, making it the most cost-efficient health insurance program in the country. [2] States are required to develop capitation rates that meet a medical loss ratio (MLR) target of at least 85 percent.[3] In 2023, the average MLR across states was 87 percent.[4] Rates of incomplete documentation or other errors in Medicaid payment and eligibility data have also declined by over 75 percent from 2019 to 2024 thanks to enhanced state Medicaid transparency efforts in recent years. Such errors now amount to no more than six percent of Medicaid payment and eligibility records. The vast majority of these errors (~80 percent) reflect insufficient documentation or technical errors, not necessarily improper payments.[5]

---

[1] Alexander, Diane and Schnell, Molly. *"The Impacts of Physician Payments on Patient Access, Use, and Health."*American Economic Journal: Applied Economics. July 2024.
[2] Machledt, David. "Medicaid is Even Leaner as Accountability Improves." National Health Law Program. February 25, 2025. https://healthlaw.org/medicaid-is-even-leaner-as-accountability-improves/.
[3] "Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability." Final rule. CMS. May 6, 2016. https://www.govinfo.gov/content/pkg/FR-2016-05-06/pdf/2016-09581.pdf.
[4] Cox, Cynthia et al. "Health Insurer Financial Performance in 2023." Kaiser Family Foundation. July 2, 2023. https://www.kff.org/medicare/issue-brief/health-insurer-financial-performance/.
[5] Machledt, David. "Medicaid is Even Leaner as Accountability Improves." National Health Law Program. February 25, 2025. https://healthlaw.org/medicaid-is-even-leaner-as-accountability-improves/.

We also disagree with the assertion that state Medicaid funds, including those raised by provider taxes, are spent without accountability for quality or patient outcomes or without commensurate benefit to the Medicaid program or its beneficiaries. States deploy a variety of quality and outcome provisions, particularly those that use managed care contracts, which cover 75 percent of the nation's Medicaid enrollees. Forty-three of 51 states had at least one delivery and payment reform initiative designed to address Medicaid cost and quality in place as of July 2021 and half (25) had multiple initiatives in place. Thirty-eight of 47 states reported using at least one specified financial incentive to promote quality of care.[6] Under 2016 and 2020 regulations, states are also required to implement the CMS-developed quality rating system (QRS) or a state alternative QRS under which it must collect data and issue annual quality ratings for each of its managed care organizations and prepaid health plans.[7] 2016 and 2020 federal rules also stipulate additional transparency around financial and quality data for state Medicaid programs. As part of these efforts, CMS began publicly posting the Managed Care Program Annual Report and the MLR Summary Reports on Medicaid.gov in 2024.[8]

CMS expresses concern that certain states are using Medicaid provider tax revenue to fill state budget shortfalls rather than reinvesting the revenue in their Medicaid programs. On this point, **the AMA agrees that provider tax revenue should be used to directly support Medicaid patients' access to care.** Fortunately, many state tax policies already align with this view, and, in many cases, state medical associations have led the charge in ensuring such guardrails are in place. For example, in California, a provider coalition brought a successful ballot initiative (Proposition 35) in November 2024 championed by the California Medical Association, so state law now requires these funds be dedicated to supporting increasing access to care for the millions of seniors, children, low-income families and people with disabilities who rely on Medicaid in the state.[9] Similarly, a recently enacted law in Minnesota requires that revenue from a new assessment on managed care organizations be used to improve access to mental and behavioral health services.[9] Another recently enacted law in Nebraska stipulates that revenue from a provider tax go into a "Medicaid Access and Quality Fund" to be used to enhance rates paid to nonhospital providers of physical health services.[10] **Rather than broadly disallowing certain provider taxes altogether, the agency should instead put guardrails in place to ensure Medicaid tax revenue is used responsibly to improve the program and increase access to care, as many states have already done.**

We are also concerned with the lack of transparency and clarity regarding definitions in the proposed rule. CMS notes several times in the rule that seven states would be impacted by the proposed changes but does not identify these seven states. It is also not clear how CMS intends to define Medicaid providers and Medicaid taxable units versus non-Medicaid providers and non-taxable units, and CMS appears to retain a large degree of autonomy and discretion in doing so. CMS provides illustrative examples in the rule but does not provide a specific threshold or definition. Without clearly defined terms, we are concerned that states will have difficulty determining whether or not they comply with the rule and the agency could significantly expand the scope of this rule in the future without public notice of comment and rulemaking. **We urge CMS to more clearly define these core concepts, including what constitutes**

---

[6] Elizabeth Hinton, Lina Stolyar, Madeline Guth, and Mike Nardone. State Delivery System and Payment Strategies Aimed at Improving Outcomes and Lowering Costs in Medicaid. Kaiser Family Foundation. January 12, 2022. https://www.kff.org/medicaid/issue-brief/state-delivery-system-and-payment-strategies-aimed-at-improving-outcomes-and-lowering-costs-in-medicaid/.

[7] Medicaid and CHIP Managed Care Final Rules. https://www.medicaid.gov/medicaid/managed-care/guidance/medicaid-and-chip-managed-care-final-rules.

[8] Elizabeth Hinton and Jada Raphael. 10 Things to Know About Medicaid Managed Care. Kaiser Family Foundation. February 27, 2025. https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-care.

[9] Minnesota House File 2, 94th Legislature, 2025 1st Special Session. Enacted June 14, 2025.

[10] Nebraska Legislative Bill 527, The Medicaid Access and Quality Act, 109th Legislature, Enacted April 7, 2025.

**a Medicaid provider and taxable unit, and to invite stakeholder comment on these important concepts before finalizing this rule.**

Lastly, the AMA appreciates that a transition period has been proposed for states with provider taxes that were approved at least two years prior. However, we disagree with the CMS view that states who received approval within the last two years received advance notice that there may be future rulemaking in this area and therefore should not be eligible for a transition period. Provider tax reforms have been floated for decades; a general warning with no specified rulemaking or timeframe does not constitute sufficient notice and does not allow states to plan for significant budgetary changes. Many states will have to amend their tax and revenue statutes via the legislative process, but most state legislatures convene briefly once each year and four convene only on a biennial basis. A transition period should be offered to all states regardless of when their tax was approved. Furthermore, the two-year period provides inadequate advance notice to the health care professionals and institutions that care for Medicaid patients who are likely to receive reduced payment rates following the states' loss of federal funding. Moreover, section 71117 of the recently enacted OBBBA provides for a transition period of up to three fiscal years and does not distinguish between states based on the approval date of their waiver, creating further confusion. **We urge CMS to set a minimum implementation timeframe of three years regardless of when a state's tax was approved by CMS.** The AMA would also strongly oppose any alternative transition period shorter than two years.

Medicaid has a long, proven track record of providing much-needed care for the 80 million vulnerable Americans it serves. The AMA and physicians nationwide urge CMS to reject the harmful cuts to federal Medicaid financing that would result from this proposed rule, which will destabilize state health systems, reduce access to care, and worsen physician shortages. Instead, we urge you to reconsider this rule in its entirety due to the Medicaid provider tax reform provisions included in the recently enacted OBBBA and to consider more targeted provisions that would address the root concerns raised by CMS in the rule, such as guardrails to ensure revenue generated by Medicaid provider taxes are used solely for the improvement of state Medicaid programs.

Thank you for your support of physicians and the patients we serve. Please reach out to me directly at 312-464-5288 or John.Whyte@ama-assn.org if you have questions or need further information.

Sincerely,



John Whyte, MD, MPH

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 201
(I-25)

Introduced by: American Association of Clinical Urologists, Utah Medical Association

Subject: Model State Legislation incorporating Medical Malpractice Tort Reform Based on Utah H.B. 503 (2025)

Referred to: Reference Committee B

---

Whereas, on March 27, 2025, the Utah State Legislature passed H.B. 503 which addressed medical malpractice tort reform. The bill was sponsored by Representative Katy Hall and Senator Scott D. Sandall, and was signed into law by Governor Spencer J. Cox on March 27, 2025; and

Whereas, this bill:

- defines terms;

- with respect to a medical malpractice action:
  - repeals requirements related to affidavits of merit;
  - prohibits prejudicing a defendant in an adjudication of a claimant's claims;
  - prohibits pursuing or collecting on a judgment against a health care provider's personal income or assets, with exceptions;
  - grants access to the court's Xchange database to the Division of Professional Licensing(division);
  - establishes data collection and reporting requirements for the division;
  - amends procedure pertaining to prelitigation review panels and panel reviews; and
  - makes a prelitigation review panel's recommendations or findings advisory; and

- makes technical changes; and

Whereas, specific highlights of the Utah bill provide that:

- A plaintiff may not pursue, collect, or execute on a judgment against an individual health care provider's personal income or assets, unless the court finds that:
  a. the provider's conduct was willful and malicious or intentionally fraudulent; or
  b. the defendant provider failed to maintain an insurance policy with a policy limit of at least $1,000,000.
- Prior to any award of damages to a plaintiff, a plaintiff may not make allegations that the court finds:
  a. are irrelevant to the adjudication of the claims at issue;
  b. are made primarily to coerce or induce settlement in an individual defendant provider; and
  c. pertain to a provider's personal income or assets.
- The court may award attorney fees and costs to a respondent provider if:
  a. (i) a prelitigation review panel renders an opinion under Subsection 78B-3-418(2)(a) that a claimant's claim or cause of action has no merit; or
  (ii) the court finds that the claimant did not receive a certificate of compliance because the plaintiff failed to reasonably cooperate in the scheduling of the

prelitigation panel review under Subsection 78B-3-416(4)(f);

b. the claimant proceeds to litigate the malpractice action against a health care provider without obtaining an affidavit of merit under Section 78B-3-423; and

c. the court finds that the claimant did not substantially prevail; and

• A claimant in a malpractice action against a health care provider, or the claimant's attorney, is liable to any respondent for the reasonable attorney fees and costs incurred by the respondent, or by the respondent's insurer, in connection with any filing, submission, panel review, arbitration, or judicial proceeding under this part for which a claimant files or submits an affidavit containing an allegation that the court or arbitrator finds that the claimant knew, or should have known, to be baseless or false at the time the affidavit was signed, filed, or submitted; and

Whereas, the full text of the bill is included in the references; therefore be it

RESOLVED, that our American Medical Association develop model state legislation incorporating medical malpractice tort reform based on Utah H.B. 503 enacted into law March 27, 2025. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/2/25

**REFERENCES**

1. https://le.utah.gov/~2025/bills/static/HB0503.html
2. https://le.utah.gov/Session/2025/bills/enrolled/HB0503.pdf

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 202
(I-25)

Introduced by: Michigan

Subject: Deepfake Technology and Harm to Physicians and Patients

Referred to: Reference Committee B

---

Whereas, deepfake technology represents a significant threat as a form of synthetic media generated by artificial intelligence that fabricates images, videos, and audio content to depict false events or actions; and

Whereas, advancements in generative deepfake technology have reached a point where distinguishing between real and fake content is increasingly difficult, especially when an individual's image, voice, and likeness are mixed with another person's; and

Whereas, deepfake technology can and is being utilized for malicious purposes, such as identity theft, legal manipulation, blackmail, the creation of non-consensual sexual content, child pornography, the dissemination of misinformation, and other forms of fraud; and

Whereas, physicians who utilize social media for patient engagement face heightened risks of reputational damage resulting from deepfake content; and

Whereas, deepfake "doctors" are garnering millions of views on social media, endorsing products from weight-loss supplements to unproven medical treatments and devices purely for financial gain, thereby jeopardizing patient safety and exposing them to serious harm; and

Whereas, the foundation of the patient-physician relationship - built on accurate information, trust, professionalism, and authenticity - is under direct threat due to deepfake content, which misleads patients and undermines their confidence in medical practice; and

Whereas, the proliferation of deepfakes has become alarmingly common, posing substantial threats to politics, national security, and critical sectors such as finance and business, by misrepresenting politicians, celebrities, and industry leaders in ways that provoke anger or fear; and

Whereas, aggressive measures must be taken to raise awareness and implement protective safeguards against deepfake content, which carries potentially devastating mental health implications for both patients and physicians; therefore be it

RESOLVED, that our American Medical Association recognize that while there are documented advantages of deepfake technology for medical education, training, and patient engagement, there currently exists a significant regulatory void, and such lack of oversight can result in harmful consequences, including the manipulation of patients, the spread of misinformation, and the potential for injury or death (New HOD Policy); and be it further

RESOLVED, that our AMA support relevant organizations including healthcare professionals, technology developers, government regulators, social media platforms, and the public, to

formulate comprehensive federal legislation and regulations regarding deepfake technology to uphold the integrity of the medical profession against malpractice, increase awareness of the risks associated with deepfake content, and safeguard patient well-being across all communities. (Directive to Take Action)

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

Received: 9/3/25

**REFERENCES**

1. Unmasking deepfakes: A systematic review of deepfake detection and generation techniques using artificial intelligence - ScienceDirect
2. Deep Fakes in Healthcare: How Deep Learning Can Help to Detect Forgeries – ScienceDirect
3. https://pmc.ncbi.nlm.nih.gov/articles/PMC11503397/
4. https://www.forbes.com/sites/shashankagarwal/2024/05/30/deepfakes-in-healthcare-addressing-dangers-and-reducing-risks/
5. Revenge Pornography: Mental Health Implications and Related Legislation | Journal of the American Academy of Psychiatry and the Law
6. Montréal Declaration on Responsible AI
7. The US has plans to tackle AI-generated deepfakes | World Economic Forum
8. www3.weforum.org/docs/WEF_The_Global_Risks_Report_2024.pdf
9. FTC Proposes New Protections to Combat AI Impersonation of Individuals | Federal Trade Commission
10. Hearing Wrap Up: Action Needed to Combat Proliferation of Harmful Deepfakes - United States House Committee on Oversight and Accountability
11. Deepfakes and doctors: How people are being fooled by social media scams | The BMJ
12. Deepfakes: The Unsung Hero of Healthcare Innovation?

## RELEVANT AMA POLICY

**Medical and Public Health Misinformation Online D-440.915**

1. Our American Medical Association encourages social media companies and organizations, search engine companies, online retail companies, online healthcare companies, and other entities owning websites to further strengthen their content moderation policies related to medical and public health misinformation, including, but not limited to enhanced content monitoring, augmentation of recommendation engines focused on false information, and stronger integration of verified health information.
2. Our AMA encourages social media companies and organizations, search engine companies, online retail companies, online healthcare companies, and other entities owning websites to recognize the spread of medical and public health misinformation over dissemination networks and collaborate with relevant stakeholders to address this problem as appropriate, including but not limited to altering underlying network dynamics or redesigning platform algorithms.
3. Our AMA will continue to support the dissemination of accurate medical and public health information by public health organizations and health policy experts.
4. Our AMA will work with public health agencies in an effort to establish relationships with journalists and news agencies to enhance the public reach in disseminating accurate medical and public health information.

**Assessing the Potentially Dangerous Intersection Between AI and Misinformation H-480.935**

1. Our American Medical Association will study and develop recommendations on the benefits and unforeseen consequences to the medical profession of large language models (LLM) such as, generative pretrained transformers (GPTs), and other augmented intelligence-generated medical advice or content, and that our AMA propose appropriate state and federal regulations with a report back at A-24.
2. Our AMA will work with the federal government and other appropriate organizations to protect patients from false or misleading AI-generated medical advice.
3. Our AMA will encourage physicians to educate our patients about the benefits and risks of consumers facing LLMs including GPTs.
4. Our AMA will support publishing groups and scientific journals to establish guidelines to regulate the use of augmented intelligence in scientific publications that include detailing the use of augmented

intelligence in the methods, exclusion of augmented intelligence systems as authors, and the responsibility of authors to validate the veracity of any text generated by augmented intelligence.

**Assessing the Intersection Between AI and Health Care H-480.931**

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 203
(I-25)

Introduced by: Academic Physicians Section

Subject: Restore and Enhance Federal Loan Programs for Medical Education

Referred to: Reference Committee B

---

Whereas, physician workforce projections indicate that the United States will face an increasing shortage of physicians[1]; and

Whereas, the cost of medical education is significant, and most medical students finance their medical education through debt[2]; and

Whereas, the Federal Loan program Grad PLUS loans provided significant benefits for medical education in comparison to private debt, such as the option to borrow up the cost of attendance, mandatory residency forbearance, and Income Driven Repayment[3]; and

Whereas, physician workforce gaps are especially prominent in primary care, rural practice, and practice in underserved areas[4]; and

Whereas, the Public Service Loan Forgiveness program supports the ability of students interested in primary care, rural practice, or practice with underserved populations to finance medical education with less debt load[5]; and

Whereas, recent legislation eliminated Grad PLUS loans and reduced the impact of Public Service Loan Forgiveness indirectly through decreased access to Public Service Loan Forgiveness with the elimination of Grad PLUS[6]; and

Whereas, the impact of recent legislation on medical student education will have a negative impact on the physician workforce through the creation of financial barriers that decrease access to medical education for many qualified applicants and reduce medical student access to future careers in primary care, rural medicine, or medical care for the underserved; therefore be it

RESOLVED, that our American Medical Association advocates for the restoration of the Grad PLUS program with loan limits established to support the cost of attendance of medical education programs. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/19/25

**REFERENCES**
1. https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/physicians-projections-factsheet.pdf
2. https://store.aamc.org/downloadable/download/sample/sample_id/368/https://www.aamc.org/media/82881/download; https://store.aamc.org/downloadable/download/sample/sample_id/633/
3. https://www.aamc.org/media/82881/download
4. https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/state-of-the-primary-care-workforce-report-2024.pdf, https://www.jec.senate.gov/public/index.cfm/democrats/2024/1/addressing-rural-health-worker-shortages-will-improve-population-health-and-create-job-opportunities, https://data.hrsa.gov/topics//health-workforce/shortage-areas
5. Marcu M. I., Kellerman A. L., Hunter C., Curtis J., Rice C., and Wilensky, G. R (2017). "Borrow or Serve? An Economic Analysis of Options for Financing a Medical School Education". Academic Medicine 92 (7): 966-975. https://www.ruralhealth.us/nationalruralhealth/media/documents/advocacy/2025/reconciliation-grad-loan-fact-sheet-6-30-25.pdf
6. https://www.congress.gov/bill/119th-congress/house-bill/1. https://www.americanbar.org/advocacy/governmental_legislative_work/publications/washingtonletter/june-25-wl/student-loan-updates-0625wl/

## RELEVANT AMA POLICY

### H-305.929 Proposed Revisions to AMA Policy on the Financing of Medical Education Programs

1. It is AMA policy that:

A. Since quality medical education directly benefits the American people, there should be public support for medical schools and graduate medical education programs and for the teaching institutions in which medical education occurs. Such support is required to ensure that there is a continuing supply of well-educated, competent physicians to care for the American public.

B. Planning to modify health system organization or financing should include consideration of the effects on medical education, with the goal of preserving and enhancing the quality of medical education and the quality of and access to care in teaching institutions are preserved.

C. Adequate and stable funding should be available to support quality undergraduate and graduate medical education programs. Our AMA and the federation should advocate for medical education funding.

D. Diversified sources of funding should be available to support medical schools' multiple missions, including education, research, and clinical service. Reliance on any particular revenue source should not jeopardize the balance among a medical school's missions.

E. All payers for health care, including the federal government, the states, and private payers, benefit from graduate medical education and should directly contribute to its funding.

F. Full Medicare direct medical education funding should be available for the number of years required for initial board certification. For combined residency programs, funding should be available for the longest of the individual programs plus one additional year. There should be opportunities to extend the period of full funding for specialties or subspecialties where there is a documented need, including a physician shortage.

G. Medical schools should develop systems to explicitly document and reimburse faculty teaching activity, so as to facilitate faculty participation in medical student and resident physician education and training.

H. Funding for graduate medical education should support the training of resident physicians in both hospital and non-hospital (ambulatory) settings. Federal and state funding formulas must take into account the resources, including volunteer faculty time and practice expenses, needed for training residents in all specialties in non-hospital, ambulatory settings. Funding for GME should be allocated to the sites where teaching occurs.

I. New funding should be available to support increases in the number of medical school and residency training positions, preferably in or adjacent to physician shortage/underserved areas and in undersupplied specialties.

2. Our AMA endorses the following principles of social accountability and promotes their application to GME funding: (a) Adequate and diverse workforce development; (b) Primary care and specialty practice workforce distribution; (c) Geographic workforce distribution; and (d) Service to the local community and the public at large.

3. Our AMA encourages transparency of GME funding through models that are both feasible and fair for training sites, affiliated medical schools and trainees.

4. Our AMA believes that financial transparency is essential to the sustainable future of GME funding and therefore, regardless of the method or source of payment for GME or the number of funding streams, institutions should publically report the aggregate value of GME payments received as well as what these payments are used for, including: (a) Resident salary and benefits; (b) Administrative support for graduate medical education; (c) Salary reimbursement for teaching staff; (d) Direct educational costs for residents and fellows; and (e) Institutional overhead.

5. Our AMA supports specialty-specific enhancements to GME funding that neither directly nor indirectly reduce funding levels for any other specialty. [CME Rep. 7, A-05 Reaffirmation I-06 Reaffirmed: Sub. Res. 314, A-07 Reaffirmation I-07 Reaffirmed: CME Rep. 4, I-08 Reaffirmed: Sub. Res. 314, A-09 Reaffirmed: CME Rep. 3, I-09 Reaffirmed: CME Rep. 15, A-10 Reaffirmation A-11 Reaffirmation A-13 Reaffirmed: CME Rep. 5, A-13 Appended: CME 05, A-16 Appended: Res. 319, A-16 Reaffirmation A-16 Reaffirmed: Res. 310, A-24]

**H-305.925 Principles of and Actions to Address Medical Education Costs and Student Debt**
The costs of medical education should never be a barrier to the pursuit of a career in medicine nor to the decision to practice in a given specialty. To help address this issue, our American Medical Association (AMA) will:

1. Collaborate with members of the Federation and the medical education community, and with other interested organizations, to address the cost of medical education and medical student debt through public- and private-sector advocacy.
2. Vigorously advocate for and support expansion of and adequate funding for federal scholarship and loan repayment programs--such as those from the National Health Service Corps, Indian Health Service, Armed Forces, and Department of Veterans Affairs, and for comparable programs from states and the private sector--to promote practice in underserved areas, the military, and academic medicine or clinical research.
3. Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.
4. Advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit:
    a. inclusion of all medical specialties in need, and
    b. service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas.
5. Encourage the National Health Service Corps to have repayment policies that are consistent with other federal loan forgiveness programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas.
6. Work to reinstate the economic hardship deferment qualification criterion known as the “20/220 pathway,” and support alternate mechanisms that better address the financial needs of trainees with educational debt.
7. Advocate for federal legislation to support the creation of student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans.

8. Work with other concerned organizations to advocate for legislation and regulation that would result in favorable terms and conditions for borrowing and for loan repayment, and would permit 100% tax deductibility of interest on student loans and elimination of taxes on aid from service-based programs.
9. Encourage the creation of private-sector financial aid programs with favorable interest rates or service obligations (such as community- or institution-based loan repayment programs or state medical society loan programs).
10. Support stable funding for medical education programs to limit excessive tuition increases, and collect and disseminate information on medical school programs that cap medical education debt, including the types of debt management education that are provided.
11. Work with state medical societies to advocate for the creation of either tuition caps or, if caps are not feasible, pre-defined tuition increases, so that medical students will be aware of their tuition and fee costs for the total period of their enrollment.
12. Encourage medical schools to:
    a. study the costs and benefits associated with non-traditional instructional formats (such as online and distance learning, and combined baccalaureate/MD or DO programs) to determine if cost savings to medical schools and to medical students could be realized without jeopardizing the quality of medical education;
    b. engage in fundraising activities to increase the availability of scholarship support, with the support of the Federation, medical schools, and state and specialty medical societies, and develop or enhance financial aid opportunities for medical students, such as self-managed, low-interest loan programs;
    c. cooperate with postsecondary institutions to establish collaborative debt counseling for entering first-year medical students;
    d. allow for flexible scheduling for medical students who encounter financial difficulties that can be remedied only by employment, and consider creating opportunities for paid employment for medical students;
    e. counsel individual medical student borrowers on the status of their indebtedness and payment schedules prior to their graduation;
    f. inform students of all government loan opportunities and disclose the reasons that preferred lenders were chosen;
    g. ensure that all medical student fees are earmarked for specific and well-defined purposes, and avoid charging any overly broad and ill-defined fees, such as but not limited to professional fees;
    h. use their collective purchasing power to obtain discounts for their students on necessary medical equipment, textbooks, and other educational supplies;
    i. work to ensure stable funding, to eliminate the need for increases in tuition and fees to compensate for unanticipated decreases in other sources of revenue; mid-year and retroactive tuition increases should be opposed.
13. Support and encourage state medical societies to support further expansion of state loan repayment programs, particularly those that encompass physicians in non-primary care specialties.
14. Take an active advocacy role during reauthorization of the Higher Education Act and similar legislation, to achieve the following goals:
    a. Eliminating the single holder rule.
    b. Making the availability of loan deferment more flexible, including broadening the definition of economic hardship and expanding the period for loan deferment to include the entire length of residency and fellowship training.
    c. Retaining the option of loan forbearance for residents ineligible for loan deferment.
    d. Including, explicitly, dependent care expenses in the definition of the “cost of attendance”.
    e. Including room and board expenses in the definition of tax-exempt scholarship income.
    f. Continuing the federal Direct Loan Consolidation program, including the ability to “lock in” a fixed interest rate, and giving consideration to grace periods in renewals of federal loan programs.
    g. Adding the ability to refinance Federal Consolidation Loans.
    h. Eliminating the cap on the student loan interest deduction.
    i. Increasing the income limits for taking the interest deduction.
    j. Making permanent the education tax incentives that our AMA successfully lobbied for as part of Economic Growth and Tax Relief Reconciliation Act of 2001.
    k. Ensuring that loan repayment programs do not place greater burdens upon married couples than for similarly situated couples who are cohabitating.

l. Increasing efforts to collect overdue debts from the present medical student loan programs in a manner that would not interfere with the provision of future loan funds to medical students.

15. Continue to work with state and county medical societies to advocate for adequate levels of medical school funding and to oppose legislative or regulatory provisions that would result in significant or unplanned tuition increases.
16. Continue to study medical education financing, so as to identify long-term strategies to mitigate the debt burden of medical students, and monitor the short-and long-term impact of the economic environment on the availability of institutional and external sources of financial aid for medical students, as well as on choice of specialty and practice location.
17. Collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition.
18. Continue to monitor the availability of and encourage medical schools and residency/fellowship programs to:
    a. provide financial aid opportunities and financial planning/debt management counseling to medical students and resident/fellow physicians;
    b. work with key stakeholders to develop and disseminate standardized information on these topics for use by medical students, resident/fellow physicians, and young physicians; and
    c. share innovative approaches with the medical education community.
19. Seek federal legislation or rule changes that would stop Medicare and Medicaid decertification of physicians due to unpaid student loan debt. Our AMA believes that it is improper for physicians not to repay their educational loans, but assistance should be available to those physicians who are experiencing hardship in meeting their obligations.
20. Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical student and physician participation in the program, and will:
    a. Advocate that all resident/fellow physicians have access to PSLF during their training years.
    b. Advocate against a monetary cap on PSLF and other federal loan forgiveness programs.
    c. Work with the United States Department of Education to ensure that any cap on loan forgiveness under PSLF be at least equal to the principal amount borrowed.
    d. Ask the United States Department of Education to include all terms of PSLF in the contractual obligations of the Master Promissory Note.
    e. Encourage the Accreditation Council for Graduate Medical Education (ACGME) to require residency/fellowship programs to include within the terms, conditions, and benefits of program appointment information on the employer's PSLF program qualifying status.
    f. Advocate that the profit status of a physician's training institution not be a factor for PSLF eligibility,
    g. Encourage medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed.
    h. Encourage medical school financial advisors to increase medical student engagement in service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas.
    i. Strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes.
    j. Monitor the denial rates for physician applicants to the PSLF.
    k. Undertake expanded federal advocacy, in the event denial rates for physician applicants are unexpectedly high, to encourage release of information on the basis for the high denial rates, increased transparency and streamlining of program requirements, consistent and accurate communication between loan servicers and borrowers, and clear expectations regarding oversight and accountability of the loan servicers responsible for the program.
    l. Work with the United States Department of Education to ensure that applicants to the PSLF and its supplemental extensions, such as Temporary Expanded Public Service Loan Forgiveness (TEPSLF), are provided with the necessary information to successfully complete the program(s) in a timely manner.
    m. Work with the United States Department of Education to ensure that individuals who would otherwise qualify for PSLF and its supplemental extensions, such as TEPSLF, are not disqualified from the program(s).
21. Advocate for continued funding of programs including Income-Driven Repayment plans for the benefit of reducing medical student load burden.

22. Strongly advocate for the passage of legislation to allow medical students, residents and fellows who have education loans to qualify for interest-free deferment on their student loans while serving in a medical internship, residency, or fellowship program, as well as permitting the conversion of currently unsubsidized Stafford and Graduate Plus loans to interest free status for the duration of undergraduate and graduate medical education.
23. Continue to monitor opportunities to reduce additional expense burden upon medical students including reduced-cost or free programs for residency applications, virtual or hybrid interviews, and other cost-reduction initiatives aimed at reducing non-educational debt.
24. Encourage medical students, residents, fellows and physicians in practice to take advantage of available loan forgiveness programs and grants and scholarships that have been historically underutilized, as well as financial information and resources available through the Association of American Medical Colleges and American Association of Colleges of Osteopathic Medicine, as required by the Liaison Committee on Medical Education and Commission on Osteopathic College Accreditation, and resources available at the federal, state and local levels.
25. Support federal efforts to forgive debt incurred during medical school and other higher education by physicians and medical students, including educational and cost of attendance debt.
26. Support that residency and fellowship application services grant fee assistance to applicants who previously received fee assistance from medical school application services or are determined to have financial need through another formal mechanism. [CME Report 05, I-18 Appended: Res. 953, I-18 Reaffirmation: A-19 Appended: Res. 316, A-19 Appended: Res. 226, A-21 Reaffirmed in lieu of: Res. 311, A-21 Modified: CME Rep. 4, I-21 Reaffirmation: A-22 Appended: CME Rep. 02, A-23 Appended: Res. 311, A-23 Reaffirmed: Res. 314, A-24 Reaffirmed: Res. 215, I-24 Reaffirmed: BOT Rep. 07, I-24]

**H-465.988 Educational Strategies for Meeting Rural Health Physician Shortage**

1. In light of the data available from the current literature as well as ongoing studies being conducted by staff, our American Medical Association recommends that:

    a. Our AMA encourage medical schools and residency programs to develop educationally sound rural clinical preceptorships and rotations consistent with educational and training requirements, and to provide early and continuing exposure to those programs for medical students and residents.

    b. Our AMA encourage medical schools to develop educationally sound primary care residencies in smaller communities with the goal of educating and recruiting more rural physicians.

    c. Our AMA encourage state and county medical societies to support state legislative efforts toward developing scholarship and loan programs for future rural physicians.

    d. Our AMA encourage state and county medical societies and local medical schools to develop outreach and recruitment programs in rural counties to attract promising high school and college students to medicine and the other health professions.

    e. Our AMA urge continued federal and state legislative support for funding of Area Health Education Centers (AHECs) for rural and other underserved areas.

    f. Our AMA continue to support full appropriation for the National Health Service Corps Scholarship Program, with the proviso that medical schools serving states with large rural underserved populations have a priority and significant voice in the selection of recipients for those scholarships.

    g. Our AMA support full funding of the new federal National Health Service Corps loan repayment program.

    h. Our AMA encourage continued legislative support of the research studies being conducted by the Rural Health Research Centers funded by the National Office of Rural Health in the Department of Health and Human Services.

    i. Our AMA continue its research investigation into the impact of educational programs on the supply of rural physicians.

j. Our AMA continue to conduct research and monitor other progress in development of educational strategies for alleviating rural physician shortages.

k. Our AMA reaffirm its support for legislation making interest payments on student debt tax deductible.

l. Our AMA encourage state and county medical societies to develop programs to enhance work opportunities and social support systems for spouses of rural practitioners.

2. Our AMA will work with state and specialty societies, medical schools, teaching hospitals, the Accreditation Council for Graduate Medical Education (ACGME), the Centers for Medicare and Medicaid Services (CMS) and other interested stakeholders to identify, encourage and incentivize qualified rural physicians to serve as preceptors and volunteer faculty for rural rotations in residency.

3. Our AMA will:

a. work with interested stakeholders to identify strategies to increase residency training opportunities in rural areas with a report back to the House of Delegates; and

b. work with interested stakeholders to formulate an actionable plan of advocacy with the goal of increasing residency training in rural areas.

4. Our AMA will encourage ACGME review committees to consider adding exposure to rural medicine as appropriate, to encourage the development of rural program tracks in training programs and increase physician awareness of the conditions that pose challenges and lack of resources in rural areas.

5. Our AMA will encourage adding educational webinars, workshops and other didactics via remote learning formats to enhance the educational needs of smaller training programs. [CME Rep. C, I-90 Reaffirmation A-00 Reaffirmation A-01 Reaffirmation I-01 Reaffirmed: CME Rep. 1, I-08 Reaffirmed: CEJA Rep. 06, A-18 Appended: Res. 956, I-18 Appended: Res. 318, A-19 Modified: CME Rep. 3, I-21 Reaffirmation: I-22 Reaffirmed: BOT Rep. 11, A-23 Reaffirmed: Res. 215, I-24 Reaffirmed: BOT Rep. 07, I-24]

**H-200.949 Principles of and Actions to Address Primary Care Workforce**
1. Our patients require a sufficient, well-trained supply of primary care physicians--family physicians, general internists, general pediatricians, and obstetricians/gynecologists--to meet the nation’s current and projected demand for health care services.

2. To help accomplish this critical goal, our American Medical Association (AMA) will work with a variety of key stakeholders, to include federal and state legislators and regulatory bodies; national and state specialty societies and medical associations, including those representing primary care fields; and accreditation, certification, licensing, and regulatory bodies from across the continuum of medical education (undergraduate, graduate, and continuing medical education).

3. Through its work with these stakeholders, our AMA will encourage development and dissemination of innovative models to recruit medical students interested in primary care, train primary care physicians, and enhance both the perception and the reality of primary care practice, to encompass the following components: a) Changes to medical school admissions and recruitment of medical students to primary care specialties, including counseling of medical students as they develop their career plans; b) Curriculum changes throughout the medical education continuum; c) Expanded financial aid and debt relief options; d) Financial and logistical support for primary care practice, including adequate reimbursement, and enhancements to the practice environment to ensure professional satisfaction and practice sustainability; and e) Support for research and advocacy related to primary care.

4. Admissions and recruitment: The medical school admissions process should reflect the specific institution’s mission. Those schools with missions that include primary care should consider those predictor variables among applicants that are associated with choice of these specialties.

5. Medical schools, through continued and expanded recruitment and outreach activities into secondary schools, colleges, and universities, should develop and increase the pool of applicants likely to practice primary care by seeking out those students whose profiles indicate a likelihood of practicing in primary care and underserved areas, while establishing strict guidelines to preclude discrimination.

6. Career counseling and exposure to primary care: Medical schools should provide to students career counseling related to the choice of a primary care specialty, and ensure that primary care physicians are well-represented as teachers, mentors, and role models to future physicians.

7. Financial assistance programs should be created to provide students with primary care experiences in ambulatory settings, especially in underserved areas. These could include funded preceptorships or summer work/study opportunities.

8. Curriculum: Voluntary efforts to develop and expand both undergraduate and graduate medical education programs to educate primary care physicians in increasing numbers should be continued. The establishment of appropriate administrative units for all primary care specialties should be encouraged.

9. Medical schools with an explicit commitment to primary care should structure the curriculum to support this objective. At the same time, all medical schools should be encouraged to continue to change their curriculum to put more emphasis on primary care.

10. All four years of the curriculum in every medical school should provide primary care experiences for all students, to feature increasing levels of student responsibility and use of ambulatory and community-based settings.

11. Federal funding, without coercive terms, should be available to institutions needing financial support to expand resources for both undergraduate and graduate medical education programs designed to increase the number of primary care physicians. Our AMA will advocate for public (federal and state) and private payers to a) develop enhanced funding and related incentives from all sources to provide education for medical students and resident/fellow physicians, respectively, in progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model) to enhance primary care as a career choice; b) fund and foster innovative pilot programs that change the current approaches to primary care in undergraduate and graduate medical education, especially in urban and rural underserved areas; and c) evaluate these efforts for their effectiveness in increasing the number of students choosing primary care careers and helping facilitate the elimination of geographic, racial, and other health care disparities.

12. Medical schools and teaching hospitals in underserved areas should promote medical student and resident/fellow physician rotations through local family health clinics for the underserved, with financial assistance to the clinics to compensate their teaching efforts.

13. The curriculum in primary care residency programs and training sites should be consistent with the objective of training generalist physicians. Our AMA will encourage the Accreditation Council for Graduate Medical Education to (a) support primary care residency programs, including community hospital-based programs, and (b) develop an accreditation environment and novel pathways that promote innovations in graduate medical education, using progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model).

14. The visibility of primary care faculty members should be enhanced within the medical school, and positive attitudes toward primary care among all faculty members should be encouraged.

15. Support for practicing primary care physicians: Administrative support mechanisms should be developed to assist primary care physicians in the logistics of their practices, along with enhanced efforts to reduce administrative activities unrelated to patient care, to help ensure professional satisfaction and practice sustainability.

16. There should be increased financial incentives for physicians practicing primary care, especially those in rural and urban underserved areas, to include scholarship or loan repayment programs, relief of professional liability burdens, and Medicaid case management programs, among others. Our AMA will advocate to state and federal legislative and regulatory bodies, among others, for development of public and/or private incentive programs, and expansion and increased funding for existing programs, to further encourage practice in underserved areas and decrease the debt load of primary care physicians. The imposition of specific outcome targets should be resisted, especially in the absence of additional support to the schools.

17. Our AMA will continue to advocate, in collaboration with relevant specialty societies, for the recommendations from the AMA/Specialty Society RVS Update Committee (RUC) related to reimbursement for E&M services and coverage of services related to care coordination, including patient education, counseling, team meetings and other functions; and work to ensure that private payers fully recognize the value of E&M services, incorporating the RUC-recommended increases adopted for the most current Medicare RBRVS.

18. Our AMA will advocate for public (federal and state) and private payers to develop physician reimbursement systems to promote primary care and specialty practices in progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model consistent with current AMA Policies H-160.918 and H-160.919.

19. There should be educational support systems for primary care physicians, especially those practicing in underserved areas.

20. Our AMA will urge urban hospitals, medical centers, state medical associations, and specialty societies to consider the expanded use of mobile health care capabilities.

21. Our AMA will encourage the Centers for Medicare & Medicaid Services to explore the use of telemedicine to improve access to and support for urban primary care practices in underserved settings.

22. Accredited continuing medical education providers should promote and establish continuing medical education courses in performing, prescribing, interpreting and reinforcing primary care services.

23. Practicing physicians in other specialties--particularly those practicing in underserved urban or rural areas--should be provided the opportunity to gain specific primary care competencies through short-term preceptorships or postgraduate fellowships offered by departments of family medicine, internal medicine, pediatrics, etc., at medical schools or teaching hospitals. In addition, part-time training should be encouraged, to allow physicians in these programs to practice concurrently, and further research into these concepts should be encouraged.

24. Our AMA supports continued funding of Public Health Service Act, Title VII, Section 747, and encourages advocacy in this regard by AMA members and the public.

25. Research: Analysis of state and federal financial assistance programs should be undertaken, to determine if these programs are having the desired workforce effects, particularly for students from disadvantaged groups and those that are underrepresented in medicine, and to gauge the impact of these programs on elimination of geographic, racial, and other health care disparities. Additional research should identify the factors that deter students and physicians from choosing and remaining in primary care disciplines. Further, our AMA should continue to monitor trends in the choice of a primary care specialty and the availability of primary care graduate medical education positions. The results of these and related research endeavors should support and further refine AMA policy to enhance primary care as a career choice. [CME Rep. 04, I-18 Reaffirmed: CMS Rep. 08, A-24]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 204
(I-25)

Introduced by: Organized Medical Staff Section

Subject: Addressing Anti-Physician Contractual Provisions

Referred to: Reference Committee B

---

Whereas, over three-quarters of physicians are under employment contracts with hospitals, hospital systems, and other corporate entities[1]; and

Whereas, our AMA has opposed anti-physician labor practices such as restrictive non-compete clauses on the grounds that they limit the career advancement of young physicians and unduly restrict competition[2]; and

Whereas, "tail insurance" must be secured to ensure continued liability coverage when a physician unenrolls from a claims-made malpractice policy, as such policies do not cover any claims made after unenrollment[3]; and

Whereas, physician contracts typically do not specify which party is responsible for paying for tail insurance with that responsibility frequently falling to physicians[4-6]; and

Whereas, tail insurance, similar to non-compete clauses, can be used as leverage to prevent physicians from leaving a practice and thereby limit the career advancement of young physicians and restrict competition[7-10]; and

Whereas, indemnification clauses are a feature of many physician contracts which render the physician financially liable for all damages incurred by an employer as part of a malpractice lawsuit, even when another practitioner or the employer were negligent[11]; and

Whereas, the financial damages created by indemnification clauses are frequently not covered by malpractice policies, leaving physicians personally liable for these damages[12]; and

Whereas, indemnification clauses have become a routine part of physician contracts over the last 20 years[11,12]; and

Whereas, the American College of Emergency Physicians has identified such clauses as "not appropriate in medical contracts" as they "unnecessarily complicate medical malpractice litigation and may result in additional liability," and has advised physicians to decline contracts containing such clauses[13]; and

Whereas, legal experts and practice groups routinely advise physicians to challenge or eliminate indemnification clauses in their contracts[14-16]; therefore be it

RESOLVED, that our American Medical Association develop model state legislation to prohibit the inclusion of clauses indemnifying employers in physician contracts (Directive to Take Action); and be it further

RESOLVED, that our AMA will actively work to increase the education and awareness of physicians on the implications of accepting employment contracts which require physicians to (i) pay for tail insurance, or (ii) indemnify their employers. (Directive to Take Action)

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

Received: 9/22/25

**REFERENCES**

1. Physicians Advocacy Institute, Avalere Health. Updated Report: Hospital and Corporate Acquisition of Physician Practices and Physician Employment 2019-2023. Physicians Advocacy Institute; 2024. Accessed April 6, 2025. https://www.physiciansadvocacyinstitute.org/PAI-Research/PAI-Avalere-Study-on-Physician-Employment-Practice-Ownership-Trends-2019-2023
2. Robeznieks A. AMA backs effort to ban many physician noncompete provisions. American Medical Association. June 13, 2023. Accessed March 9, 2025. https://www.ama-assn.org/medical-residents/transition-resident-attending/ama-backs-effort-ban-many-physician-noncompete.
3. Malpractice Insurance: What You Need to Know. J Oncol Pract. 2007;3(5):274-277. doi:10.1200/JOP.0756501
4. Guglielmo WJ. Tail insurance: watch out for the gotcha!. *Med Econ*. 2008;85(4):35-39.
5. Prevalence of Medical Liability Premium Increases Unseen Since 2000s Continues for Fourth Year in a Row. American Medical Association. 2023. Accessed March 9, 2025. https://www.ama-assn.org/system/files/prp-mlm-premiums-2022.pdf.
6. Physician contracting: Job duties and liability insurance. American Medical Association. February 11, 2025. Accessed March 9, 2025. https://www.ama-assn.org/medical-residents/transition-resident-attending/physician-contracting-job-duties-and-liability.
7. Moawad H. Medical malpractice tail coverage know-how for doctors. MedicalEconomics. November 12, 2020. Accessed March 9, 2025. https://www.medicaleconomics.com/view/medical-malpractice-tail-coverage-know-how-doctors.
8. Malpractice insurance. American College of Physicians. Accessed March 9, 2025. https://www.acponline.org/about-acp/about-internal-medicine/career-paths/residency-career-counseling/resident-career-counseling-guidance-and-tips/malpractice-insurance.
9. Career Development in Academic Medicine. American Professors of Gynecology and Obstetrics. 2012. Accessed March 9, 2025. http://tools.apgo.org/binary/CareerBook_3rd%20Ed.pdf.
10. Salib S, Moreno A. Good-Bye and Good Luck: Teaching Residents the Business of Medicine After Residency. J Grad Med Educ. 2015;7(3):338-340. doi:10.4300/JGME-D-14-00720.1
11. Indemnification clauses in emergency medicine contracts. American College of Emergency Physicians. April 2016. Accessed March 9, 2025. https://www.acep.org/siteassets/uploads/uploaded-files/acep/clinical-and-practice-management/policy-statements/information-papers/indemnification-clauses-in-emergency-medicine-contracts---information-paper.pdf.
12. Weiss L. Read Your Contract: It's Dangerous! Common Sense: Voice of the American Academy of Emergency Medicine. 2019. https://issuu.com/aaeminfo/docs/26-3_mayjun_2019.
13. Sellinger T. Breaking down indemnification clauses. Physician's Weekly. January 23, 2025. Accessed March 9, 2025. https://www.physiciansweekly.com/qa-breaking-down-indemnification-clauses/.

## RELEVANT AMA POLICY

### Insurer Accountability When Prior Authorization Harms Patients D-320.974

1. Our American Medical Association advocates for increased legal accountability of insurers and other payers when delay or denial of prior authorization leads to patient harm, including but not limited to the prohibition of mandatory pre-dispute arbitration regarding prior authorization determinations and limitation on class action clauses in beneficiary contracts.
2. Our American Medical Association advocates that low-cost noninvasive procedures that meet existing standard Medicare guidelines should not require prior authorization.
3. Our AMA supports that physicians be allowed to bill insurance companies for all full time employee hours required to obtain prior authorization.
4. Our AMA supports that patients be allowed to sue insurance carriers which preclude any and all clauses in signed contracts should there be an adverse outcome as a result of an inordinate delay in care.

Citation: Res. 711, A-24

**Approaches to Increase Payer Accountability H-320.968**

Our AMA supports the development of legislative initiatives to assure that payers provide their insureds with information enabling them to make informed decisions about choice of plan, and to assure that payers take responsibility when patients are harmed due to the administrative requirements of the plan. Such initiatives should provide for disclosure requirements, the conduct of review, and payer accountability.

1. Disclosure Requirements. Our American Medical Association supports the development of model draft state and federal legislation to require disclosure in a clear and concise standard format by health benefit plans to prospective enrollees of information on:
    a. Coverage provisions, benefits, and exclusions.
    b. Prior authorization or other review requirements, including claims review, which may affect the provision or coverage of services.
    c. Plan financial arrangements or contractual provisions that would limit the services offered, restrict referral or treatment options, or negatively affect the physician's fiduciary responsibility to their patient.
    d. Medical expense ratios.
    e. Cost of health insurance policy premiums. (Ref. Cmt. G, Rec. 2, A-96; Reaffirmation A-97)
2. Conduct of Review. Our AMA supports the development of additional draft state and federal legislation to:
    a. Require private review entities and payers to disclose to physicians on request the screening criteria, weighting elements and computer algorithms utilized in the review process, and how they were developed.
    b. Require that any physician who recommends a denial as to the medical necessity of services on behalf of a review entity be of the same specialty as the practitioner who provided the services under review.
    c. Require every organization that reviews or contracts for review of the medical necessity of services to establish a procedure whereby a physician claimant has an opportunity to appeal a claim denied for lack of medical necessity to a medical consultant or peer review group which is independent of the organization conducting or contracting for the initial review.
    d. Require that any physician who makes judgments or recommendations regarding the necessity or appropriateness of services or site of service be licensed to practice medicine in the same jurisdiction as the practitioner who is proposing the service or whose services are being reviewed.
    e. Require that review entities respond within 48 hours to patient or physician requests for prior authorization, and that they have personnel available by telephone the same business day who are qualified to respond to other concerns or questions regarding medical necessity of services, including determinations about the certification of continued length of stay.
    f. Require that any payer instituting prior authorization requirements as a condition for plan coverage provide enrollees subject to such requirements with consent forms for release of medical information for utilization review purposes, to be executed by the enrollee at the time services requiring such prior authorization are recommended or proposed by the physician.
    g. Require that payers compensate physicians for those efforts involved in complying with utilization review requirements that are more costly, complex and time consuming than the completion of standard health insurance claim forms. Compensation should be provided in situations such as obtaining preadmission certification, second opinions on elective surgery, and certification for extended length of stay.
3. Accountability. Our AMA believes that draft federal and state legislation should also be developed to impose similar liability on health benefit plans for any harm to enrollees resulting from failure to disclose prior to enrollment the information on plan provisions and operation specified under Section 1 (a)-(d) above.

Citation: Issued: BOT Rep. M, I-90; Reaffirmed: Res. 716, A-95; Reaffirmed: CMS Rep. 4, A-95; Reaffirmed: I-96; Reaffirmed: Rules and Cred. Cmt, I-97; Reaffirmed: CMS Rep. 13; I-98; Reaffirmed: I-98; Reaffirmed:A-99; Reaffirmation: I-99; Reaffirmed: A-00; Reaffirmed in lieu of: Res. 839, I-08; Reaffirmed: A-09; Reaffirmed: Sub. Res. 728, A-10; Modified: CMS Rep. 4, I-10; Reaffirmed: A-11; Reaffirmed in lieu of Res. 108, A-12; Reaffirmed: Res. 709, A-12; Reaffirmed; CMS Rep. 07, A-16; Reaffirmed in lieu of: Res. 242, A-17; Reaffirmed in lieu of: Res. 106, A-17; Reaffirmed: A-17; Reaffirmed: A-18; Reaffirmed: A-19; Reaffirmed: Res. 206, I-20; Reaffirmed: A-22; Modified: Speakers Rep. 02, I-24

**Promoting Accountability in Prior Authorization D-285.960**

1. Our American Medical Association will advocate that peer-to-peer (P2P) prior authorization (PA) determinations must be made and actionable at the end of the P2P discussion notwithstanding mitigating circumstances, which would allow for a determination within 24 hours of the P2P discussion.
2. Our AMA will advocate that the reviewing P2P physician must have the clinical expertise to treat the medical condition or disease under review and have knowledge of the current, evidence-based clinical guidelines and novel treatments.
3. Our AMA will advocate that P2P PA reviewers follow evidence-based guidelines consistent with national medical specialty society guidelines where available and applicable.
4. Our AMA will continue to advocate for a reduction in the overall volume of health plans' PA requirements and urge temporary suspension of all PA requirements and the extension of existing approvals during a declared public health emergency.
5. Our AMA will advocate that health plans must undertake every effort to accommodate the physician's schedule when requiring peer-to-peer prior authorization conversations.
6. Our AMA will advocate that health plans must not require prior authorization on any medically necessary surgical or other invasive procedure related or incidental to the original procedure if it is furnished during the course of an operation or procedure that was already approved or did not require prior authorization.

Citation: CMS Rep. 4, A-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 205
(I-25)

Introduced by: Private Practice Physicians Section

Subject: Restoring Balance Billing and Allowing Copay Forgiveness to Preserve Independent Practice and Improve Access to Care

Referred to: Reference Committee B

---

Whereas, the American Medical Association mission is to promote the art and science of medicine and the betterment of public health, and core advocacy positions include access to health care and physician well-being & burnout; and

Whereas, over the past 20+ years, reimbursement rates have declined significantly in real-dollar items (led by Medicare at 30 percent—more in inflation-adjusted terms—but more often than not leading other insurance organizational policy in parallel), while practice overhead (rent, staff, EHR compliance, and malpractice insurance) has risen sharply. Physicians are no expected to provide increasingly complex care while bearing financial risk, without the ability to charge fair value or relieve financial burden for struggling patients; and

Whereas, efforts to redress this disparity by advocacy to improve third party fee schedules, particularly Medicare, have so far been unproductive of relief; and

Whereas, balance billing refers to a physician's ability to charge a patient for the difference between the provider's fee and what the insurer reimburses. This was historically permitted in Massachusetts until reforms during the Dukakis administration in the 1980s prohibited balance billing, even for non-participating physicians treating Medicare patients. Massachusetts General Laws and Board of Registration regulations further prohibit charging beyond allowable amounts for many insured patients, irrespective of network participation; and

Whereas, thirty-three states have some form of prohibition on balance billing and subsequently the federal No Surprises Act was enacted in 2020 that protects patients from receiving unexpected, high out-of-network medical bills for certain emergency and non-emergency services. The law limits balance billing by out-of-network providers at in-network facilities and prevents out-of-network providers from balancing billing for certain services, such as air ambulance services (but not land ambulance services). Patients are generally responsible only for their in-network cost-sharing amounts, such as copayments and deductibles; and

Whereas, at the same time, federal regulations and payer contracts—largely through anti-kickback statutes and insurer agreements—restrict a physician's ability to waive or forgive co-pays and deductibles, even in cases of demonstrated financial hardship; and

Whereas, the prohibition of balance billing and mandated collection of co-pays, even from indigent or financially stressed patients, places independent physicians in an untenable position—both economically and ethically; and

Whereas, hospitals, by contrast, can negotiate higher rates, apply facility fees, and benefit from vertical integration and government subsidies. Independent practitioners are increasingly forced

to sell their practices, retire early, or reduce services. Patient, in turn, face reduced access, fewer choices, and more corporatized care; and

Whereas, private/independent physician practices need both the freedom to set fair, transparent fees and the discretion to relieve patients of financial hardship when appropriate. Restoring regulated balance billing for outpatient, non-emergency care—combined with lifting restrictions on copay forgiveness in cases of financial hardship—would provide physicians with essential flexibility and improve practice's financial sustainability while preserving transparency and protecting vulnerable patients; and

Whereas, the AMA has multiple policies addressing the need for, right of, and promotion of advocacy for, balanced billing but has not prioritized that in advocacy, in preference to advocating for fee schedule improvement; and

Whereas, the AMA has policy to monitor the effect of balance billing on rural health and to report back "at every HOD meeting its progress toward completion of all these goals" on balance billing though such reporting is obscure[1,2]; and

Whereas, there are successful models in other professional service industries (e.g., law, dentistry), where clients/patients may opt for higher-cost services if they perceive value, and practitioners may offer charitable relief when warranted, and the AMA acknowledges patient choice as a relevant factor[3]; therefore be it

RESOLVED, that our American Medical Association assign high priority to advocacy to support legislation or regulatory reform to restore private physicians' ability to balance bill patients for non-emergency, outpatient medical services, regardless of insurance network participation status (Directive to Take Action); and be it further

RESOLVED, that our AMA oppose artificial caps on private physician balance billing amounts, especially of less than 100 percent above the insurer's allowed amount, to reflect and offset decades of reimbursement erosion (New HOD Policy); and be it further

RESOLVED, that our AMA support the continuation of protections from balance billing for emergency care, Medicaid beneficiaries, and other vulnerable populations as currently required under state and federal law (New HOD Policy); and be it further

RESOLVED, that our AMA advocate at the federal level for reform of anti-kickback and payer contracting rules that prohibit physicians from waiving co-pays and deductibles for patients experiencing financial hardship. (Directive to Take Action)

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

Received: 9/22/25

**REFERENCES**

1. AMA Policy H-465.985 "Medicare Balance Billing"
2. AMA Policy D-380.996 "Balance Billing for All Physicians"
3. AMA Policy H-390.854 "Freedom of Choice"

**RELEVANT AMA POLICY**

**Balance Billing for All Physicians D-380.996**
1. Our AMA will devote the necessary political and financial resources to introduce national legislation at the appropriate time to bring about implementation of Medicare balance billing and to introduce legislation to end the budget neutral restrictions inherent in the current Medicare physician payment structure that interferes with patient access to care.

2. This national legislation will be designed to pre-empt state laws that prohibit balance billing and prohibit inappropriate inclusion of balance billing bans in insurance-physician contracts.

3. Our AMA will develop model language for physicians to incorporate into any insurance contracts that attempt to restrict a physician's right to balance bill any insured patient.

4. Our AMA Board of Trustees will report back to our AMA House of Delegates electronically by March 15, 2008 and at every HOD meeting its progress toward the completion of all of these goals.

Citation: Res. 925, I-07; Reaffirmed: BOT Rep. 22, A-17

**Balance Billing H-385.991**
Our AMA supports the right of the physician to balance bill a patient for any care given, regardless of method of payment, where permissible by law or contractual agreement.

Citation: Sub. Res. 128, I-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: Sub. Res. 704, A-01; Reaffirmed: A-04; Reaffirmed: A-05; Reaffirmed: A-06; Reaffirmed per BOT Action in response to referred for decision Res. 236, A-06; Reaffirmed: CMS Rep. 01, A-16

**Parity in Medicare Reimbursement D-390.969**
Our AMA will continue its comprehensive advocacy campaign to: (1) repeal the reductions in Medicare payment for imaging services furnished in physicians' offices, as mandated by the Deficit Reduction Act of 2005; (2) pass legislation allowing physicians to share in Medicare Part A savings that are achieved when physicians provide medical care that results in fewer in-patient complications, shorter lengths-of-stays, and fewer hospital readmissions; and (3) advocate for other mechanisms to ensure adequate payments to physicians, such as balance billing and gainsharing.

Citation: BOT Action in response to referred for decision Res. 236, A-06; Reaffirmed: I-08; Modified: BOT Rep. 09, A-18; Reaffirmed in lieu of: Res. 823, I-18

**Medicare Balance Billing D-390.986**
1. Our American Medical Association advocate that physicians be allowed to balance bill Medicare recipients to the full amount of their normal charge with the patient responsible for the difference between the Medicare payment and the physician charges
2. Our AMA seek introduction of national legislation to bring about implementation of balance billing of Medicare recipients.
3. Our AMA further advocate that such federal laws and regulations pre-empt state laws that prohibit balance billing.

Citation: Res. 713, I-02; Reaffirmed: A-04; Reaffirmed: A-06; Reaffirmed per BOT Action in response to referred for decision Res. 236, A-06; Reaffirmed: CMS Rep. 5, I-12; Reaffirmed: BOT Rep. 9, A-22

**Medicare Balance Billing D-390.985**
Our AMA will work on behalf of physicians to regain the right to balance bill Medicare patients for the full reasonable fees as they determine appropriate.

Citation: Res. 119, A-03; Reaffirmed: A-04; Reaffirmed: A-06; Reaffirmed per BOT Action in response to referred for decision Res. 236, A-06; Modified: CMS Rep. 01, A-16

**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.

Citation: CMS Rep. K, A-90; Modified: Sunset Report, I-00; Reaffirmed: BOT Rep. 6, A-10; Reaffirmed: CMS Rep. 3, A-15; Reaffirmed: CMS Rep. 01, A-25

**Freedom of Choice H-390.854**
(1) The AMA will seek appropriate cases to challenge the legality and constitutionality of Medicare restrictions on non-participating physicians' medical practice and on patient freedom of choice by such mechanisms as limitations on balance billing and prohibitions on private "opt out" arrangements between physicians and patients. (2) The AMA will strongly resist such restrictions being extended to other payers in national health care reform legislation.

Citation: Res. 117, I-92; Reaffirmed: CMS Rep. 10, A-03; Renumbered: CMS Rep. 7, I-05; Reaffirmed: A-06; Reaffirmed: CMS Rep. 01, A-16

**Reform the Medicare System D-330.924**
Our AMA will renew its commitment for total reform of the current Medicare system by making it a high priority on the AMA legislative agenda beginning in 2009 and the AMA's reform efforts will be centered on our long-standing policy of pluralism (AMA Policy H-165.844), freedom of choice (H-165.920, H-373.998, H-390.854), and balance billing (D-380.996, H-385.991, D-390.969).

Citation: Res. 834, I-08; Reaffirmed: CMS Rep. 6, A-09; Modified: CMS Rep. 01, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 206
(I-25)

Introduced by: Colorado

Subject: Restore Funding to USAID

Referred to: Reference Committee B

---

Whereas, In a recent detailed Analysis of the impact of withdrawal of funding from USAID, it is estimated that there will be an increase of 14 Million preventable deaths worldwide in the next 5 years[1]; and

Whereas, the AMA Declaration of Professional Responsibility[2] calls on us, among other things, to:

1. Respect human life and the dignity of every individual.
2. Work freely with colleagues to discover, develop, and promote advances in medicine and public health that ameliorate suffering and contribute to human well-being.
3. Educate the public and polity about present and future threats to the health of humanity.
4. Advocate for social, economic, educational, and political changes that ameliorate suffering and contribute to human well-being; and

Whereas, the withdrawal of support for USAID, and its mission to treat global infectious diseases, will likely lead to large numbers of people with partially treated tuberculosis, HIV and other infectious diseases. This in turn will lead to the development of drug resistant disease putting the world population at higher risk; therefore be it

RESOLVED, that our American Medical Association vigorously advocate for restoration of funding to USAID including resumption of aid to Africa (Directive to Take Action); and be it further

RESOLVED, that our AMA make public statements regarding the cost in human life of withdrawal of funding for USAID (Directive to Take Action); and be it further

RESOLVED, that our AMA make public statements regarding the worldwide health risks associated with withdrawal of funding for treatment of infectious diseases such as Tuberculosis, HIV, Ebola, and others. (Directive to Take Action)

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

Received: 9/22/25

**REFERENCES**

1. https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(25)01186-9/fulltext
2. https://www.ama-assn.org/system/files/2020-03/declaration-professional-responsibility-english.pdf

## RELEVANT AMA POLICY

**Continued Support of World Health Organization (WHO) & United States Agency for International Development (USAID) D-250.986**

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 207
(I-25)

Introduced by: American Academy of Family Physicians

Subject: Support for a Federal Tax Incentive for Volunteer Community Preceptors

Referred to: Reference Committee B

---

Whereas, community-based preceptors are essential to the clinical education of medical students and residents, especially in primary care and underserved areas, where most health care is delivered; and

Whereas, the United States faces a significant and growing physician shortage, with the Association of American Medical Colleges (AAMC) projecting a shortfall of up to 124,000 physicians by 2034[1]; and

Whereas, to address this shortage, medical schools have expanded class sizes and opened new campuses, increasing the demand for clinical training sites and qualified preceptors[2]; and

Whereas, many community physicians volunteer their time to teach without compensation, yet face increasing clinical demands, administrative burdens, and burnout, which reduce their capacity and willingness to serve as preceptors[3]; and

Whereas, studies show that effective recruitment and retention of community preceptors depend on both intrinsic motivations and external incentives, such as recognition and financial support[3]; and

Whereas, states like Alabama, Colorado, Georgia, Hawaii, Maryland, Missouri, and South Carolina have implemented tax deductions of up to $8,500 for community-based faculty, resulting in improved recruitment and retention of preceptors[4-10]; and

Whereas, a national tax credit or deduction would provide a standardized, equitable incentive across all states, helping to sustain and grow the preceptor workforce critical to medical education; therefore be it

RESOLVED, that our American Medical Association advocate for the establishment of a national tax credit or tax deduction for physicians who serve as community preceptors for medical students and residents, provided these services are rendered without financial compensation from any educational institution. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/23/25

**REFERENCES**

1. Dall T, Reynolds R, Chakrabarti R, Ruttinger C, Zarek P, Parker O. The Complexities of Physician Supply and Demand: Projections From 2021 to 2036. Washington, DC: Association of American Medical Colleges; 2024. doi:10.1000/aamc.2024.75231
2. Babalola D, Mobolaji A, Welch B, Stubbs R. The Impact of Fluctuating Preceptors Recruitment and Retention in View of an Increasing Medical School Class Size. *STFM Education Columns*. August 2020. Available from: https://www.stfm.org/publicationsresearch/publications/educationcolumns/2020/august/
3. Minor S, Huffman M, Lewis PR, Kost A, Prunuske J. Community Preceptor Perspectives on Recruitment and Retention: The CoPPRR Study. *Fam Med*. 2019;51(5):389–398. doi: 10.22454/FamMed.2019.937544
4. Alabama Legislature. Senate Bill 186: Preceptor Tax Incentive Act. Montgomery, AL: Alabama State Legislature; 2023. Available from: https://www.legislature.state.al.us/pdf/SearchableInstruments/2023RS/E134CC-1.pdf
5. Colorado General Assembly. House Bill 22-1005: Reauthorization of Preceptor Tax Credit. Denver, CO: State of Colorado; 2022. Available from: https://leg.colorado.gov/sites/default/files/2022a_1005_signed.pdf
6. Georgia General Assembly. House Bill 308: Extension of Preceptor Tax Credit Sunset. Atlanta, GA: State of Georgia; 2023. Available from: https://legiscan.com/GA/text/HB308/2023
7. Hawaii State Legislature. Senate Bill 2298: Preceptor Tax Credit Act. Honolulu, HI: State of Hawaii; 2018. Available from: http://preceptortaxcredit.hawaii.edu/wp-content/uploads/2018/12/Act-43-Preceptor-Tax-Credits-GM1143_.pdf
8. Maryland General Assembly. Senate Bill 0411: Preceptor Tax Credit Legislation. Annapolis, MD: State of Maryland; 2016. Available from: https://mgaleg.maryland.gov/mgawebsite/Legislation/Details/sb0411/?ys=2016rs
9. Missouri Senate. Senate Bill 801: Preceptor Tax Credit Program. Jefferson City, MO: State of Missouri; 2022. Available from: https://www.senate.mo.gov/22info/BTS_Web/Bill.aspx?SessionType=R&BillID=71259836
10. South Carolina Legislature. Senate Bill 314: Preceptor Tax Credit Structure. Columbia, SC: State of South Carolina; 2020. Available from: https://www.scstatehouse.gov/sess123_2019-2020/prever/314_20190508.htm

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 208
(I-24)

Introduced by: Tennessee

Subject: Centralization of Medicare Provider Data Sources

Referred to: Reference Committee B

---

Whereas, it is with growing frequency that physicians and providers are responsible for providing personal and practice data to multiple outlets for participation in panels; and

Whereas, this is another redundant administrative task that can be reduced by deployment of technology to centralized and align provider data; and

Whereas, our American Medical Association has current policies addressing the accuracy of provider directories and the timeliness by which plans should update information to aid patients and further protections for patients to report network inadequacies; and

Whereas, our AMA policy can be further improved by addressing the burden placed on physicians for needless administrative data input to populate directories; therefore be it

RESOLVED, that our American Medical Association advocate that the Centers for Medicare and Medicaid Services (CMS) adopt centralized, standardized, and interoperable provider data repositories for Medicare and Medicare Advantage provider directory purposes, including acceptance of validated data from nationally recognized sources such as the Coalition for Affordable Quality Healthcare (CAQH) or equivalent, and eliminate duplicative attestations by physicians when accurate data has already been submitted through such systems (Directive to Take Action); and be it further

RESOLVED, that our AMA continue to urge CMS to harmonize provider directory requirements across programs and promote automation, data governance standards, and streamlined workflows that improve directory accuracy, reduce administrative burden, and ensure patients have timely access to reliable provider information. (Directive to Take Action)

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

Received: 9/24/25

**REFERENCES**

1. AMA White Paper: Improving Health Plan Provider Directories - www.ama-assn.org/system/files/improving-health-plan-provider-directories.pdf

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 209
(I-25)

Introduced by: Florida, South Carolina, Tennessee, Oklahoma

Subject: Support for Legislative Changes Allowing Partial Medicare Opt-Out for Physicians

Referred to: Reference Committee B

---

Whereas, despite efforts by our AMA to reform Medicare payment, ongoing cuts are planned and many physicians are unable to sustain their private practices and may need to work in multiple settings; and

Whereas, in order to start a private practice or work in certain practice settings, physicians may desire to 'opt out' of Medicare; and

Whereas, current federal Medicare regulations require physicians who opt out of Medicare to do so entirely, without the ability to selectively participate in certain practice settings, as Medicare billing is linked to a physician's NPI number; and

Whereas, this "all-in or all-out" policy prevents physicians who practice in different settings from billing Medicare for services provided in separate roles such as hospice, inpatient care, or locum tenens (outside of emergency care exceptions) without jeopardizing their opt-out status; and

Whereas, this restriction discourages physicians from opening innovative practice models that can improve access, reduce administrative burden, and enhance patient satisfaction; and

Whereas, the inability to partially opt out of Medicare can create physician shortages in high-need areas such as small practices, hospice, rural hospitals, and skilled nursing facilities, where part-time or moonlighting physicians could otherwise fill gaps; and

Whereas, AMA policy supports a physician's right to opt out of Medicare; therefore be it

RESOLVED, that our American Medical Association advocate for federal legislation or regulatory changes to allow physicians to opt out of Medicare in one employment setting while maintaining the ability to bill Medicare for services provided in other practice settings (e.g., private practices, hospice, inpatient hospital care, or other defined roles).
(Directive to Take Action)

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

Received: 9/24/25

**REFERENCES**


1. Centers for Medicare & Medicaid Services. Manage your enrollment. Opt out of Medicare. Accessed August 14, 2025. https://www.cms.gov/medicare/enrollment-renewal/providers-suppliers/chain-ownership-system-pecos/manage-your-enrollment#
2. Eskew, P. Opted-Out Moonlighting. Direct Primary Care Frontier. Accessed August 14, 2025. https://www.dpcfrontier.com/opted-out-moonlighting.
3. Shay, D. Opting Out of Medicare: How to Get Out and Stay Out. Fam Pract Manag. 2017;24(6):17-20

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 210
(I-25)

Introduced by: Florida, South Carolina, Tennessee, Oklahoma

Subject: PBM Divestiture and Transparency

Referred to: Reference Committee B

---

Whereas, Pharmacy Benefit Managers (PBMs) are facing increasing scrutiny due to middlemen practices that are seen as harmful to patients, pharmacies, and the overall healthcare system. These include driving up drug costs, prioritizing profits over patient care, and engaging in anticompetitive practices; and

Whereas, PBMs negotiate rebates with drug manufacturers and often don't pass these savings onto consumers, instead marking up prices and pocketing the difference. This practice, known as "spread pricing," leads to higher costs for patients and health plans; and

Whereas, PBMs often prioritize drugs formularies by prioritizing profits over patient health that yield higher rebates, even if they are not the most effective or cost-effective options for patients. This can lead to patients being steered towards more expensive drugs or having access to necessary medications restricted through formularies and prior authorization requirements; and

Whereas, the dominance of a few large PBMs (the "Big 3") raises concerns about anticompetitive behavior. They can favor their own affiliated pharmacies, and infusion centers and manipulate formularies to benefit certain manufacturers, and engage in self-preferencing, which can harm independent pharmacies, and practices not owned by the insurance company and affiliate PBMs and limit patient choice; and

Whereas, ownership of PBMs by insurance companies creates a conflict of interest that rewards profits over patients and can only be solved by divestitures of PBM ownership by insurance companies; and

Whereas, the complex contracts and negotiations between PBMs, manufacturers, and health plans often lack transparency, making it difficult for stakeholders to understand how drug prices are set and how rebates are used. This lack of transparency hinders oversight and allows PBMs to operate with less accountability; and

Whereas, PBMs' practices have been linked to higher costs for taxpayers in government health programs like Medicare Part D, as well as for employers and insurers who pay for prescription drug benefits; and

Whereas, PBMs' actions can restrict patient access to medications, particularly those not on their preferred formularies, and can increase out-of-pocket costs for patients, especially those with chronic conditions; and

Whereas, bills regarding divestment of PBMs were introduced in congress in the 2024 session and are expected to be reintroduced this year; therefore be it

RESOLVED, that our American Medical Association will work with appropriate parties to support and lobby for divestment of Pharmacy Benefit Managers (PBMs) from ownership by insurance companies (Directive to Take Action); and be it further

RESOLVED, that our AMA will work with appropriate parties to support and lobby for divestment of PBMs from owning affiliate pharmacies and infusion centers. (Directive to Take Action)

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

Received: 9/24/25

**RELEVANT AMA POLICY**

**D-120.933 Pharmacy Benefit Managers Impact on Patients**
Our AMA will: (1) gather more data on the erosion of physician-led medication therapy management in order to assess the impact pharmacy benefit manager (PBM) tactics may have on patients timely access to medications, patient outcomes, and the physician-patient relationship; (2) examine issues with PBM-related claw backs and direct and indirect remuneration (DIR) fees to better inform existing advocacy efforts; and (3) request from PBMs, and compile, data on the top twenty-five medication precertification requests and the percent of such requests approved after physician challenge. [Citation: Res. 225, A-18; Reaffirmed: CMS Rep. 06, A-24]

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

**H-110.981 Public Reporting of PBM Rebates**
Our AMA will advocate for: (1) Pharmacy Benefit Managers (PBMs) and state regulatory bodies to make rebate and discount reports and disclosures available to the public; and (2) the inclusion of required public reporting of rebates and discounts by PBMs in federal and state PBM legislation. [Citation: Res. 813, I-19]

**D-120.924 Pharmacy Benefit Manager (PBM) Control of Treating Disease States**
1. Our American Medical Association will take a strong public stance against allowing payors and pharmacy benefit managers to divert patients to their own care teams for medical care and medication prescribing.
2. Our AMA will take immediate action (which may include legal or policy action) to assess and pursue appropriate measures designed to prevent payors and pharmacy benefit managers from diverting patients to their own care teams for medical care and medication prescribing. [Citation: Res. 234, I-23]

**D-110.987 The Impact of Pharmacy Benefit Managers on Patients and Physicians**
1. Our AMA supports the active regulation of pharmacy benefit managers (PBMs) under state departments of insurance.
2. Our AMA will develop model state legislation addressing the state regulation of PBMs, which shall include provisions to maximize the number of PBMs under state regulatory oversight.
3. Our AMA supports requiring the application of manufacturer rebates and pharmacy price concessions, including direct and indirect remuneration (DIR) fees, to drug prices at the point-of-sale.
4. Our AMA supports efforts to ensure that PBMs are subject to state and federal laws that prevent discrimination against patients, including those related to discriminatory benefit design and mental health and substance use disorder parity.
5. Our AMA supports improved transparency of PBM operations, including disclosing:
- Utilization information;

- Rebate and discount information;
- Financial incentive information;
- Pharmacy and therapeutics (P&T) committee information, including records describing why a medication is chosen for or removed in the P&T committee's formulary, whether P&T committee members have a financial or other conflict of interest, and decisions related to tiering, prior authorization and step therapy;
- Formulary information, specifically information as to whether certain drugs are preferred over others and patient cost-sharing responsibilities, made available to patients and to prescribers at the point-of-care in electronic health records;
- Methodology and sources utilized to determine drug classification and multiple source generic pricing; and
- Percentage of sole source contracts awarded annually.

6. Our AMA encourages increased transparency in how DIR fees are determined and calculated.

[Citation: CMS Rep. 05, A-19; Reaffirmed: CMS Rep. 6, I-20; Reaffirmed: CSAPH Rep. 02, I-24]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 211
(I-25)

Introduced by: Utah

Subject: Access to, and Retention of, Electronic Medical Records

Referred to: Reference Committee B

---

Whereas, retention of patient records is important for continuing medical care; and

Whereas, codified duration of record retention is not uniform for all health care providers or centers in all states; and

Whereas, third-party web-based electronic medical record platforms are becoming commonplace; and

Whereas, web-based data is saved in various formats that may not be accessible without proprietary software; and

Whereas, transitioning from one electronic medical record (EMR) provider to another creates the potential of patient data loss through the transferring or extracting process; and

Whereas, there is a risk for significant additional cost to the health care provider or system to "re-extract" or access this information; and

Whereas, there is a potential for permanent loss of medical information if an EMR provider deletes the information after contract termination or becomes insolvent; therefore be it

RESOLVED, that our American Medical Association support federal legislation to standardize the duration of all medical record retention and to require that records of discharged patients be compiled, reviewed for completeness, and authenticated within 30 days of discharge (New HOD Policy); and be it further

RESOLVED, that our American Medical Association adopt as its formal policy and also support federal legislation that mandates the following:

a) All EMR vendors must retain patient data electronically to comply with state laws regardless of whether the provider or health-care system contract is still in effect;
b) All EMR vendors must arrange for custodians of all electronic medical files to comply with state law regarding medical record retention in case of insolvency; and
c) All EMR vendors must deliver an individual patient's medical records when requested to lawful recipients in a timely manner, at reasonable or no cost, and in formats that are readily accessible to the general public.

(New HOD Policy)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/24/25

**RELEVANT AMA POLICY**

**National Health Information Technology D-478.995**

1. Our American Medical Association will closely coordinate with the newly formed Office of the National Health Information Technology Coordinator all efforts necessary to expedite the implementation of an interoperable health information technology infrastructure, while minimizing the financial burden to the physician and maintaining the art of medicine without compromising patient care.

2. Our AMA:
   a. Advocates for standardization of key elements of electronic health record (EHR) and computerized physician order entry (CPOE) user interface design during the ongoing development of this technology.
   b. Advocates that medical facilities and health systems work toward standardized login procedures and parameters to reduce user login fatigue.
   c. Advocates for continued research and physician education on EHR and CPOE user interface design specifically concerning key design principles and features that can improve the quality, safety, and efficiency of health care.
   d. Advocates for continued research on EHR, CPOE and clinical decision support systems and vendor accountability for the efficacy, effectiveness, and safety of these systems.

3. Our AMA will request that the Centers for Medicare & Medicaid Services:
   a. Support an external, independent evaluation of the effect of Electronic Medical Record (EMR) implementation on patient safety and on the productivity and financial solvency of hospitals and physicians' practices.
   b. Develop, with physician input, minimum standards to be applied to outcome-based initiatives measured during this rapid implementation phase of EMRs.

4. Our AMA will:
   a. Seek legislation or regulation to require all EHR vendors to utilize standard and interoperable software technology components to enable cost efficient use of electronic health records across all health care delivery systems including institutional and community-based settings of care delivery.
   b. Work with CMS to incentivize hospitals and health systems to achieve interconnectivity and interoperability of electronic health records systems with independent physician practices to enable the efficient and cost-effective use and sharing of electronic health records across all settings of care delivery.

5. Our AMA will seek to incorporate incremental steps to achieve electronic health record (EHR) data portability as part of the Office of the National Coordinator for Health Information Technology's (ONC) certification process.

6. Our AMA will collaborate with EHR vendors and other stakeholders to enhance transparency and establish processes to achieve data portability.

7. Our AMA will directly engage the EHR vendor community to promote improvements in EHR usability.

8. Our AMA will advocate for appropriate, effective, and less burdensome documentation requirements in the use of electronic health records.

9. Our AMA will urge EHR vendors to adopt social determinants of health templates, created with input from our AMA, medical specialty societies, and other stakeholders with expertise in social determinants of health metrics and development, without adding further cost or documentation burden for physicians.

**AMA Policy: Electronic Data Interchange Status Report H-315.979**

Our AMA will: (1) work to establish consensus on industry security guidelines for electronic storage and transmission of medical records as an important means of protecting patient privacy in a manner that avoids undue and non-productive burdens on physician practices; and (2) develop relevant educational tools or models in accordance with industry electronic security guidelines to assist physicians in compliance with state and federal regulations.

**AMA POLICY: Guiding Principles, Collection and Warehousing of Electronic Medical Record Information H-315.974**
Our American Medical Association expressly advocates for physician ownership of all claims data, transactional data and de-identified and/or aggregate data created, established and maintained by a physician practice, regardless of how and where such data is stored but specifically including any such data derived from a physician's medical records, electronic health records, or practice management system, while preserving the principle that physicians act as trusted stewards of Protected Health Information.

**Guiding Principles, Collection and Warehousing of Electronic Medical Record Information H-315.974**

Our American Medical Association expressly advocates for physician ownership of all claims data, transactional data and de-identified and/or aggregate data created, established and maintained by a physician practice, regardless of how and where such data is stored but specifically including any such data derived from a physician's medical records, electronic health records, or practice management system, while preserving the principle that physicians act as trusted stewards of Protected Health Information.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 212
(I-25)

Introduced by: American Society of Addiction Medicine

Subject: Acknowledging Flexibility on Buprenorphine Mono-product Use for Opioid Use Disorder

Referred to: Reference Committee B

---

Whereas, the opioid overdose crisis remains a significant public health emergency;[1] and

Whereas, provisional data, although encouraging, reflects national drug overdose deaths remain above pre-COVID-19 pandemic levels;[2] and

Whereas, there is a 20-fold increased risk of early death for patients with opioid use disorder (OUD);[3] and

Whereas, opioid agonist treatment, like buprenorphine,[4] is lifesaving for patients suffering from OUD; and

Whereas, buprenorphine for OUD improves treatment retention[5] and criminal justice outcomes;[6] and

Whereas, buprenorphine for OUD reduces intravenous drug use and improves maternal-fetal health outcomes, Hepatitis C treatment, social functioning, and quality of life;[7] and

Whereas, the American Society of Addiction Medicine (ASAM) National Practice Guideline for the Treatment of Opioid Use Disorder - 2020 Focused Update favors buprenorphine/naloxone (BNX) over buprenorphine mono-product (BUP) outside narrow circumstances like initiation in patients who are physically dependent on methadone or other long-acting opioid products or pregnancy, primarily due to the belief that naloxone in the sublingual formulation is an effective intravenous use deterrent;[8] and

Whereas, ASAM has since acknowledged that the addition of naloxone to buprenorphine may not add any real misuse deterrent utility, indicating the use of BUP outside those narrow clinical exceptions is also appropriate at the prescribers' professional discretion;[9] and

Whereas, diverted buprenorphine products are primarily used for self-treatment;[10] and

Whereas, naloxone may be systemically absorbed at higher doses of BNX, and, though rare, a few case reports describe precipitated opioid withdrawal following oral naloxone use, including one involving a patient switching from BUP to BNX;[11] and

Whereas, BUP, like BNX, is an FDA-approved, evidence-based, and lifesaving treatment for OUD;[12] and

Whereas, although BUP is not considered a first-line sublingual formulation like BNX, there is no specific prohibition against using BUP instead of BNX on a case-by-case basis when deemed

the most suitable treatment option in ASAM guidelines or the Substance Abuse and Mental Health Services Administration (SAMHSA) publications;[8,13] and

Whereas, patient-centered care is a fundamental treatment principle in general and specifically for Addiction Medicine;[14] and

Whereas, revised guidance on medications for OUD from the National Association of Boards of Pharmacy and the National Community Pharmacists Association acknowledges that prescribing BUP instead of BNX for OUD is a reasonable clinical approach for cost consideration or adverse effects from BNX and that BUP prescriptions for OUD should generally not raise red flags;[15] therefore be it

RESOLVED, that our American Medical Association advocate at the state and federal level to remove “red-flag” or “suspicious order” designations suspecting or distinguishing between buprenorphine mono-product and buprenorphine/naloxone that are approved for treatment of OUD (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate that Medicare, Medicaid, and all commercial health plans and other payers, be required to cover medications to treat opioid use disorder in all formulations without prior authorization, step therapy, fail first requirements, or other inappropriate utilization management. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/25/25

**REFERENCES**

1. Renewal of determination that a public health emergency exists. Renewal of Determination that a Public Health Emergency Exists as a Result of the Continued Consequences of the Opioid Crisis. June 18, 2025. Accessed August 29, 2025. https://aspr.hhs.gov/legal/PHE/Pages/Opioids-Renewal-18June2025.aspx#:~:text=%C2%A7%20247d%2C%20do%20hereby%20renew,public%20health%20emergency%20exists%20nationwide.&text=_____-,Robert,Kennedy%20Jr.
2. Ahmad FB, Cisewski JA, Rossen LM, Sutton P. Provisional drug overdose death counts. National Center for Health Statistics. 2025. DOI: https://dx.doi.org/10.15620/cdc/20250305008
3. Schuckit MA. Treatment of Opioid-Use Disorders. N Engl J Med. 2016;375(4):357-368. doi:10.1056/NEJMra1604339
4. Methadone and buprenorphine reduce risk of death after opioid overdose. National Institutes of Health website. https://www.nih.gov/news-events/news-releases/methadone-buprenorphine-reduce-risk-death-after-opioid-overdose#:~:text=A%20National%20Institutes%20of%20Health,reductions%20in%20opioid%20related%20mortality. Published June 19, 2018. Accessed August 29, 2025.
5. Mattick RP, Breen C, Kimber J, Davoli M. Buprenorphine maintenance versus placebo or methadone maintenance for opioid dependence. Cochrane website. https://www.cochrane.org/CD002207/ADDICTN_buprenorphine-maintenance-versus-placebo-or-methadone-maintenance-for-opioid-dependence. Published February 6, 2014. Accessed August 29, 2025.
6. Evans, EA, Zhu Y, Yoo C, Huang D, Hser Y. Criminal justice outcomes over 5 years after randomization to buprenorphine-naloxone or methadone treatment for opioid use disorder. *Addiction*. 2019 Aug;114(8):1396-1404. doi: 10.1111/add.14620.
7. National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Health Sciences Policy; Committee on Medication-Assisted Treatment for Opioid Use Disorder; Mancher M, Leshner AI, editors. Medications for Opioid Use Disorder Save Lives. Washington (DC): National Academies Press (US); 2019 Mar 30. 2, The Effectiveness of Medication-Based Treatment for Opioid Use Disorder. Available from: https://www.ncbi.nlm.nih.gov/books/NBK541393/
8. American Society of Addiction Medicine. *The ASAM National Practice Guideline for the Treatment of Opioid Use Disorder 2020 Focused Update*. Rockville, MD: American Society of Addiction Medicine, 2020:40.
9. Public Policy Statement on the Role of Pharmacists in Medications for Addiction Treatment. American Society of Addiction Medicine, Public Policy Statements. July 19, 2024:3 Accessed August 29, 2025. https://downloads.asam.org/sitefinity-production-blobs/docs/default-source/public-policy-statements/final-pps-on-the-role-of-pharmacists-in-medications-for-addiction-treatment_with-amendments.pdf?sfvrsn=d3dac290_1.
10. Cicero TJ, Ellis MS, Chilcoat HD. Understanding the use of diverted buprenorphine. Drug Alcohol Depend. 2018 Dec 1;193:117-123. doi: 10.1016/j.drugalcdep.2018.09.007. Epub 2018 Oct 12. PMID: 30359928.
11. The Pharmacy Access to Resources and Medication for Opioid Use Disorder (PhARMOUD) Guideline. https://nabp.pharmacy/wp-content/uploads/2025/04/PhARM-OUD-Guidance.pdf. Accessed August 28, 2025.
12. Heidbreder C, Fudala PJ, Greenwald MK. History of the discovery, development, and FDA-approval of buprenorphine medications for the treatment of opioid use disorder. Drug Alcohol Depend Rep. 2023 Jan 10;6:100133. doi: 10.1016/j.dadr.2023.100133. PMID: 36994370; PMCID: PMC10040330.

13. Substance Abuse and Mental Health Services Administration. Medications for Opioid Use Disorder. Treatment Improvement Protocol (TIP) Series 63, 2018 at 3-53, 3-54 & 3-67. Updated 2021. Accessed August 29, 2025. https://store.samhsa.gov/sites/default/files/pep21-02-01-002.pdf
14. American Society of Addiction Medicine Public Policy Statement on Medical Ethics in Addiction Medicine. American Society of Addiction Medicine. April 3, 2024. Accessed August 29, 2025. https://downloads.asam.org/sitefinity-production-blobs/docs/default-source/public-policy-statements/final-pps-on-medical-ethics-in-addiction-medicine.pdf?sfvrsn=dd340991.
15. The Pharmacy Access to Resources and Medication for Opioid Use Disorder (PhARMOUD) Guideline. https://nabp.pharmacy/wp-content/uploads/2025/04/PhARM-OUD-Guidance.pdf. Accessed August 28, 2025.

## RELEVANT AMA POLICY

**Expanding Access to Buprenorphine for the Treatment of Opioid Use Disorder D-95.972**

1. Our American Medical Association's Opioid Task Force will publicize existing resources that provide advice on overcoming barriers and implementing solutions for prescribing buprenorphine for treatment of Opioid Use Disorder
2. 2. Our AMA supports eliminating the requirement for obtaining a waiver to prescribe buprenorphine for the treatment of opioid use disorder.
3. 3. Our AMA supports patients' ability to receive buprenorphine doses that exceed dosage limits listed in FDA-approved labeling when recommended by their prescriber for the treatment of opioid use disorder.
4. 4. Our AMA urges interested parties, including federal agencies, manufacturers, medical organizations, and health plans to review the evidence concerning buprenorphine dosing and revise labels and policies accordingly, in light of increasing mortality related to high-potency synthetic opioids.

**Eliminate Fail First Policy in Addiction Treatment H-320.941**

Our AMA will advocate for the elimination of the "fail first" policy implemented at times by some insurance companies and managed care organizations for addiction treatment.

Click or tap here to enter text.

MERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 213
(I-25)

Introduced by: International Medical Graduates Section

Subject: Pathways to U. S. Permanent Residency for H-1B Physicians

Referred to: Reference Committee B

---

Whereas, the United States faces a worsening physician shortage that has been further exacerbated by the COVID-19 pandemic, with critical gaps in primary care, mental health, and specialty services, especially in rural and underserved areas; and

Whereas, International Medical Graduates (IMGs) continue to provide care to millions of patients nationwide, with immigrant physicians now representing nearly one in four practicing physicians in the U.S.; and

Whereas, immigrant physicians do not displace U.S. workers, but instead fill essential workforce gaps, create jobs, and disproportionately serve high-need communities; and

Whereas, the Department of Veterans Affairs continues to face significant physician staffing shortages, with ongoing delays in access to care for Veterans despite increased funding, underscoring the urgency of mobilizing qualified physicians already practicing in the United States; and

Whereas, thousands of physicians, including nearly 15,000 IMGs from India alone, remain stuck in employment-based green card backlogs that may take decades to resolve, leaving them and their families in prolonged uncertainty; and

Whereas, these delays prevent physicians from working at multiple sites, limit career advancement, restrict opportunities to expand practices, and undermine long-term workforce stability in the U.S.; and

Whereas, despite years of recognition of this problem, meaningful progress has not been made, and the current political climate with bipartisan acknowledgment of healthcare workforce shortages and immigration reform needs demand immediate action; therefore be it

RESOLVED**,** that our American Medical Association urgently, aggressively, and continuously collaborate with the Office of the Inspector General, the Department of Veterans Affairs, U.S. Citizenship and Immigration Services, Congress, and the Executive Branch to advocate for establishing an expedited and separate pathway for physicians to obtain permanent residence and U.S. citizenship, enabling them to practice immediately and without restrictions—including within the Veterans Affairs healthcare system—to address the critical and rapidly worsening physician shortages threatening access to care across the United States. (Directive to Take Action)

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

Received: 9/25/25

**REFERENCES**

Adashi, E.Y., O'Mahony, D.P. & Gruppuso, P.A. The National Physician Shortage: Disconcerting HRSA and AAMC Reports. *J GEN INTERN MED* (2025). https://doi.org/10.1007/s11606-025-09575-7
OIG Determination of Veterans Health Administration's Severe Occupational Staffing Shortages, FY 2025. VA OIG (Aug 12, 2025). https://www.vaoig.gov/sites/default/files/reports/2025-08/vaoig-25-01135-196-final.pdf

*Fewer qualified doctors for hire: Survey.* Axios (August 26, 2025) https://www.axios.com/2025/08/26/health-care-workforce-doctor-shortage-survey

## RELEVANT AMA POLICY

### Permanent Residence Status for Physicians on H1-B Visas D-255.979

Our AMA will work with all relevant stakeholders to: (1) clear the backlog for conversion from H1-B visas for physicians to permanent resident status; and (2) allow the children of H-1B visa holders, who have aged out of the H-4 non-immigrant classification, to remain in the U.S. legally while their parents' green card applications are pending.
Res. 229, A-18 Appended: BOT Rep. 01, I-19

### Impact of Immigration Barriers on the Nation's Health D-255.980

1. Our AMA recognizes the valuable contributions and affirms our support of international medical students and international medical graduates and their participation in U.S. medical schools, residency and fellowship training programs and in the practice of medicine.
2. Our AMA will oppose laws and regulations that would broadly deny entry or re-entry to the United States of persons who currently have legal visas, including permanent resident status (green card) and student visas, based on their country of origin and/or religion.
3. Our AMA will oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion.
4. Our AMA will advocate for the immediate reinstatement of premium processing of H-1B visas for physicians and trainees to prevent any negative impact on patient care.
5. Our AMA will advocate for the timely processing of visas for all physicians, including residents, fellows, and physicians in independent practice.
6. Our AMA will work with other stakeholders to study the current impact of immigration reform efforts on residency and fellowship programs, physician supply, and timely access of patients to health care throughout the U.S.
7. Our AMA will update the House of Delegates by the 2017 Interim Meeting on the impact of immigration barriers on the physician workforce.

Citation: Alt. Res. 308, A-17; Modified: CME Rep. 01, A-18; Reaffirmation: A-19; Reaffirmed: CME Rep. 4, A-21; Reaffirmed: Res. 234, A-22; Reaffirmed: Res. 210, A-23;

### Conrad 30 - J-1 Visa Waivers D-255.985

1. Our AMA will:
    a. lobby for the reauthorization of the Conrad 30 J-1 Visa Waiver Program;
    b. advocate that the J-1 Visa waiver slots be increased from 30 to 50 per state;
    c. advocate for expansion of the J-1 Visa Waiver Program to allow IMGs to serve on the faculty of medical schools and residency programs in geographic areas or specialties with workforce shortages;
    d. publish on its website J-1 visa waiver (Conrad 30) statistics and information provided by state Conrad 30 administrators along with a frequently asked questions (FAQs) document about the Conrad 30 program;
    e. advocate for solutions to expand the J-1 Visa Waiver Program to increase the overall number of waiver positions in the US in order to increase the number of IMGs who are willing to work in underserved areas to alleviate the physician workforce shortage;

   f. work with the Educational Commission for Foreign Medical Graduates and other stakeholders to facilitate better communication and information sharing among Conrad 30 administrators, IMGs, US Citizenship and Immigration Services and the State Department; and
   g. continue to communicate with the Conrad 30 administrators and IMGS members to share information and best practices in order to fully utilize and expand the Conrad 30 program.
2. Our AMA will continue to monitor legislation and provide support for improvements to the J-1 Visa Waiver program.
3. Our AMA will continue to promote its educational or other relevant resources to IMGs participating or considering participating in J-1 Visa waiver programs.
4. As a benefit of membership, our AMA will provide advice and information on Federation and other resources (but not legal opinions or representation), as appropriate to IMGs in matters pertaining to work-related abuses.
5. Our AMA encourages IMGs to consult with their state medical society and consider requesting that their state society ask for assistance by the AMA Litigation Center, if it meets the Litigation Center's established case selection criteria.
   Res. 233, A-06 Appended: CME Rep. 10, A-11 Appended: Res. 303, A-11 Reaffirmation I-11; Modified: BOT Rep. 5, I-12

**Expedited Immigrant Green Card Visa for J-1 Visa Waiver Physicians Serving in Underserved Areas D-255.976**

Our American Medical Association will advocate that physicians who are on J-1 visas be granted a waiver and H-1B status for serving in underserved areas, be given highest priority in visa conversion to green cards upon completion of their service commitment, and be exempt from the per country limitation of H-1B visa to green card conversion. Res. 218, A-22

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

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

**Expansion of US Veterans' Health Care Choices H-510.983**

1. Our AMA will continue to work with the Veterans Administration (VA) to provide quality care to veterans.
2. Our AMA will continue to support efforts to improve the Veterans Choice Program (VCP) and make it a permanent program.
3. Our AMA encourages the VA to continue enhancing and developing alternative pathways for veterans to seek care outside of the established VA system if the VA system cannot provide adequate or timely care, and that the VA develop criteria by which individual veterans may request alternative pathways.
4. Our AMA will support consolidation of all the VA community care programs.
5. Our AMA encourages the VA to use external assessments as necessary to identify and address systemic barriers to care.
6. Our AMA will support interventions to mitigate barriers to the VA from being able to achieve its mission.
7. Our AMA will advocate that clean claims submitted electronically to the VA should be paid within 14 days and that clean paper claims should be paid within 30 days.
8. Our AMA encourages the acceleration of interoperability of electronic personal and medical health records in order to ensure seamless, timely, secure and accurate exchange of information between VA and non-VA providers and encourage both the VA and physicians caring for veterans outside of the VA to exchange medical records in a timely manner to ensure efficient care.
9. Our AMA encourages the VA to engage with physicians providing care in the VA system to explore and develop solutions on improving the health care choices of veterans.
10. Our AMA will advocate for new funding to support expansion of the Veterans Choice Program.
CMS Rep. 06, A-17 Reaffirmation: A-22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 214
(I-25)

Introduced by: International Medical Graduates Section

Subject: Physician Visa Protection and Pathway to Serve Underserved Communities

Referred to: Reference Committee B

---

Whereas, international medical graduates (IMGs) represent 25% of the U.S. physician workforce and are essential in addressing physician shortages, particularly in primary care, rural, and underserved areas; and

Whereas, thousands of U.S. trained physicians in the United States rely on H-1B visas at various stages of their careers, including residency and fellowship training, during transitions from J-1 status, and while serving in underserved communities through the Conrad 30 and other J-1 waiver programs; and

Whereas, the President's administration has proposed a rule imposing a $100,000 fee for H-1B visas, which, if applied to physicians, would create an insurmountable barrier to entry and retention of qualified doctors in the U.S.; and

Whereas, physicians are often unintended collateral damage in broader immigration policy changes, despite their essential contributions to U.S. healthcare delivery and their commitment to serving in areas of greatest need; and

Whereas, there is precedent for creating a healthcare-specific visa category, as demonstrated by the H -1C visa program, which was created exclusively for nurses during a severe nursing shortage before being discontinued in 2009; and

Whereas, the National Interest Waiver provision has previously been used as a precedent to recognize physicians serving in rural and underserved areas as eligible for immigration benefits, underscoring the federal government's recognition of their critical role in meeting national health care needs; and

Whereas, restricting or discouraging physicians from obtaining H-1B visas would worsen existing physician shortages, threaten continuity of patient care, and undermine federal and state efforts to expand healthcare access; therefore be it

RESOLVED, that our American Medical Association advocate for the federal government to work to ensure physicians are exempt from any proposed increases in H-1B visa fees, including the proposed $100,000 charge, <u>through feasible alternatives such as</u> by including them in the National Interest Waiver (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for the creation of a dedicated non-immigrant visa pathway specifically for physicians, in recognition of their essential role in U.S. healthcare and to prevent them from being unintended casualties of broader immigration policy changes. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/25/25

**RELEVANT AMA POLICY**

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

**Expedited Immigrant Green Card Visa for J-1 Visa Waiver Physicians Serving in Underserved Areas D-255.976**
Our American Medical Association will advocate that physicians who are on J-1 visas be granted a waiver and H-1B status for serving in underserved areas, be given highest priority in visa conversion to green cards upon completion of their service commitment, and be exempt from the per country limitation of H-1B visa to green card conversion. Res. 218, A-22

**Impact of Immigration Barriers on the Nation's Health D-255.980**
1. Our American Medical Association recognizes the valuable contributions and affirms our support of international medical students and international medical graduates and their participation in U.S. medical schools, residency and fellowship training programs and in the practice of medicine.
2. Our AMA will oppose laws and regulations that would broadly deny entry or re-entry to the United States of persons who currently have legal visas, including permanent resident status (green card) and student visas, based on their country of origin and/or religion.
3. Our AMA will oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion.
4. Our AMA will advocate for the immediate reinstatement of premium processing of H-1B visas for physicians and trainees to prevent any negative impact on patient care.
5. Our AMA will advocate for the timely processing of visas for all physicians, including residents, fellows, and physicians in independent practice.
6. Our AMA will work with other stakeholders to study the current impact of immigration reform efforts on residency and fellowship programs, physician supply, and timely access of patients to health care throughout the U.S.

Alt. Res. 308, A-17 Modified: CME Rep. 01, A-18 Reaffirmation: A-19 Reaffirmed: CME Rep. 4, A-21 Reaffirmed: Res. 234, A-22 Reaffirmed: Res. 210, A-23

**J-1 Visas and Waivers D-255.993**
1. Our American Medical Association shall encourage HHS and other interested government agencies to continue sponsorship of the J-1 visa waiver program.
2. Our AMA will work with federal agencies to ensure better coordination of federal, state, and local agencies in monitoring the placement and enforcement of physicians' service requirements through the J-1 waiver and Conrad-30 programs.
3. Our AMA will work towards regulation and/or legislation to allow physicians on H-1B waiver visas, who are limited to serving in medically underserved areas, to continue to care for their patients who require hospitalization in the closest appropriate medical facility which may not be in the underserved area.
4. Our AMA supports a national data repository of J-1 Visa Waiver statistics so that J-1 Visa Waiver unoffered positions can be transferred to states as needed to treat underserved communities and to monitor the success of this program.

BOT Rep. 11, I-02 Appended: Res. 324, A-11 Appended: Res. 904, I-11Reaffirmation A-14 Modified: BOT Rep. 09, A-24

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 215
(I-25)

Introduced by: Women Physicians Section

Subject: Extending the Medicaid Work Requirement Exemption up to 12 Months Postpartum

Referred to: Reference Committee B

---

Whereas, Medicaid work requirements were signed into law under H.R.1 - *One Big Beautiful Bill Act* on July 4, 2025; and

Whereas, our American Medical Association has strong policy opposing Medicaid work requirements, citing evidence that such requirements lead to coverage loss due to administrative burdens and eligibility confusion, disproportionately harming low-income and historically marginalized populations; and

Whereas, the implementation of such requirements remains an opportunity for physicians to mitigate harm and ensure protection for high-risk groups, including postpartum individuals; and

Whereas, women constitute over half of adult Medicaid enrollees;[1] and

Whereas, Medicaid is the largest single payer for pregnancy-related services in the United States, financing over 40% of all births;[2] and

Whereas, prior to H.R.1, Georgia was the only state to implement Medicaid work requirements, initially exempting postpartum individuals for only 60 days until the American Rescue Plan Act of 2021 extended postpartum Medicaid coverage in participating states to 12 months;[3] and

Whereas, H.R.1 does not mandate a postpartum exemption beyond the federal minimum of 60 days, despite the recognized medical and mental health needs extending well beyond that timeframe; and

Whereas, the Centers for Disease Control and Prevention (CDC), American College of Obstetricians and Gynecologists (ACOG), and the AMA recognize the first 12 months postpartum as a critical window for maternal health monitoring, with elevated risks for conditions such as postpartum depression, cardiovascular disease, and substance use disorders; and

Whereas, requiring women to meet work or reporting requirements during the postpartum period may exacerbate health inequities, increase maternal morbidity and mortality, disrupt continuity of care, and compound socioeconomic stressors, particularly for low-income women and those without access to childcare or paid leave; therefore be it

RESOLVED, that our American Medical Association supports a clear, mandatory exemption from Medicaid work requirements for all postpartum women up to 12 months postpartum. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 9/25/25

**REFERENCES**
1. Kaiser Family Foundation. Distribution of Adults Ages 19–64 Enrolled in Medicaid, by Sex. State Health Facts. Published 2023. Accessed July 28, 2025. https://www.kff.org/medicaid/state-indicator/medicaid-distribution-adults-19-64-by-sex/
2. Martin JA, Hamilton BE, Osterman MJK, Driscoll AK, Mathews TJ. *Births: Final Data for 2019*. Natl Vital Stat Rep. 2021;70(2):1–50. Published March 23, 2021. Accessed July 28, 2025. https://www.cdc.gov/nchs/data/nvsr/nvsr70/nvsr70-02-508.pdf
3. Georgia Department of Community Health. Postpartum Extension Demonstration. Georgia Medicaid. Published online. Accessed July 28, 2025. https://medicaid.georgia.gov/programs/all-programs/postpartum-extension

**RELEVANT AMA POLICY**

**H-290.961 Opposition to Medicaid Work Requirements**

Our AMA opposes work requirements as a criterion for Medicaid eligibility [Res. 802, I-17; Reaffirmation: A-18]

**D-290.979 Medicaid Expansion**

1. Our American Medical Association, at the invitation of state medical societies, will work with state and specialty medical societies in advocating at the state level to expand Medicaid eligibility to 133% (138% FPL including the income disregard) of the Federal Poverty Level as authorized by the ACA and will advocate for an increase in Medicaid payments to physicians and improvements and innovations in Medicaid that will reduce administrative burdens and deliver healthcare services more effectively, even as coverage is expanded.
2. Our AMA will:
    a. continue to advocate strongly for expansion of the Medicaid program to all states and reaffirm existing policies D-290.979, H 290.965 and H-165.823.
    b. work with interested state medical associations and national medical specialty societies to provide AMA resources on Medicaid expansion and covering the uninsured to health care professionals to inform the public of the importance of expanded health insurance coverage to all. [Res. 809, I-12; Reaffirmed: CMS Rep. 02, A-19; Reaffirmed: CMS Rep. 5, I-20; Reaffirmed: CMS Rep. 3, A-21; Reaffirmed: CMS Rep. 9, A-21; Reaffirmed: CMS Rep. 3, I-21; Reaffirmed: Joint CMS/CSAPH Rep. 1, I-21; Appended: Res. 122, A-22]

**D-290.974 Extending Medicaid Coverage for One Year Postpartum**

Our AMA will work with relevant stakeholders to: (1) support and advocate, at the state and federal levels, for extension of Medicaid and Children's Health Insurance Program (CHIP) coverage to at least 12 months after the end of pregnancy; and (2) expand Medicaid and CHIP eligibility for pregnant and postpartum non-citizen immigrants. [Res. 221, A-19; Modified: Joint CMS/CSAPH Rep. 1, I-21; Modified: Res. 701, I-21]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 216
(I-25)

Introduced by: International Medical Graduates Section

Subject: Ensuring Timely J-1 Visa Processing to Protect IMG Participation in Residency Programs

Referred to: Reference Committee B

---

Whereas, our American Medical Association acknowledges the significant contributions of International Medical Students and Graduates and unequivocally supports their participation in the U.S. residency and fellowship programs. According to the 2023-2024 GME Data Resource Book from ACGME, of the 133,776 total active residents in specialty programs, 21.7% (29,058) are international medical school graduates (IMGs)[(1);] and

Whereas, according to the AAMC 2024 U.S. Physician Workforce Data Dashboard, of the 1,010,892 active physicians in the country, 24.7% (249,690) were International Medical Graduates[(2);] and

Whereas, our AMA recognizes that more than twenty million people in the United States reside in areas where foreign-trained physicians comprise at least half of the physician workforce. Furthermore, in these rural and underserved areas, at-risk U.S. citizens depend on visa-sponsored physicians to provide essential primary care and specialty health services[(3)]; and

Whereas, our AMA advocates for the immediate issuance and the resumption of the J-1 visa appointment scheduling to prevent further disruption to International Medical Graduates and the U.S. Healthcare system[(4);] and

Whereas, our AMA collaborates with Educational Commission on Foreign Medical Graduates to reduce the J-1 visa delays for IMGs seeking to enter the United States for postgraduate training and/or medical practice[(5);] and

Whereas, our AMA encourages the timely visa processing for all physicians, including residents and fellows[(4);] and

Whereas, our AMA collaborates with key stakeholder to mitigate delays in visa processing for International Medical Graduates (IMGs) pursuing Graduate Medical Education training programs or medical practice in the United States[(5);] and

Whereas, our AMA will continue to work with relevant authorities to support residency program directors to establish the necessary and effective connection with the State Department and the Department of Homeland Security when needed, to streamline and expedite the necessary procedures for qualified residency or fellowship applicants and, therefore, reduce the uncertainty involved in considering International graduates for residency positions[(5)]; and

Whereas, misinformation about immigration requirements, delayed visa processing times, and increased bureaucratic hurdles can disproportionately impact the recruitment and retention of

International Medical Graduates (IMGs) in residency programs, exacerbating workforce shortages and limiting access to care in underserved areas; and

Whereas, international medical graduates comprise a significant portion of the U.S. residency workforce and are essential in addressing physician shortages, particularly in underserved areas; and

Whereas, the 2025 suspension of J-1 visa appointments created widespread uncertainty and nearly prevented many IMGs from beginning training, leading some residency programs to limit or avoid interviewing IMG applicants; and

Whereas, although J-1 appointments have resumed, the lack of consistent guarantees regarding timely visa processing undermines program directors' confidence in ranking IMGs, thus threatening their participation in the Match; and

Whereas, predictable and timely visa processing is critical to ensuring IMG residents begin training on July 1, thereby avoiding disruptions in workforce planning and patient care; therefore be it

RESOLVED, that our American Medical Association advocate with the U.S. Department of State, Department of Homeland Security, and other relevant agencies to guarantee timely J-1 visa appointments and processing for all IMGs who have matched into U.S. residency programs, ensuring arrival and participation by July 1 (Directive to Take Action); and be it

RESOLVED, that the American Medical Association collaborate with key stakeholders, including Intealth and the Educational Commission for Foreign Medical Graduates (ECFMG), to advocate for the timely issuance and scheduling of J-1 visas for eligible IMGs, while addressing misinformation about immigration policies that may discourage or mislead potential IMGs and residency programs (Directive to Take Action); and be it further

RESOLVED, that our AMA work with relevant stakeholders to improve processes that reduce visa delays and ensure equitable opportunities for international medical graduates, thereby strengthening the physician workforce (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for contingency protocols at federal agencies to prevent future visa disruptions from jeopardizing IMG participation in the U.S. residency Match (Directive to Take Action); and be it further

RESOLVED, that our AMA report back at the 2026 Annual Meeting on actions taken to secure timely visa processing for IMGs entering U.S. residency programs. (Directive to Take Action)

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

Received: 9/26/25

**REFERENCES**

1. https://www.acgme.org/about/publications-and-resources/graduate-medical-education-data-resource-book/
2. https://www.aamc.org/data-reports/report/us-physician-workforce-data-dashboard
3. https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2022-2-14-AMA-Statement-for-the-Record-re-Immigration.pdf
4. https://policysearch.ama-assn.org/policyfinder/detail/international%20medical%20graduate?uri=%2FAMADoc%2Fdirectives.xml-D-255.969.xml
5. https://policysearch.ama-assn.org/policyfinder/detail/visa%20?uri=%2FAMADoc%2Fdirectives.xml-0-645.xml
6. https://policysearch.ama-assn.org/policyfinder/detail/international%20medical%20graduates?uri=%2FAMADoc%2Fdirectives.xml-D-255.980.xml

## RELEVANT AMA POLICY

### AMA Principles on International Medical Graduates H-255.988

1. Our American Medical Association supports current U.S. visa and immigration requirements applicable to foreign national physicians who are graduates of medical schools other than those in the United States and Canada.
2. Our AMA supports current regulations governing the issuance of exchange visitor visas to foreign national IMGs, including the requirements for successful completion of the USMLE.
3. Our AMA reaffirms its policy that the U.S. and Canada medical schools be accredited by a nongovernmental accrediting body.
4. Our AMA supports cooperation in the collection and analysis of information on medical schools in nations other than the U.S. and Canada.
5. Our AMA supports continued cooperation with the ECFMG and other appropriate organizations to disseminate information to prospective and current students in foreign medical schools. An AMA member, who is an IMG, should be appointed regularly as one of the AMA's representatives to the ECFMG Board of Trustees.
6. Our AMA supports working with the Accreditation Council for Graduate Medical Education (ACGME) and the Federation of State Medical Boards (FSMB) to assure that institutions offering accredited residencies, residency program directors, and U.S. licensing authorities do not deviate from established standards when evaluating graduates of foreign medical schools.
7. In cooperation with the ACGME and the FSMB, our AMA supports only those modifications in established graduate medical education or licensing standards designed to enhance the quality of medical education and patient care.
8. Our AMA continues to support the activities of the ECFMG related to verification of education credentials and testing of IMGs.
9. Our AMA supports that special consideration be given to the limited number of IMGs who are refugees from foreign governments that refuse to provide pertinent information usually required to establish eligibility for residency training or licensure.
10. Our AMA supports that accreditation standards enhance the quality of patient care and medical education and not be used for purposes of regulating physician manpower.
11. Our AMA representatives to the ACGME, residency review committees and to the ECFMG should support AMA policy opposing discrimination. Medical school admissions officers and directors of residency programs should select applicants on the basis of merit, without considering status as an IMG or an ethnic name as a negative factor.
12. Our AMA supports the requirement that all medical school graduates complete at least one year of graduate medical education in an accredited U.S. program in order to qualify for full and unrestricted licensure. State medical licensing boards are encouraged to allow an alternate set of criteria for granting licensure in lieu of this requirement:
    a. completion of medical school and residency training outside the U.S.;
    b. extensive U.S. medical practice; and
    c. evidence of good standing within the local medical community.
13. Our AMA supports publicizing existing policy concerning the granting of staff and clinical privileges in hospitals and other health facilities.
14. Our AMA supports the participation of all physicians, including graduates of foreign as well as U.S. and Canadian medical schools, in organized medicine. Our AMA offers encouragement and

assistance to state, county, and specialty medical societies in fostering greater membership among IMGs and their participation in leadership positions at all levels of organized medicine, including AMA committees and councils, the Accreditation Council for Graduate Medical Education and its review committees, the American Board of Medical Specialties and its specialty boards, and state boards of medicine, by providing guidelines and non-financial incentives, such as recognition for outstanding achievements by either individuals or organizations in promoting leadership among IMGs.

15. Our AMA supports studying the feasibility of conducting peer-to-peer membership recruitment efforts aimed at IMGs who are not AMA members.
16. Our AMA membership outreach to IMGs to include
    a. using its existing publications to highlight policies and activities of interest to IMGs, stressing the common concerns of all physicians;
    b. publicizing its many relevant resources to all physicians, especially to nonmember IMGs;
    c. identifying and publicizing AMA resources to respond to inquiries from IMGs; and
    d. expansion of its efforts to prepare and disseminate information about requirements for admission to accredited residency programs, the availability of positions, and the problems of becoming licensed and entering full and unrestricted medical practice in the U.S. that face IMGs. This information should be addressed to college students, high school and college advisors, and students in foreign medical schools.
17. Our AMA supports recognition of the common aims and goals of all physicians, particularly those practicing in the U.S., and support for including all physicians who are permanent residents of the U.S. in the mainstream of American medicine.
18. Our AMA supports its leadership role to promote the international exchange of medical knowledge as well as cultural understanding between the U.S. and other nations.
19. Our AMA supports institutions that sponsor exchange visitor programs in medical education, clinical medicine and public health to tailor programs for the individual visiting scholar that will meet the needs of the scholar, the institution, and the nation to which he will return.
20. Our AMA supports informing foreign national IMGs that the availability of training and practice opportunities in the U.S. is limited by the availability of fiscal and human resources to maintain the quality of medical education and patient care in the U.S., and that those IMGs who plan to return to their country of origin have the opportunity to obtain GME in the United States.
21. Our AMA supports U.S. medical schools offering admission with advanced standing, within the capabilities determined by each institution, to international medical students who satisfy the requirements of the institution for matriculation.
22. Our AMA supports the Federation of State Medical Boards, its member boards, and the ECFMG in their willingness to adjust their administrative procedures in processing IMG applications so that original documents do not have to be recertified in home countries when physicians apply for licenses in a second state.
23. Our AMA supports continued efforts to protect the rights and privileges of all physicians duly licensed in the U.S. regardless of ethnic or educational background and opposes any legislative efforts to discriminate against duly licensed physicians on the basis of ethnic or educational background.
24. Our AMA supports continued study of challenges and issues pertinent to IMGs as they affect our country's health care system and our physician workforce.
25. Our AMA supports advocacy to Congress to fund studies through appropriate agencies, such as the Department of Health and Human Services, to examine issues and experiences of IMGs and make recommendations for improvements.

**Urgent Advocacy to Restore J-1 Visa Processing for International Medical Graduate Physicians D-255.969**

1. Our American Medical Association will
    a. work with the ECFMG to minimize delays in the visa process for International Medical Graduates applying for visas to enter the US for postgraduate medical training and/or medical practice.
    b. promote regular communication between the Department of Homeland Security and AMA IMG representatives to address and discuss existing and evolving issues related to the immigration and registration process required for International Medical Graduates.

   c. work through the appropriate channels to assist residency program directors, as a group or individually, to establish effective contacts with the State Department and the Department of Homeland Security, in order to prioritize and expedite the necessary procedures for qualified residency applicants to reduce the uncertainty associated with considering a non-citizen or permanent resident IMG for a residency position.
2. Our AMA International Medical Graduates Section will continue to monitor any H-1B visa denials as they relate to IMGs? inability to complete accredited GME programs.
3. Our AMA will study, in collaboration with the Educational Commission on Foreign Medical Graduates and the Accreditation Council for Graduate Medical Education, the frequency of such J-1 Visa reentry denials and its impact on patient care and residency training.
4. Our AMA will, in collaboration with other stakeholders, advocate for unfettered travel for IMGs for the duration of their legal stay in the US in order to complete their residency or fellowship training to prevent disruption of patient care.

**Visa Complications for IMGs in GME D-255.991**

1. Our American Medical Association will
   a. work with the ECFMG to minimize delays in the visa process for International Medical Graduates applying for visas to enter the US for postgraduate medical training and/or medical practice.
   b. promote regular communication between the Department of Homeland Security and AMA IMG representatives to address and discuss existing and evolving issues related to the immigration and registration process required for International Medical Graduates.
   c. work through the appropriate channels to assist residency program directors, as a group or individually, to establish effective contacts with the State Department and the Department of Homeland Security, in order to prioritize and expedite the necessary procedures for qualified residency applicants to reduce the uncertainty associated with considering a non-citizen or permanent resident IMG for a residency position.
2. Our AMA International Medical Graduates Section will continue to monitor any H-1B visa denials as they relate to IMGs? inability to complete accredited GME programs.
3. Our AMA will study, in collaboration with the Educational Commission on Foreign Medical Graduates and the Accreditation Council for Graduate Medical Education, the frequency of such J-1Visa reentry denials and its impact on patient care and residency training.
4. Our AMA will, in collaboration with other stakeholders, advocate for unfettered travel for IMGs for the duration of their legal stay in the US in order to complete their residency or fellowship training to prevent disruption of patient care.

**Impact of Immigration Barriers on the Nation's Health D-255.980**

1. Our American Medical Association recognizes the valuable contributions and affirms our support of international medical students and international medical graduates and their participation in U.S. medical schools, residency and fellowship training programs and in the practice of medicine.
2. Our AMA will oppose laws and regulations that would broadly deny entry or re-entry to the United States of persons who currently have legal visas, including permanent resident status (green card) and student visas, based on their country of origin and/or religion.
3. Our AMA will oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion.
4. Our AMA will advocate for the immediate reinstatement of premium processing of H-1B visas for physicians and trainees to prevent any negative impact on patient care.
5. Our AMA will advocate for the timely processing of visas for all physicians, including residents, fellows, and physicians in independent practice.
6. Our AMA will work with other stakeholders to study the current impact of immigration reform efforts on residency and fellowship programs, physician supply, and timely access of patients to health care throughout the U.S.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 217
(I-25)

Introduced by: New Jersey

Subject: Protecting Access to Public Service Loan Forgiveness (PSLF), Income-Driven Repayment (IDR), and Direct Plus Loans for Graduate or Professional Students (Grad PLUS Loans)

Referred to: Reference Committee B

---

Whereas, the average medical school graduate will have $264,519 in student loan, which is 2.25 times greater than the average postgraduate student; and

Whereas, the average medical resident has a monthly net income of $4,400; and

Whereas, the Public Service Loan Forgiveness (PSLF) program offers loan forgiveness to federal student loan borrowers who work for the government, such as a federally qualified health center, or a not-for-profit organization after making 120 consecutive payments; and

Whereas, Income-Driven Repayment (IDR) plans tie monthly loan payment amounts to a percentage of the borrower's discretionary income; and

Whereas, Direct PLUS Loans for Graduate or Professional Students (Grad PLUS Loans) assist borrowers in paying for education-related expenses, such as housing, that are not covered by other financial aid options; and

Whereas, there have been recent federal orders that have paused access to IDR applications, changed the eligibility requirements for PSLF, and put into motion the transfer of federal student loans away from the Department of Education and to the Small Business Administration; therefore be it

RESOLVED, that our American Medical Association advocates for protection of access to Public Service Loan Forgiveness (PSLF), Income-Driven Repayment (IDR), and Direct Plus Loans for Graduate or Professional Students (Grad PLUS Loans). (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/26/25

**REFERENCES**


1. Hanson, Melanie. Average Medical School Debt. EducationData.org. Updated August 28, 2024. Accessed March 27, 2025. https://educationdata.org/average-medical-school-debt
2. Living on a Resident's Budget. Association of American Medical Colleges. Accessed March 27, 2025. https://students-residents.aamc.org/media/9956/download
3. Office of Federal Student Aid. Public Service Loan Forgiveness (PSLF). Department of Education. Accessed March 27, 2025. https://studentaid.gov/manage-loans/forgiveness-cancellation/public-service
4. Office of Federal Student Aid. Income-Driven Repayment Plans. Department of Education. Accessed March 27, 2025. https://studentaid.gov/manage-loans/repayment/plans/income-driven
5. Office of Federal Student Aid. Direct PLUS Loans for Graduate or Professional Students. Department of Education. Accessed March 27, 2025. https://studentaid.gov/understand-aid/types/loans/plus/grad

6. Office of Communications and Outreach. U.S. Department of Education Opens Revised Income-Driven Repayment Plan and Loan Consolidation Applications for Borrowers. Department of Education. Updated March 26, 2025. Accessed March 27, 2025. https://www.ed.gov/about/news/press-release/us-department-of-education-opens-revised-income-driven-repayment-plan-and-loan-consolidation-applications-borrowers
7. Trump, Donald J. Restoring Public Service Loan Forgiveness. The White House. Updated March 7, 2025. Accessed March 27, 2025. https://www.whitehouse.gov/presidential-actions/2025/03/restoring-public-service-loan-forgiveness/
8. Minsky, Adam S. 40 Million Student Loan Borrowers Hit By Trio Of Trump Orders - Here's Where Things Stand. Forbes. Updated March 25, 2025. Accessed March 27, 2025. https://www.forbes.com/sites/adamminsky/2025/03/25/40-million-student-loan-borrowers-hit-by-trio-of-trump-orders---heres-where-things-stand/

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 218
(I-25)

Introduced by: New York

Subject: Amend AMA Policy D-160.921 on Sensitive Locations to Protected Areas

Referred to: Reference Committee B

---

Whereas, the American Medical Association (AMA) Policy D-160.921[1], originally adopted in 2017 states the following; and

> "Our AMA: (1) advocates for and supports legislative efforts to designate healthcare facilities as sensitive locations by law; (2) will work with appropriate stakeholders to educate medical providers on the rights of undocumented patients while receiving medical care, and the designation of healthcare facilities as sensitive locations where U.S. Immigration and Customs Enforcement (ICE) enforcement actions should not occur; (3) encourages healthcare facilities to clearly demonstrate and promote their status as sensitive locations; and (4) opposes the presence of ICE enforcement at healthcare facilities."

Whereas, our AMA has a policy on the "Guiding Principles for the Healthcare of Migrants" [2, 3] stating these organizations will:

> "Advocate for the development of adequate policies and/or legislation to address the healthcare needs of migrants and asylum seekers in cooperation with relevant legislators and stakeholders based on the following guiding principles, adapted from the High-level meeting of the Global Consultation on Migrant Health, i.e. the 'Colombo Statement'",
>
> "affirm the importance of multi-sectoral coordination and inter-country engagement and partnership in enhancing the means of addressing health aspects of migration." and

Whereas, on January 21st, 2025, the Department of Homeland Security Spokesperson on Directives Expanding Law Enforcement and Ending the Abuse of Humanitarian Parole stated[4] that the Acting Department of Homeland Security Secretary issued a directive "to rescind the Biden Administration's guidelines for Immigration and Customs Enforcement (ICE) and Customs and Border Protection (CBP) enforcement actions that thwart law enforcement in or near so-called 'sensitive' areas."; and

Whereas, the policy rescinded, the former Department of Homeland Security (DHS) Memo[5] "Guidelines for Enforcement Actions in or Near Protected Areas" listed as an example of a "protected area" as "a medical or mental healthcare facility, such as a hospital, doctor's office, health clinic, vaccination or testing site, urgent care center, site that serves pregnant individuals, or community health center."; and

Whereas, previous United States Immigrations and Customs Enforcement [6] and Customs and Border Protection [7] memorandums referred to the above healthcare facilities as "sensitive locations" instead of "protected areas", but this language was internally updated to "protected areas" in 2021 [8]; and

Whereas, these changes will allow for ICE Agents to operate in formerly defined "protected areas" in all circumstances; and

Whereas, prior DHS "Guidelines for Enforcement Actions in or Near Protected Areas" listed several exceptions that would allow ICE agents to conduct business in "protected areas", including "national security threat … imminent risk of death, violence or physical harm … hot pursuit of an individual who poses a public safety threat / personally observed border-crosser" and others; and

Whereas, the AMA has a policy on "sensitive locations"; therefore be it

RESOLVED, that our American Medical Association amend policy D-160.921 by addition and deletion as follows:

"Our AMA: (1) advocates for and supports legislative efforts to designate healthcare facilities as ~~sensitive locations~~ protected areas by law; (2) will work with appropriate stakeholders to educate medical providers on the rights of undocumented patients while receiving medical care, and the designation of healthcare facilities as ~~sensitive locations~~ protected areas where U.S. Immigration and Customs Enforcement (ICE) enforcement actions should not occur; (3) encourages healthcare facilities to clearly demonstrate and promote their status as ~~sensitive locations~~ protected areas; and (4) opposes the presence of ICE enforcement at healthcare facilities."

(Modify Current HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 9/26/25

**REFERENCES:**

1. American Medical Association. Policy D-160.921, Enforcement Actions in Sensitive Locations. Published 2017. Accessed February 4, 2025. https://policysearch.ama-assn.org/policyfinder/detail/Sensitive%20locations?uri=%2FAMADoc%2Fdirectives.xml-D-160.921.xml
2. American Medical Association. Policy H-65.938, Guiding Principles for the Healthcare of Migrants. Published June 2024. Accessed February 4, 2025. https://policysearch.ama-assn.org/policyfinder/detail/Guiding%20principles%20healthcare%20m igrants?uri=%2FAMADoc%2FHOD.xml-H-65.938.xml
3. Medical Society of the State of New York. Policy 120.876, Guiding Principles for the Healthcare of Migrants. Published April 2024. Accessed February 4, 2025. https://www.positionstatements.mssny.org/120-876-guiding-principles-for-the-healthcare-of-migr ants/
4. US Department of Homeland Security. Statement from DHS Spokesperson on Directives Expanding Law Enforcement and Ending Abuse. Published January 21, 2025. Accessed February 4, 2025. https://www.dhs.gov/news/2025/01/21/statement-dhs-spokesperson-directives-expanding-law-e nforcement-and-ending-abuse
5. US Department of Homeland Security. Guidelines for Enforcement Actions in or Near Protected Areas. Published October 27, 2021. Accessed February 4, 2025. https://www.dhs.gov/sites/default/files/publications/21_1027_opa_guidelines-enforcement-action s-in-near-protected-areas.pdf
6. US Immigration and Customs Enforcement. Enforcement Actions at or Focused on Sensitive Locations. Policy No. 10029.2. Published 2011. Accessed February 4, 2025. https://www.ice.gov/doclib/ero-outreach/pdf/10029.2-policy.pdf
7. US Customs and Border Protection. Enforcement Actions at or Near Certain Community Locations. Published 2013. Accessed February 4, 2025. https://niwaplibrary.wcl.american.edu/wp-content/uploads/CBP-Sensitive-Locations-Policy-2013. pdf
8. National Association of Foreign Student Advisers (NAFSA). DHS Rescinds Biden "Protected Areas" Enforcement Policy. Accessed February 4, 2025. https://www.nafsa.org/regulatory-information/dhs-rescinds-biden-protected-areas-enforcement-p olicy

**RELEVANT AMA POLICY**

**Presence and Enforcement Actions of Immigration and Customs Enforcement (ICE) in Healthcare D-160.921**
Our AMA: (1) advocates for and supports legislative efforts to designate healthcare facilities as sensitive locations by law; (2) will work with appropriate stakeholders to educate medical providers on the rights of undocumented patients while receiving medical care, and the designation of healthcare facilities as sensitive locations where U.S. Immigration and Customs Enforcement (ICE) enforcement actions should not occur; (3) encourages healthcare facilities to clearly demonstrate and promote their status as sensitive locations; and (4) opposes the presence of ICE enforcement at healthcare facilities.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 219
(I-25)

Introduced by: New York

Subject: Addressing the Harms and Misleading Nature of Medicare Advantage Plans

Referred to: Reference Committee B

---

Whereas, although Medicare Advantage (MA) was initially purported to save taxpayer money, MA is now more costly than traditional Medicare. MA plans are wholly owned and administered by private insurance companies, especially the four biggest for- profit companies. All costs of these plans are paid by the U.S taxpayers. Therefore, the increased expense of MA is depleting the Medicare budget; and

Whereas, the term Medicare Advantage, is often a misnomer, especially to seniors with complex medical problems or chronic diseases, who are often disadvantaged when they need complex or chronic or long-term care. In addition, they may be disadvantage by a narrow drug formulary, the lack of appropriate specialists, the availability of hospitals near them accepting these plans, and even problems obtaining long term care for necessary times in rehabilitation facilities, nursing homes and hospice care, which do not participate in MA because of lower levels of reimbursement than in traditional Medicare; and

Whereas, MA has become the dominant plan, as more than half of the nation's seniors are enrolled in MA plans, rather than traditional Medicare. Each November and December, there is advertising to encourage seniors to enroll in MA. This advertising does not disclose the risks of MA enrollment and forgoing traditional Medicare, unlike other advertising (such as for medications) that disclose risks. In addition, "Medicare agents" working for insurance MA companies advertise for a "free service", while they are paid large amounts (up to 24 $1500 per enrollee) by the MA companies to get seniors into MA; and

Whereas, costs of actual patient care in MA is often capitated. Patients are not informed of this arrangement and do not understand capitation nor Valued Care. Valued Care means Cost, not the actual medical value, so again this is a misnomer; and

Whereas, when a senior wants to get out of a MA, the senior now has "preexisting conditions" preventing him from getting into a better traditional Medicare plan. In addition, MA plans have been known to do "cherry picking" choosing the healthiest seniors who require the least care, avoiding sicker more costly persons. Therefore, especially with capitation, they provide the least care and earn the most profit per patient. This also may contribute further to disparities in health care and increased morbidity and even mortality; and

Whereas, MA have the narrowest drug formularies to increase profit of the plan. This impacts both the patients, who might have to switch medications to a cheaper alternative, which might be less effective, even if they have been on another medication for a long time. In addition, it requires physicians or providers to submit Prior Authorizations (PA) and 5 Appeals in attempts to get the best medication for a patient; and

Whereas, MA plans have more preauthorization's for procedures than traditional Medicare. For example, every MRI needs preauthorization under MA, whereas traditional Medicare rarely needs preauthorization for an MRI. Again, this requires more work for physicians and providers and may delay or obstruct a medically necessary procedure; and

Whereas, MA plans required more PA for hospitalization and may require shorter hospitalizations than traditional Medicare. In addition, this might prevent hospitalization or proper long-term care for a patient, such as in rehabilitation or a long-term facility or hospice; and

Whereas, the PA work for medications, procedures and hospitalizations is discouraging and often unsuccessful, leading poorer patient care and to burnout or abdication of the attempt to get the best care for a patient; and

Whereas, this excess PA work is contributing to increased costs of maintaining a small practice, and physician burnout, and physicians leaving private practice to go to a larger group or institution or retiring. This may contribute to shortages in primary care for patients. In certain urban areas like New York City, physicians are no longer participating in Medicare, further depleting the group of physicians caring for senior citizens; and

Whereas, the mayoral administration in NYC has tried to force retirees into MA, but the retirees had successfully blocked this 13 times in the courts, as they do not want to be enrolled in MA; therefore be it

RESOLVED, that our American Medical Association emphasize to Congress the excessive cost, the use of taxpayer funding, the depletion of taxpayer monies supporting traditional Medicare by the Medicare Advantage (MA) programs. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/26/25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 220
(I-25)

Introduced by: New York

Subject: Medicare Should not Unfairly Penalize Physicians

Referred to: Reference Committee B

---

Whereas, in just six years, the administrative burdens imposed by the Health Information Technology for Economic and Clinical Health Act (2009), the value-based payment programs created by the Affordable Care Act (ACA, 2010), and the Medicare Access and CHIP Reauthorization Act (MACRA, 2015) led to a widespread acquisition of independent practices by hospitals, insurance companies, and private equity firms, ultimately relegating patients to a corporatized healthcare system; and

Whereas, despite their ability to leverage capital, management, and scale, vertically consolidated healthcare systems and corporate entities failed to reduce costs. Instead, they presented barriers to providing better care at a lower cost by diminishing competition and enabling monopolistic pricing of healthcare services; and

Whereas, research clearly demonstrates that healthcare costs are significantly higher for medical practices and hospitals affiliated with health systems or private equity groups than independent medical practices and solo community hospitals; and

Whereas, disturbingly, a January 2025 bipartisan Senate Budget Committee report warned the entry of private equity was associated with reductions in quality and “potentially poses a threat to the nation’s healthcare infrastructure.”[10] In addition, hospital-acquired practices offered no significant improvements in the quality of care; and

Whereas, of great concern are the conflicts of interest between physicians and patients inherent in value-based payment models, health system non-disclosure agreements, and profit-driven corporations, as they deny patients independent, unbiased medical opinions; and

Whereas, according to a survey from NORC at the University of Chicago, about 61% of employed physicians said they have moderate or no autonomy to make referrals outside of their practice or ownership system, and 47% said they adjust patient treatment options to reduce costs based on practice policies or incentives; and

Whereas, The Congressional Budget Office's (CBO) September 2023 report revealed that only six out of the 49 value-based payment (VBP) programs created by the Center for Medicare and Medicaid Innovation (CMMI) generated any savings. A staggering 88% of the VBP programs they launched did not meet their objectives. Initially, the CBO projected that CMMI's initiatives would significantly reduce federal spending. However, CBO's 10-year analysis revealed that CMMI's activities instead resulted in increased spending and alarmingly projected this trend to continue over the next 10 years; and

Whereas, The Medicare Trustees have cautioned, “expect access to Medicare-participating physicians to become a significant issue in the long term. ”One of several reasons, particularly

in New York County, is the escape to concierge medicine, projected to increase nationally by 10.4% annually; therefore be it

RESOLVED, that our American Medical Association advocate for the repeal of any law or regulation that imposes a penalty or deduction on Medicare physician payment based upon the result of a value-based payment program. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/26/25

**REFERENCES**

1. Rooke-Ley H, Song Z, Zhu JM. Value-Based Payment and Vanishing Small Independent Practices. JAMA. 2024 Sep 17;332(11):871-872. doi: 10.1001/jama.2024.12900.
2. Ekaireb R, Yap A, Kucejko. Vertical integration and market consolidation in healthcare: Policy drivers and impact on physicians and patient care; https://www.sciencedirect.com/journal/seminars-in-colon-and-rectal-surgery/vol/35/issue/3
3. "The Rise Of Health Care Consolidation And What To Do About It" Health Affairs Forefront, September 9, 2024 DOI: 10.1377/forefront.20240906.397095
4. Beaulieu ND, Chernew ME, McWilliams JM, et al. Organization and Performance of US Health Systems. JAMA. Jan 24 2023;329(4):325-335. doi:10.1001/jama.2022.24032
5. How I Was Wrong About Obamacare by Bob Kocher https://www.wsj.com/articles/i-was-wrong-about-obamacare-1469997311
6. BIG by Matt Stoller, "How Obamacare Created Big Medicine," Matt Stoller, April 4, 2023 https://www.thebignewsletter.com/p/how-obamacare-created-big-medicine
7. Ho V, Metcalfe L, Vu L, Short M, Morrow R. Annual Spending per Patient and Quality in Hospital-Owned Versus Physician-Owned Organizations: an Observational Study. J Gen Intern Med. 2020 Mar;35(3):649-655. doi: 10.1007/s11606-019-05312-z. Epub 2019 Sep 3. PMID: 31482340; PMCID: PMC7080686
8. Robinson JC, Miller K. Total expenditures per patient in hospital-owned and physician-owned physician organizations in California. JAMA. 2014 Oct 22-29;312(16):1663-9. doi: 10.1001/jama.2014.14072. PMID: 253351
9. Singh Y, Song Z, Polsky D, Bruch JD, Zhu JM. Association of Private Equity Acquisition of Physician Practices With Changes in Health Care Spending and Utilization. JAMA Health Forum. 2022 Sep 2;3(9):e222886. doi: 10.1001/jamahealthforum.2022.2886. PMID: 36218927; PMCID: PMC9440392.
10. The Harmful Effects of Private Equity on the U.S. Healthcare System https://www.budget.senate.gov/imo/media/doc/profits_over_patients_the_harmful_effects_of_private_equity_on_the_ushealthcaresystem1.pdf
11. Kannan S, Bruch JD, Song Z. Changes in Hospital Adverse Events and Patient Outcomes Associated With Private Equity Acquisition. JAMA. 2023 Dec 26;330(24):2365-2375. doi: 10.1001/jama.2023.23147
12. Bhatla A, Bartlett VL, Liu M, Zheng Z, Wadhera RK. Changes in Patient Care Experience After Private Equity Acquisition of US Hospitals. JAMA. Published online January 09, 2025. doi:10.1001/jama.2024.23450
13. Gabow PA, Wynia MK. Oaths, Conscience, Contracts, and Laws-The Gathering Storm Confronting Medical Professionalism. JAMA. 2024 Aug 27;332(8):615-616. doi: 10.1001/jama.2024.10761. PMID: 39083253
14. The Impact of Practice Acquisitions and Enplymnet on Physician Experience and Care Delivery https://www.physiciansadvocacyinstitute.org/PAI-Research/Employed-Physician-Survey
15. Federal Budgetary Effects of the Activities of the Center for Medicare & Medicaid Innovation https://www.cbo.gov/publication/59274
16. Medicare Physician Payment Reform After Two Years: Examining MACRA Implementation and the Road Ahead https://www.congress.gov/event/116th-congress/senate-event/LC65700/text
17. U.S. Concierge Medicine Market Size, Share & Trends Analysis Report https://www.grandviewresearch.com/industry-analysis/us-concierge-medicine-market-report#:~:text=The%20U.S.%20concierge%20medicine%20market,anticipated%20to%20drive%20market%20growth
18. Wadhera RK, Joynt Maddox KE, Wasfy JH, Haneuse S, Shen C, Yeh RW. Association of the Hospital Readmissions Reduction Program With Mortality Among Medicare Beneficiaries Hospitalized for Heart Failure, Acute Myocardial Infarction, and Pneumonia. JAMA. 2018 Dec 25;320(24):2542-2552. doi: 10.1001/jama.2018.19232
19. McWilliams JM. Pay for Performance: When Slogans Overtake Science in Health Policy. JAMA. 2022 Dec 6;328(21):2114-2116. doi: 10.1001/jama.2022.20945. PMID: 36472613.
20. Holmgren AJ, Adler-Milstein J, Apathy NC. Electronic Health Record Documentation Burden Crowds Out Health Information Exchange Use By Primary Care Physicians.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 221
(I-25)

Introduced by: New York

Subject: Not-for-Profit Status

Referred to: Reference Committee B

---

Whereas, a number of healthcare systems and individual hospitals have been granted not-for-profit status the rationale for the aforementioned status is based on giving back to the community, especially to the uninsured population; and

Whereas, insurability has changed due to the Affordable Care Act; and

Whereas, hospital systems receive increasingly large reimbursements, including professional fees for their staff, who are employed physicians; and

Whereas, these entities actually place a strain on their localities due to vastly reduced tax revenues; and

Whereas, there is very little oversight of these not-for-profit entities; and

Whereas, a huge amount of money is used to reward non-clinical leadership at the expense of patient care and physician income; therefore be it

RESOLVED, that our American Medical Association advocate that the granting and maintenance of healthcare entities of not-for-profit status be reassessed by both the state legislature and the US Congress. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/26/25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 222
(I-25)

Introduced by: Private Practice Physicians Section

Subject: Tackling Administrative Waste—Let Us Be Part of the Solution to Putting Our Health System on a Sustainable Path

Referred to: Reference Committee B

---

Whereas, a Trilliant Health analysis revealed that U.S. healthcare expenditures increased from $2.8 trillion in 2012 to $4.5 trillion in 2022—an increase of over 50 percent—with little change in the utilization of health services[1]; and

Whereas, in the 1980s, healthcare was organized around independent practices with minimal administrative support but over the past 40 years, significant changes driven by increasingly complex regulations and technology requirements have resulted in a staggering 4,500 percent increase in the number of administrators needed to manage the system while the number of physicians has only increased by 150 percent[2]; and

Whereas, the largest category of wasteful spending that could be eliminated without negatively impacting patient care is administrative costs; and

Whereas, the AMA has policy to monitor the effect of balance billing on rural health and to report back “at every HOD meeting its progress toward completion of all these goals” on balance billing though such reporting is obscure[1,2]; and

Whereas, the newly created U.S. Department of Government Efficiency presents physicians with a unique opportunity to leverage our knowledge to identify costly programs and requirements that neither improve the quality of care nor reduce costs but have contributed to the overwhelming number of healthcare administrators and their burgeoning associated costs; therefore be it

RESOLVED, that our American Medical Association work with all relevant government agencies to identify sources of administrative waste to advocate for elimination of high-cost bureaucratic excesses and revision or replacement of the counterproductive payment strategies of the past two decades. (Directive to Take Action)

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

Received: 9/22/25

**REFERENCES**

1. Trilliant Health (2024). 2024 trends shaping the health economy. https://www.trillianthealth.com/market-research/reports/2024-health-economy-trends. Accessed August 28, 2025.
2. Bureau of Labor Statistics. (2025). Occupational Outlook Handbook – Medical and Health Services Managers. https://www.bls.gov/ooh/management/medical-and-health-services-managers.htm. Accessed August 28, 2025.
3. American Hospital Association. (2024). Skyrocketing hospital administrative costs, burdensome commercial insurer policies are impacting patient care. https://www.aha.org/system/files/media/file/2024/09/Skyrocketing-Hospital-Administrative-Costs-Burdensome-Commercial-Insurer-Policies-Are-Impacting-Patient-Care.pdf. Accessed August 28, 2025.
4. Rosenthal, E. (2014). Medicine's top earners are not the M.D.s. *The New York Times*. May 7, 2014: https://www.nytimes.com/2014/05/18/sunday-review/doctors-salaries-are-not-the-big-cost.html?searchResultPosition=1. Accessed August 28, 2025.
5. Congressional Budget Office. (2023). Federal budget effects of the activities of the Center for Medicare & Medicaid Innovation. September 28, 2023: https://www.cbo.gov/publication/59274. Accessed August 28, 2025.
6. McWilliams, J.M. (2022). Pay for performance: When slogans overtake science in health policy. *JAMA*; (328, 21). https://jamanetwork.com/journals/jama/article-abstract/2799177. Accessed August 28, 2025.

## RELEVANT AMA POLICY

### Legislation to Reduce Administrative Waste in Health Insurance by Accurate Reporting of Medical Expense Ratios D-155.993

Our AMA:
(1) will develop model state legislation and regulations that would require that all private health plans make publicly available annually, and publish separately, their medical care costs and their administrative costs, using the format called for in AMA Policy H 155.963;
(2) supports state legislation to require that all private health plans make publicly available annually, and publish separately, their medical care costs and their administrative costs; and
(3) supports the development and implementation of a uniform, national accounting and reporting system to report administrative expenses and medical expense ratios as part of greater, national uniformity of market regulation.

Citation: Res. 717, A-08; Reaffirmed in lieu of: Res. 106, A-17

### Legislation to Reduce Administrative Waste in Health Insurance by Accurate Reporting of Medical Expense Ratios H-155.959

AMA policy is that private health plans should be required to report data related to administrative costs, expenses and rate setting to appropriate state regulatory bodies to allow for the calculation of medical expense ratios to be consistent on the state level.

Citation: Res. 727, A-08; Reaffirmed in lieu of: Res. 106, A-17

### Health Care Expenditures D-155.996

1. Our AMA will work to improve our health care system by: (a) researching and collating existing studies on how health care dollars are currently spent; (b) identifying the amount of public and private health care spending that is transferred to insurance administration compared to industry and corporate standards, including money spent on defensive medicine; and (c) disseminating these findings to the American public, US Congress, and appropriate agencies.

2. Our AMA will continue its efforts to identify ways to reduce waste in the health care sector so that the trend of increasing health care costs over the years could be reversed.

Citation: Res. 103, A-05; Appended: Res. 121, A-10; Reaffirmed: CMS Rep. 01, A-20

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 223
(I-25)

Introduced by: Private Practice Physicians Section

Subject: Halt the Rollout of New Payment Models by the Center for Medicare & Medicaid Innovation (CMMI)—A New Administration Offers an Opportunity

Referred to: Reference Committee B

---

Whereas, in their September 28, 2023 report "Federal Budgetary Effects of the Activities of the Center for Medicare & Medicaid Innovation," the Congressional Budget Office revealed CMMI increased federal spending in its first 10 years and will do so again in the next 10 years[1]; and

Whereas, Health Affairs in September of 2024 said, "…the number and complexity of clinician payment models in Medicare Part B has grown substantially without yielding the expected savings or quality improvement;"[2] and

Whereas, in addition to the value-based payment (VBP) programs created directly by legislation, CMMI created and tested 50+ VBP programs, only six of which yielded statistically significant savings; thus a staggering 88 percent failed to meet this objective[3]; and

Whereas, research shows that the overall impact of VBP models on care quality is inconsistent at best, with some programs leading to increased mortality rates (the Hospital Readmission Reduction Program) and exacerbating healthcare disparities (the Merit-Based Payment Incentive Program)[3,4,5,6]; and

Whereas, fifty tries and ten years should have been enough before the patient—the U.S. healthcare system—says enough is enough, evaluates the results, and disbands CMMI, saving its $10 billion budget; therefore be it

RESOLVED, that our American Medical Association advocate and urge Congress to halt the Center for Medicare & Medicaid Innovation's (CMMI) creation and rollout of new value-based payment models, quickly discontinue programs that have had negative effects on care, while supporting CMMI's evaluation of the models currently being tested. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/22/25

**REFERENCES**

1. Congressional Budget Office. (2023). Federal budgetary effects of the activities of the Center for Medicare & Medicaid Innovation. September 28, 2023: https://www.cbo.gov/publication/59274. Accessed August 28, 2025.
2. Everhart, A.O, Lyu, P.F., Hockenberry, J.M., & Johnston, K.J. (2024). Medicare Part B clinician payment programs and the growing costs of administrative complexity. September 11, 2024: https://www.healthaffairs.org/content/forefront/medicare-part-b-clinician-payment-programs-and-growing-costs-administrative-complexity. Accessed August 28, 2025.
3. The Commonwealth Fund. (2022). The impact of the payment and delivery system reforms of the Affordable Care Act. April 28, 2022: https://www.commonwealthfund.org/publications/2022/apr/impact-payment-and-delivery-system-reforms-affordable-care-act. Accessed August 28, 2025.
4. Khera, R.; Dharmarajan, K., & Wang, Y. (2018). Association of the Hospital Readmissions Reduction Program with mortality during and after hospitalization for acute myocardial infarction, heart failure, and pneumonia. *JAMA Network Open*, Vol. 1, No. 5. September 28, 2018: https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2703947. Accessed August 28, 2025.
5. Samarghandi, A. & Qayyum, R. (2023). Effect of Hospital Readmission Reduction Program on hospital readmissions and mortality rates. *Journal of Hospital Medicine*, Vol. 14, no. 9. August 10, 2023: https://shmpublications.onlinelibrary.wiley.com/doi/abs/10.12788/jhm.3302. Accessed August 28, 2025.
6. McWilliams, J.M. (2022). Pay for performance: When slogans overtake health policy. *JAMA*, Vol. 328, No. 21. December 6, 2022: https://jamanetwork.com/journals/jama/article-abstract/2799177. Accessed August 28, 2025.

## RELEVANT AMA POLICY

### CMMI Payment Reform Models D-385.950

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

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

1. Our American Medical Association supports appropriate demonstration projects, carve outs, and adjustments for pediatric patients and services provided to pediatric patients within the payment reform arena.
2. Our AMA will extend ongoing payment reform research, education, and advocacy to address the needs of specialties and patient populations not served by current CMMI models or other Medicare-focused payment reform efforts.
3. Our AMA will support and work with national medical specialty societies that are developing alternative payment models for specific conditions or episodes, target patient populations including pediatric populations, and medical and surgical specialties and continue to advocate that the Centers for Medicare and Medicaid Services, including the Center for Medicare and Medicaid Innovation; state Medicaid agencies; and other payers implement physician-developed payment models.
4. Our AMA will consider improved Medicaid payment rates to be a priority given the critical impact these payment rates have on patient care and patient access to care.
5. Our AMA will support and collaborate with state and national medical specialty societies and other interested parties on the development and adoption of physician-developed alternative payment models for pediatric health care that address the distinct prevention and health needs of children and take long-term, life-course impact into account.

Citation: Res. 817, I-23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 224
(I-25)

Introduced by: Private Practice Physicians Section

Subject: Recoupment by CMS Recovery and Audit Contractors (RAC)—Due Process

Referred to: Reference Committee B

---

Whereas, the AMA has adopted policies on health plan recoupment but the problems are not decreasing; they are exponentially increasing; and

Whereas, the Centers for Medicare & Medicaid Services (CMS) is asking the industry for ideas to increase opportunities for recoupment using claims data mining to detect fraud and abuse and offering significant finder fees equal to 15 percent of the amount, often more than what physicians make on office-administered medications, but using claims data is an imprecise tool that cannot easily discern legitimate claims from fraud; and

Whereas, requests for medical records by Medicare Recovery and Audit Contractors (RAC) is a costly process, both financially and administratively, which is not fully compensated by the meager payments by Medicare RAC and requires separate processes for records submission from the usual Medicare Administrative Contractor portal and often requires faxing or mailing information, as was the case with Peformant RAC, a contractor of NGS Medicare in New York; and

Whereas, on a recorded call, the Medicare RAC Performant Medical Director stated that Performant is “not looking for fraud or abuse” but is looking for “documentation technicalities;” and

Whereas, this illustrates that Medicare RAC contractors have a conflict of interest in the appeals process as they get 15 percent if they deny; and

Whereas, physicians are often forced through the process illegitimately where there is neither fraud nor abuse and are forced to spend significant amounts of time and money to clear their good name; and

Whereas, physicians who appeal may win after multiple appeals but still lose financially as every minute fighting illegitimate recoupment determinations adds to losses; and

Whereas, while physicians earn 4.3 percent on office-administered drugs with sequestration, RUC contractors are not obligated to appear in administrative law judge proceedings, but may if they choose to, creating one-sided rights and depriving physicians from mounting an adequate defense by not being able to take deposition from and perform discovery on the RAC contractors; therefore be it

RESOLVED, that our American Medical Association advocates for legislation and regulation that Medicare contractors must be compelled to appear during administrative or legal proceedings if requested (Directive to Take Action); and be it further

RESOLVED, that our AMA advocates for legislation and regulation that Medicare contractors (recovery and audit contractors and others) must pay the physician for expenses incurred during the appeal process (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate that successful appeals be further compensated equal to the amount that the Centers for Medicare & Medicaid Services pays to contractors to recoup successfully. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/22/25

**RELEVANT AMA POLICY**

**Reasonable Time Limitations on Post-Payment Audits and Recoupments by Third Party Payers H-70.926**
Our AMA policy is that post-payment audits, post-payment downcodes and other similar requests for recoupment by third party payers be made within one year of the date the claim is submitted or within the same amount of time permitted for submission of the claim, whichever is less.

Citation: Res. 815, A-01; Reaffirmed: I-04; Reaffirmed: A-08; Reaffirmed in lieu of: Res. 202, I-13; Reaffirmed: Res. 707, A-16; Reaffirmed: Res. 227, A-25

**Payment for Pre-Certified/Preauthorized Procedures H-385.900**

1. Our American Medical Association supports the position that the practice of retrospective denial of payment or payment recoupment for care which has been pre-certified by an insurer should be prohibited under federal statute, except when materially false or fraudulent information has knowingly been given to the insurer by the physician, hospital or ancillary service provider to obtain pre-certification.
2. Our AMA will continue to advocate for legislation, regulation, or other appropriate means to ensure that all health plans including those regulated by ERISA, pay for services that are pre-authorized, or pre-certified by such health plan, including services that are deemed pre-authorized or pre-certified because the physician participates in a “Gold Card” program operated by that health plan.
3. Our AMA encourages legal action against health plans that engage in inappropriate post-service payment denials and payment recoupment.

Citation: Res. 818, I-24; Reaffirmed in lieu of: Res. 225, A-25; Reaffirmed: Res. 227, A-25

**Medical Office Screens H-335.981**
It is the policy of the AMA to take the following actions:
(1) seek specific clarification from CMS on the process, procedures, and criteria of physician office postpayment review and recoupment;
(2) lobby for full due process protection for carrier postpayment review and recoupment situation;
(3) oppose the concept and application of extrapolation;
(4) oppose arbitrary, erratic, or inappropriate components of postpayment review and recoupment; and
(5) seek appropriate relief to achieve equitable treatment of physicians in office postpayment review and recoupment situations.

Citation: Sub. Res. 271, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: BOT Rep. 6, A-10; Reaffirmed: CMS Rep. 08, A-17; Reaffirmed: Res. 227, A-25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 225
(I-25)

Introduced by: American Academy of Emergency Medicine

Subject: Federal Legislation to Prohibit the Corporate Practice of Medicine

Referred to: Reference Committee B

---

Whereas, the interests of patients are best served when medical decisions regarding their care are made by licensed physicians, unencumbered by influence from corporate, business, or financial interests; and

Whereas, lay corporations that employ physicians have been known to interfere with physician autonomy, in a manner that prioritizes corporate financial interests over the interests of patient care; and

Whereas, specific corporate behaviors that compromise physician autonomy have been enumerated, to enable a clear definition of instances where the "Corporate Practice of Medicine"(CPOM) is occurring (for such an enumeration, see AMA Policy H-160.891, Item 1-j[3]); and

Whereas, CPOM threatens physician autonomy, interferes with the physician-patient relationship, and prioritizes financial interests over patient care; and

Whereas, our American Medical Association (AMA) opposes undue corporate influence in medicine, advocating for policies that ensure physicians retain independent medical judgment; and

Whereas, AMA policy H-215.981 affirms our AMA's opposition to CPOM, emphasizing the need for physician autonomy and patient-centered care, and while acknowledging the need for federal legislation not to pre-empt state legislation, stronger language is necessary to advocate for federal baseline standards[1]; and

Whereas, AMA policies H-225.950 and H-160-891 address concerns regarding physician employment arrangements and corporate influence in medicine, emphasizing the importance of maintaining physician autonomy and professional integrity[2,3]; and

Whereas, the growing consolidation of healthcare entities and private equity acquisitions of medical practices have led to increased costs, decreased competition, and reduced access to quality care for patients; and

Whereas, many states have enacted laws prohibiting or restricting CPOM, but the lack of uniform enforcement allows corporations to circumvent such regulations, undermining the effectiveness of state laws; and

Whereas, health policy legal opinion[4] supports federal jurisdiction over CPOM as staffing corporations, hospitals, and insurance companies often operate across state lines, and there is precedent for federal involvement with laws such as EMTALA and HIPAA; and

Whereas, a federal framework prohibiting CPOM should serve as a baseline standard while preserving stronger state regulations; and

Whereas, the National Academy for State Health Policy (NASHP) has developed model legislation for state oversight of healthcare mergers and corporate influence[5], which can serve as a guide for federal legislation to prevent corporate control over medical practice; therefore be it

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

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

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

2. Our AMA vigorously opposes any effort to pass state or federal legislation or regulation that removes or weakens existing state laws prohibiting the corporate practice of medicine. (Modify Current HOD Policy)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/26/25

**REFERENCES**

1. American Medical Association. Policy H-215.981 - Corporate Practice of Medicine. Available at: https://policysearch.ama-assn.org/policyfinder/detail/corporate%20practice?uri=%2FAMADoc%2FHOD.xml-0-1440.xml
2. American Medical Association. Policy H-225.950 - Principles for Physician Employment. Available at: https://policysearch.ama-assn.org/policyfinder/detail/%22AMA%20Principles%20for%20Physician%20Employment%20H-225.950%22?uri=%2FAMADoc%2FHOD.xml-0-1535.xml
3. American Medical Association Policy H-160.891 - Corporate investors and other corporate entities. Available at: https://policysearch.ama-assn.org/policyfinder/detail/Corporate%20Practice%20of%20Medicine?uri=%2FAMADoc%2FHOD.xml-H-160.891.xml
4. Hall, M., Fuse-Brown, E., and Rooke-Ley, H. Letter regarding federal authority to regulate corporate ownership and control of medical practices. 11/2023
5. National Academy for State Health Policy (NASHP). A Model Act for State Oversight of Proposed Healthcare Mergers. Available at: https://nashp.org/a-model-act-for-state-oversight-of-proposed-health-care-mergers/

**RELEVANT AMA POLICY**

**H-215.981 - Corporate Practice of Medicine**

1. Our American Medical Association vigorously opposes any effort to pass federal legislation or regulation preempting state laws prohibiting the corporate practice of medicine.
2. Our AMA vigorously opposes any effort to pass legislation or regulation that removes or weakens state laws prohibiting the corporate practice of medicine.
3. Our AMA opposes the corporate practice of medicine and supports the restriction of ownership and operational authority of physician medical practices to physicians or physician-owned groups.
4. Our AMA, at the request of state medical associations, will provide guidance, consultation, and model legislation regarding the corporate practice of medicine, to ensure the autonomy of hospital medical staffs, employed physicians in non-hospital settings, and physicians contracting with corporately owned management service organizations.

5. Our AMA will continue to monitor the evolving corporate practice of medicine with respect to its effect on the patient-physician relationship, financial conflicts of interest, patient centered care and other relevant issues.
6. Our AMA will work with interested state medical associations, the federal government, and other interested parties to develop and advocate for regulations and appropriate legislation pertaining to corporate control of practices in the healthcare sector such that physician clinical autonomy and operational authority are preserved and protected.
7. Our AMA will create a state corporate practice of medicine template to assist state medical associations and national medical specialty societies as they navigate the intricacies of corporate investment in physician practices and health care generally at the state level and develop the most effective means of prohibiting the corporate practice of medicine in ways that are not detrimental to the sustainability of physician practices.

**H-225.950 - Principles for Physician Employment**
1. Addressing Conflicts of Interest
a. Physicians should always make treatment and referral decisions based on the best interests of their patients. Employers and the physicians they employ must assure that agreements or understandings (explicit or implicit) restricting, discouraging, or encouraging particular treatment or referral options are disclosed to patients.
b. In any situation where the economic or other interests of the employer are in conflict with patient welfare, patient welfare must take priority.
c. Employed physicians should be free to exercise their personal and professional judgment in voting, speaking and advocating on any manner regarding patient care interests, the profession, health care in the community, and the independent exercise of medical judgment. Employed physicians should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests. Employed physicians also should enjoy academic freedom to pursue clinical research and other academic pursuits within the ethical principles of the medical profession and the guidelines of the organization.
d. A physician's paramount responsibility is to their patients. Additionally, given that an employed physician occupies a position of significant trust, they owe a duty of loyalty to their employer. This divided loyalty can create conflicts of interest, such as financial incentives to over- or under-treat patients, which employed physicians should strive to recognize and address.
i. No physician should be required or coerced to perform or assist in any non-emergent procedure that would be contrary to their religious beliefs or moral convictions.
ii. No physician should be discriminated against in employment, promotion, or the extension of staff or other privileges because they either performed or assisted in a lawful, non-emergent procedure, or refused to do so on the grounds that it violates their religious beliefs or moral convictions.
e. Assuming a title or position that may remove a physician from direct patient-physician relationships--such as medical director, vice president for medical affairs, etc.--does not override professional ethical obligations. Physicians whose actions serve to override the individual patient care decisions of other physicians are themselves engaged in the practice of medicine and are subject to professional ethical obligations and may be legally responsible for such decisions. Physicians who hold administrative leadership positions should use whatever administrative and governance mechanisms exist within the organization to foster policies that enhance the quality of patient care and the patient care experience.

Refer to the AMA Code of Medical Ethics for further guidance on conflicts of interest.
2. Advocacy for Patients and the Profession
a. Patient advocacy is a fundamental element of the patient-physician relationship that should not be altered by the health care system or setting in which physicians practice, or the methods by which they are compensated.
b. Employed physicians should be free to engage in volunteer work outside of, and which does not interfere with, their duties as employees.
3. Contracting
a. Physicians should be free to enter into mutually satisfactory contractual arrangements, including employment, with hospitals, health care systems, medical groups, insurance plans, and other entities as permitted by law and in accordance with the ethical principles of the medical profession.
b. Physicians should never be coerced into employment with hospitals, health care systems, medical

groups, insurance plans, or any other entities. Employment agreements between physicians and their employers should be negotiated in good faith. Both parties are urged to obtain the advice of legal counsel experienced in physician employment matters when negotiating employment contracts.

c. When a physician's compensation is related to the revenue they generate, or to similar factors, the employer should make clear to the physician the factors upon which compensation is based.

d. Termination of an employment or contractual relationship between a physician and an entity employing that physician does not necessarily end the patient-physician relationship between the employed physician and persons under their care. When a physician's employment status is unilaterally terminated by an employer, the physician and their employer should notify the physician's patients that the physician will no longer be working with the employer and should provide them with the physician's new contact information. Patients should be given the choice to continue to be seen by the physician in their new practice setting or to be treated by another physician still working with the employer. Records for the physician's patients should be retained for as long as they are necessary for the care of the patients or for addressing legal issues faced by the physician; records should not be destroyed without notice to the former employee. Where physician possession of all medical records of their patients is not already required by state law, the employment agreement should specify that the physician is entitled to copies of patient charts and records upon a specific request in writing from any patient, or when such records are necessary for the physician's defense in malpractice actions, administrative investigations, or other proceedings against the physician.

e. Physician employment agreements should contain provisions to protect a physician's right to due process before termination for cause. When such cause relates to quality, patient safety, or any other matter that could trigger the initiation of disciplinary action by the medical staff, the physician should be afforded full due process under the medical staff bylaws, and the agreement should not be terminated before the governing body has acted on the recommendation of the medical staff. Physician employment agreements should specify whether or not termination of employment is grounds for automatic termination of hospital medical staff membership or clinical privileges. When such cause is non-clinical or not otherwise a concern of the medical staff, the physician should be afforded whatever due process is outlined in the employer's human resources policies and procedures.

f. Physicians are encouraged to carefully consider the potential benefits and harms of entering into employment agreements containing without cause termination provisions. Employers should never terminate agreements without cause when the underlying reason for the termination relates to quality, patient safety, or any other matter that could trigger the initiation of disciplinary action by the medical staff.

g. Physicians are discouraged from entering into agreements that restrict the physician's right to practice medicine for a specified period of time or in a specified area upon termination of employment.

h. Physician employment agreements should contain dispute resolution provisions. If the parties desire an alternative to going to court, such as arbitration, the contract should specify the manner in which disputes will be resolved.

Refer to the AMA Annotated Model Physician-Hospital Employment Agreement and the AMA Annotated Model Physician-Group Practice Employment Agreement for further guidance on physician employment contracts.

4. Hospital Medical Staff Relations

a. Employed physicians should be members of the organized medical staffs of the hospitals or health systems with which they have contractual or financial arrangements, should be subject to the bylaws of those medical staffs, and should conduct their professional activities according to the bylaws, standards, rules, and regulations and policies adopted by those medical staffs.

b. Regardless of the employment status of its individual members, the organized medical staff remains responsible for the provision of quality care and must work collectively to improve patient care and outcomes.

c. Employed physicians who are members of the organized medical staff should be free to exercise their personal and professional judgment in voting, speaking, and advocating on any matter regarding medical staff matters and should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests.

d. Employers should seek the input of the medical staff prior to the initiation, renewal, or termination of exclusive employment contracts.

Refer to the AMA Conflict of Interest Guidelines for the Organized Medical Staff for further guidance on the relationship between employed physicians and the medical staff organization.

5. Peer Review and Performance Evaluations

a. All physicians should promote and be subject to an effective program of peer review to monitor and evaluate the quality, appropriateness, medical necessity, and efficiency of the patient care services provided within their practice settings.
b. Peer review should follow established procedures that are identical for all physicians practicing within a given health care organization, regardless of their employment status.
c. Peer review of employed physicians should be conducted independently of and without interference from any human resources activities of the employer. Physicians--not lay administrators--should be ultimately responsible for all peer review of medical services provided by employed physicians.
d. Employed physicians should be accorded due process protections, including a fair and objective hearing, in all peer review proceedings. The fundamental aspects of a fair hearing are a listing of specific charges, adequate notice of the right to a hearing, the opportunity to be present and to rebut evidence, and the opportunity to present a defense. Due process protections should extend to any disciplinary action sought by the employer that relates to the employed physician's independent exercise of medical judgment.
e. Employers should provide employed physicians with regular performance evaluations, which should be presented in writing and accompanied by an oral discussion with the employed physician. Physicians should be informed before the beginning of the evaluation period of the general criteria to be considered in their performance evaluations, for example: quality of medical services provided, nature and frequency of patient complaints, employee productivity, employee contribution to the administrative/operational activities of the employer, etc.
f. Upon termination of employment with or without cause, an employed physician generally should not be required to resign their hospital medical staff membership or any of the clinical privileges held during the term of employment, unless an independent action of the medical staff calls for such action, and the physician has been afforded full due process under the medical staff bylaws. Automatic rescission of medical staff membership and/or clinical privileges following termination of an employment agreement is tolerable only if each of the following conditions is met:
i. The agreement is for the provision of services on an exclusive basis.
ii. Prior to the termination of the exclusive contract, the medical staff holds a hearing, as defined by the medical staff and hospital, to permit interested parties to express their views on the matter, with the medical staff subsequently making a recommendation to the governing body as to whether the contract should be terminated, as outlined in AMA Policy H-225.985.
iii. The agreement explicitly states that medical staff membership and/or clinical privileges must be resigned upon termination of the agreement.
Refer to the AMA Principles for Incident-Based Peer Review and Disciplining at Health Care Organizations (AMA Policy H-375.965) for further guidance on peer review.
6. Payment Agreements
a. Although they typically assign their billing privileges to their employers, employed physicians or their chosen representatives should be prospectively involved if the employer negotiates agreements for them for professional fees, capitation or global billing, or shared savings. Additionally, employed physicians should be informed about the actual payment amount allocated to the professional fee component of the total payment received by the contractual arrangement.
b. Employed physicians have a responsibility to assure that bills issued for services they provide are accurate and should therefore retain the right to review billing claims as may be necessary to verify that such bills are correct. Employers should indemnify and defend, and save harmless, employed physicians with respect to any violation of law or regulation or breach of contract in connection with the employer's billing for physician services, which violation is not the fault of the employee.

Our AMA will disseminate the AMA Principles for Physician Employment to graduating residents and fellows and will advocate for adoption of these Principles by organizations of physician employers such as, but not limited to, the American Hospital Association and Medical Group Management Association.

**AMA Policy H-160.891 - Corporate Investors and Other Corporate Entities**
1. Our AMA encourages physicians who are contemplating corporate investor partnerships or corporate entity relationships, including those under “friendly” physician professional corporation (PC) arrangements with Management Service Organizations (MSOs), to consider the following guidelines:
a. Physicians should consider how the practice’s current mission, vision, and long-term goals align with those of the corporate investor/entity.
b. Due diligence should be conducted that includes, at minimum, review of the corporate

investor/entity's business model, strategic plan, leadership and governance, and culture.
c. External legal, accounting and/or business counsels should be obtained to advise during the exploration and negotiation of corporate investor/entity transactions.
d. Retaining negotiators to advocate for best interests of the practice and its employees should be considered.
e. Physicians should consider whether and how corporate relationships may require physicians to cede varying degrees of control over practice decision-making and day-to-day management.
f. Physicians should consider the potential impact of corporate relationships on physician and practice employee satisfaction and future physician recruitment.
g. Physicians should have a clear understanding of compensation agreements, mechanisms for conflict resolution, processes for exiting corporate relationships, and application of restrictive covenants, including any changes in the scope or implementation of any current or proposed restrictive covenants based on the corporate relationship.
h. Physicians should consider corporate procedures for medical staff representation on the board of directors and medical staff leadership selection as well as processes for resolution of conflict between medical staff leadership and the corporate entity.
i. Physicians should retain responsibility for clinical governance, patient welfare and outcomes, physician clinical autonomy, and physician due process under corporate relationships.
j. Prior to entering into a relationship with a corporate entity, physicians and the corporate entity should explicitly identify the types of clinical and business decisions that should remain in the ultimate control of the physician, including but not limited to:
1. Determining which diagnostic tests are appropriate;
2. Determining the need for referrals to, or consultation with another physician or licensed health professional;
3. Being responsible for the ultimate overall care of the patient, including treatment options available to the patient;
4. Determining how many patients a physician shall see in a given period of time or how many hours a physician should work;
5. Determining the content of patient medical records;
6. Selecting, hiring, or firing physicians, other licensed health care professionals, and/or other medical staff based on clinical competency or proficiency;
7. Setting the parameters under which a physician or physician practice shall enter into contractual relationships with third-party entities;
8. Making decisions regarding coding and billing procedures for patient care services; and
9. Approving the selection of medical equipment and medical supplies.
k. Each individual physician should have the ultimate decision for medical judgment in patient care and medical care processes, including supervision of non-physician practitioners.
l. Clear protection and dispute resolution processes for physicians advocating on patient care and quality issues should be incorporated into an agreement between physicians and corporate entities.
m. Physicians should retain primary and final responsibility for structured medical education inclusive of undergraduate medical education including the structure of the program, program curriculum, selection of faculty and trainees, as well as education and disciplinary issues related to these programs.
2. Our AMA supports improved transparency regarding corporate investments in and/or relationships to physician practices, subsidiaries and/or related organizations that interact with the physician group and/or patients of the physicians, and subsequent changes in health care prices, quality, access, utilization, and physician payment.
3. Our AMA encourages national medical specialty societies to research and develop tools and resources on the impact of corporate investor relationships on patients and the physicians practicing in that specialty.
4. Our AMA supports consideration of options for gathering information on the impact of private equity and corporate investors/entities on the practice of medicine.
5. Our AMA supports meaningful physician representation in any corporate governance structure (e.g., seats on the board of directors, and/or other relevant leadership bodies) of any entity with which a physician practice, hospital, or other health care organization establishes a corporate relationship.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 226
(I-25)

Introduced by: American Academy of Emergency Medicine

Subject: Transparency with the Term “Emergency Department”

Referred to: Reference Committee B

---

Whereas, a recent study has shown that one out of every 13 emergency departments in the country does not have a physician staffing on-site[1]; and

Whereas, the Emergency Medical Treatment and Active Labor Act of 1986, commonly known as “EMTALA” (42 U.S.C. § 1395dd) mandates that Medicare-participating hospitals with an emergency department must provide a medical screening exam to any patient requesting emergency care and provide stabilizing treatment or an appropriate transfer, regardless of ability to pay or insurance status; and

Whereas, EMTALA defines an “emergency department” functionally, not explicitly by name, and refers to a department or facility that provides emergency care 24/7, not necessarily one named “Emergency Department.”; and

Whereas, under Medicare, billing for emergency services uses revenue codes and CPT/HCPCS codes that reflect the type of care delivered, not necessarily the department name, with reimbursement reflecting: the scope and level of service provided, the licensing/certification of the facility and clinicians, and the documentation of emergency care delivered; and

Whereas, Critical Access Hospitals (CAHs) do not require a specifically named “Emergency Department” but must be able to provide emergency care necessary to meet the needs of its inpatients and outpatients, as per the Code of Federal Regulations, Title 42, Chapter IV, Subchapter G, Part 485, Subpart F regarding “Conditions of participation: Critical Access Hospitals (CAHs)[3]; and

Whereas, AMA policy H130.929 On-Site Physician Requirements for Emergency Departments recognizes that the preferred model of emergency care is having a physician on-site in the emergency department 24/7[2], but does not address the misleading use of the term “emergency department” for facilities without a physician present; and

Whereas, via patient rights and informed consent standards 42 CFR § 482.13 and 42 CFR § 489.20(w)(5)[4,5], a hospital should disclose with conspicuous signage if no physician is staffing the emergency department, but there is no enforcement for them to do so; and

Whereas, patients may assume that any and all facilities which are referred to as emergency departments (EDs) or emergency rooms (ERs) will provide emergency medical care by a physician; therefore be it

RESOLVED, that our American Medical Association advocates for the designation of “emergency department” or “emergency room” to be restricted to facilities with the presence of

at least one physician on-site and on-duty, who is responsible for the emergency department at all times (Directive to Take Action); and be it further

RESOLVED, that our AMA recommends that facilities without physician staffing use alternative terminology, such as Acute Care Unit, as a matter of truth and transparency for patients, so that patients are not expecting care by a physician (New HOD Policy); and be it further

RESOLVED, that our AMA work with the Joint Commission, Det Norske Veritas (DNV), and other authorities/regulators to educate them about this issue, and to encourage them to implement correct "emergency department" terminology designations to ensure truth and transparency at all times for our patients. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/26/25

**REFERENCES**

1. Carlos A. Camargo, Krislyn M. Boggs, Ashley F. Sullivan, Janice A. Espinola, Maeve Swanton, Deborah D. Fletcher. Lack of 24/7 Attending Physician Coverage in US Emergency Departments, 2022, JACEP Open, Volume 6, Issue 2, 2025, https://doi.org/10.1016/j.acepjo.2025.100050.
2. AMA policy H130.929 On-Site Physician Requirements for Emergency Departments. Available at: https://policysearch.ama-assn.org/policyfinder/detail/emergency%20physician?uri=%2FAMADoc%2FHOD.xml-H-130.929.xml
3. Code of Federal Regulations, Title 42, Chapter IV, Subchapter G, Part 485, Subpart F, 485.618 regarding "Conditions of participation: Critical Access Hospitals (CAHs)
4. Code of Federal Regulations, Title 42, Chapter IV, Subchapter G, Part 482, Subpart B, 482.13, "Conditions of participation for Hospitals: Administration: Patients' Rights"
5. Code of Federal Regulations, Title 42, Chapter IV, Subchapter G, Part 489, Subpart B, 489.20 (w) (5), "Essentials of Provider Agreements: Basic Commitments"

**RELEVANT AMA POLICY**

**H130.929 On-Site Physician Requirements for Emergency Departments**

1. Our American Medical Association recognizes that the preferred model of emergency care is the on-site presence of a physician in the emergency department (ED) whose primary duty is to provide care in that ED, and support state and federal legislation or regulation requiring that a hospital with an ED must have a physician on-site and on duty who is primarily responsible for the emergency department at all times the emergency department is open.

2. Our AMA, in the pursuit of any legislation or regulation requiring the on-site presence of a physician who is primarily responsible for care in the emergency department (ED), supports state medical associations in developing appropriate rural exceptions to such a requirement if, based on the needs of their states, the association chooses to pursue certain alternative supervision models for care provided in EDs in remote rural areas that cannot meet such a requirement due to workforce limitations, ensuring that exceptions only apply where needed. These exceptions shall preserve 24/7 physician supervision of the ED and provide for the availability of a physician to provide on-site care.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 227
(I-25)

Introduced by: Senior Physicians Section

Subject: Call for Immediate and Aggressive Action by the AMA to Reverse Medicaid Cuts Impacting Seniors

Referred to: Reference Committee B

---

Whereas, our American Medical Association has declared that healthcare is a human right; and

Whereas, our AMA has policy opposing work requirements in Medicaid; and

Whereas, the recently enacted 'One Big Beautiful Bill Act' (Public Law No: 119-21) [OBBBA] includes an estimated $1 trillion in cuts to the Medicaid program, with negative impacts on state budgets across the country[1]; and

Whereas, the OBBBA is projected to result in the loss of healthcare coverage for millions of eligible Medicaid recipients, including seniors[2]; and

Whereas, six leading medical organizations have taken the bold step of suing the U.S. Department of Health & Human Services (HHS) for its stance on immunization practices[3]; and

Whereas, the fiscal changes in the OBBBA will lead to the closure of rural hospitals across the country[4]; and

Whereas, the previous policy decisions of our AMA were not sufficient to block or mitigate the passage of the OBBBA; therefore be it

RESOLVED, that our American Medical Association publicly denounce cuts to Medicaid in the 'One Big Beautiful Bill Act' (Public Law No: 119-21) in no uncertain terms (Directive to Take Action); and be it further

RESOLVED, that our AMA through, but not limited to, press releases, position statements, op-eds in major outlets, press conferences and reinvigorated lobbying on House and Senate leadership, work to reverse or mitigate the ‘One Big Beautiful Bill Act,’ as it relates to Medicaid (Directive to Take Action); and be it further

RESOLVED, that our AMA build coalitions with state medical societies, patient advocacy groups, hospital systems and safety net organizations to unite and advocate with a single voice for the reversal of Medicaid-related cuts in the ‘One Big Beautiful Bill Act.’ (Directive to Take Action); and be it further

RESOLVED, that our AMA hold policymakers publicly accountable using public scorecards and highlight the electoral consequences for cutting funding to essential health care (Directive to Take Action); and be it further

RESOLVED, that our AMA report back to the AMA's House of Delegates at A-26 on measurable progress to remove cuts, passage of any mitigating legislation and maintain its robust communications with coalition partners and our elected representatives. (Directive to Take Action)

Fiscal Note: $88,442 – Create and compile report.

Received: 9/26/25

**REFERENCES**

1. Congressional Budget Office (CBO), "Estimated Budgetary Effects of Public Law 119-21, to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14, Relative to the Budget Enforcement Baseline for Consideration in the Senate" (July 21, 2025), available at: https://www.cbo.gov/publication/61569.
2. Tanne J., Looi M. "Some 11.8 million Americans projected to lose health insurance as Trump's One Big Beautiful Bill Act passes." BMJ. 2025 Jul 4;390:r1400. doi: 10.1136/bmj.r1400. PMID: 40615164.
3. Mandavilli, A. "Medical Societies Sue Kennedy and H.H.S. Over Vaccine Advice." New York Times [Digital Edition], 7 July 2025. Available at: Medical Societies Sue Kennedy and H.H.S. Over Vaccine Advice - The New York Times.
4. "The 'One Big Beautiful Bill,' Now Law, Does Not Protect Rural Hospitals", Health Affairs Forefront, July 23, 2025. DOI: 10.1377/forefront.20250722.555330

## RELEVANT AMA POLICY

### Health System Reform Legislation H-165.838

1. Our American Medical Association is committed to working with Congress, the Administration, and other stakeholders to achieve enactment of health system reforms that include the following seven critical components of AMA policy:
    a. Health insurance coverage for all Americans.
    b. Insurance market reforms that expand choice of affordable coverage and eliminate denials for pre-existing conditions or due to arbitrary caps.
    c. Assurance that health care decisions will remain in the hands of patients and their physicians, not insurance companies or government officials.
    d. Investments and incentives for quality improvement and prevention and wellness initiatives.
    e. Repeal of the Medicare physician payment formula that triggers steep cuts and threaten seniors' access to care.
    f. Implementation of medical liability reforms to reduce the cost of defensive medicine.
    g. Streamline and standardize insurance claims processing requirements to eliminate unnecessary costs and administrative burdens.
2. Our AMA advocates that elimination of denials due to pre-existing conditions is understood to include rescission of insurance coverage for reasons not related to fraudulent representation.
3. Our AMA House of Delegates supports AMA leadership in their unwavering and bold efforts to promote AMA policies for health system reform in the United States.
4. Our AMA supports health system reform alternatives that are consistent with AMA policies concerning pluralism, freedom of choice, freedom of practice, and universal access for patients.
5. AMA policy is that insurance coverage options offered in a health insurance exchange be self-supporting, have uniform solvency requirements; not receive special advantages

from government subsidies; include payment rates established through meaningful negotiations and contracts; not require provider participation; and not restrict enrollees' access to out-of-network physicians.

6. Our AMA will actively and publicly support the inclusion in health system reform legislation the right of patients and physicians to privately contract, without penalty to patient or physician.
7. Our AMA will actively and publicly oppose the Independent Medicare Commission (or other similar construct), which would take Medicare payment policy out of the hands of Congress and place it under the control of a group of unelected individuals.
8. Our AMA will actively and publicly oppose, in accordance with AMA policy, inclusion of the following provisions in health system reform legislation:
    a. Reduced payments to physicians for failing to report quality data when there is evidence that widespread operational problems still have not been corrected by the Centers for Medicare and Medicaid Services.
    b. Medicare payment rate cuts mandated by a commission that would create a double-jeopardy situation for physicians who are already subject to an expenditure target and potential payment reductions under the Medicare physician payment system.
    c. Medicare payments cuts for higher utilization with no operational mechanism to assure that the Centers for Medicare and Medicaid Services can report accurate information that is properly attributed and risk-adjusted.
    d. Redistributed Medicare payments among providers based on outcomes, quality, and risk-adjustment measurements that are not scientifically valid, verifiable and accurate.
    e. Medicare payment cuts for all physician services to partially offset bonuses from one specialty to another.
    f. Arbitrary restrictions on physicians who refer Medicare patients to high quality facilities in which they have an ownership interest.
9. Our AMA will continue to actively engage grassroots physicians and physicians in training in collaboration with the state medical and national specialty societies to contact their Members of Congress, and that the grassroots message communicate our AMA's position based on AMA policy.
10. Our AMA will use the most effective media event or campaign to outline what physicians and patients need from health system reform.
11. AMA policy is that national health system reform must include replacing the sustainable growth rate (SGR) with a Medicare physician payment system that automatically keeps pace with the cost of running a practice and is backed by a fair, stable funding formula, and that the AMA initiate a "call to action" with the Federation to advance this goal.
12. AMA policy is that creation of a new single payer, government-run health care system is not in the best interest of the country and must not be part of national health system reform.
13. AMA policy is that effective medical liability reform that will significantly lower health care costs by reducing defensive medicine and eliminating unnecessary litigation from the system should be part of any national health system reform.

14. Our AMA will continue monitoring federal and state health reform proposals, including the development of state plans and/or waiver applications seeking program approval for unified financing.

Citation: Reaffirmed: CMS Report 09, A-19; Reaffirmed: CMS Rep. 3, I-21; Reaffirmed A-22; Reaffirmed: CMS Rep.02, I-23; Appended CMS Rep. 02, I-24; Appended: CMS Rep. 02, I-24; Reaffirmed: CMS Rep. 02, I-24; Reaffirmed: Res. 826, I-24

**Opposition to Medicaid Work Requirements H-290.961**

Our AMA opposes work requirements as a criterion for Medicaid eligibility.
Citation: Res. 802, I-17; Reaffirmation: A-18

**Cuts in Medicare and Medicaid Reimbursement H-330.932**

1. Our American Medical Association continues to oppose payment cuts in the Medicare and Medicaid budgets that may reduce patient access to care and undermine the quality of care provided to patients.
2. Our AMA supports the concept that the Medicare and Medicaid budgets need to expand adequately to adjust for factors such as cost of living, the growing size of the Medicare population, and the cost of new technology.
3. Our AMA aggressively encourages CMS to affirm the patient's and the physician's constitutional right to privately contract for medical services.
4. If the reimbursement is not improved, our AMA declares the Medicare reimbursement unworkable and intolerable, and seek immediate legislation to allow the physician to balance bill the patient according to their usual and customary fee.
5. Our AMA supports a mandatory annual "cost-of-living" or COLA increase in Medicaid, Medicare, and other appropriate health care reimbursement programs, in addition to other needed payment increases.

Citation: Reaffirmed: Reaffirmation A-05; Reaffirmed in lieu of Res. 207, A-13; Reaffirmed: Res. 212, I-21; Reaffirmed in lieu of: Res. 225, A-25.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 228
(I-25)

Introduced by: Underrepresented in Medicine Advocacy Section

Subject: Support Permanent Funding and Expansion of Native Hawaiian Healthcare

Referred to: Reference Committee B

---

Whereas, Native Hawaiians (or Kānaka Maoli) are the Indigenous peoples of Hawai'i who trace their ancestry to the Hawai'ian islands since time immemorial and/or since pre-Western Pacific navigation[1,2]; and

Whereas, the Kingdom of Hawai'i was a sovereign Indigenous nation from 1795-1893 serving Native Hawaiians and other Hawaiian citizens in the Hawai'ian Islands and which obtained international treaties recognizing its existence, including with the United States[2]; and

Whereas, the illegal 1893 overthrow and 1898 annexation of the Hawaiian Kingdom by the United States directly harmed the Native Hawaiian people and their political sovereignty[2]; and

Whereas, after Western contact and American occupation, Native Hawaiians sustained intergenerational biopsychosocial wounds manifesting in socioeconomic disparity, community discord, and disparate rates of metabolic disorders, cancers, infectious disease, and mental health distress at higher rates than other populations in the United States[1,3-13]; and

Whereas, Native Hawaiian and Pacific Islander youth experience disproportionately high rates of suicide, with suicide being the leading cause of death for ages 15–24, while Native Hawaiians overall are less likely to receive mental health treatment compared with non-Hispanic whites[9]; and

Whereas, culturally grounded identity and traditional healing practices serve as protective factors against stress and poor health outcomes among Native Hawaiians, with studies showing that stronger engagement in Native Hawaiian culture is associated with reduced stress and improved well-being among young adults[14,15]; and

Whereas, in recognition of its wrongful termination of Native Hawaiian sovereignty and the adversity experienced by Native Hawaiians, the United States Congress codified a political trust relationship with Native Hawaiians as an Indigenous community and has since repeatedly reaffirmed this relationship through subsequent acts, in parallel with legislation concerning American Indian and Alaska Native tribes[2]; and

Whereas, this trust relationship obligates the United States to provide funding and policy support to Native Hawaiians to better their conditions[2,16,17]; and

Whereas, on this trust principle and with precedent from the 1976 Indian Health Care Improvement Act (IHCIA), the federal government enacted the Native Hawaiian Health Care Improvement Act (NHHCIA), codified under 42 U.S. Code Chapter 122 and initially enacted as the Native Hawaiian Health Care Act of 1988, to improve health outcomes for Native Hawaiians by funding disease prevention, health promotion, and culturally relevant services,[2,16,17,18]; and

Whereas, the NHHCIA funds the Native Hawaiian Health Care Systems (NHHCS) which deliver essential subsidized primary care services to Native Hawaiians with system sites on the Hawaiian islands of Oʻahu, Kauaʻi, Molokaʻi, Maui, and Hawaiʻi[2,16,17]; and

Whereas, the NHHCIA established Papa Ola Lōkahi, a public health and NHHCS oversight body with the responsibility of advancing the public health and wellbeing of Native Hawaiians through community-based initiatives, research, and public policy[2,16,17]; and

Whereas, the NHHCS and Papa Ola Lōkahi are uniquely designed to improve the condition of Native Hawaiian health by delivering health care that is attuned to Native Hawaiian values, language, culture, history, intergenerational traumas, and traditional medicines[2,16,17]; and

Whereas, the NHHCIA is funded through HRSA Health Center Program appropriation[2,8,19,20]; and

Whereas, unlike the Indian Health Care Improvement Act which established the Indian Health Service for American Indians and Alaska Natives, the NHHCIA is subject to periodic reauthorization and limited discretionary funding, meaning Native Hawaiians are the only Indigenous population with a federal trust relationship who do not have a permanently authorized and funded health care system[2,8,18,19,21,22]; and

Whereas, Native Hawaiian physician workforce shortages, insufficient funding, and limited system locations are impeding the effectiveness of the NHHCIA, with experts recognizing a need for permanent funding to implement wider access and increased workforce development[23-26]; therefore be it

RESOLVED, that our American Medical Association supports federal policies that uphold the federal trust obligations to improve the health of Native Hawaiian communities by strengthening access to comprehensive, culturally informed, and physician-led health care (New HOD Policy); and be it further

RESOLVED, that our AMA supports stable, long-term federal funding and infrastructure for Native Hawaiian health care programs to ensure continuity of care, workforce development, and equitable access to services across all islands (New HOD Policy); and be it further

RESOLVED, that our AMA supports the expansion of Native Hawaiian Health Care Systems, including additional sites, mobile clinics, transportation support, workforce development, and culturally grounded health services that integrate traditional Indigenous healing alongside physician-led care (New HOD Policy); and be it further

RESOLVED, that our AMA encourages collaboration with Native Hawaiian organizations, leaders, and communities to ensure that federally supported health care initiatives are responsive to local needs, culturally respectful, and community-driven. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 09/29/25

**REFERENCES**

1. Look MA, Soong S, Kaholokula JK. Assessment and Priorities for the Health and Well-Being in Native Hawaiians and Pacific Islanders. Published online 2020.
2. 42 USC Ch. 122: Native Hawaiian Health Care.; 2025. Accessed March 27, 2025. https://uscode.house.gov/view.xhtml?path=/prelim@title42/chapter122&edition=prelim
3. Ka'apu K, Burnette CE. A Culturally Informed Systematic Review of Mental Health Disparities Among Adult Indigenous Men and Women of the USA: What is known? Br J Soc Work. 2019;49(4):880-898. doi:10.1093/bjsw/bcz009
4. Taparra K, Qu V, Pollom E. Disparities in Survival and Comorbidity Burden Between Asian and Native Hawaiian and Other Pacific Islander Patients With Cancer. JAMA Netw Open. 2022;5(8):e2226327. doi:10.1001/jamanetworkopen.2022.26327
5. Kaholokula JK, Samoa RA, Miyamoto RES, Palafox N, Daniels SA. COVID-19 Special Column: COVID-19 Hits Native Hawaiian and Pacific Islander Communities the Hardest. Hawaii J Health Soc Welf. 2020;79(5):144-146. Accessed July 24, 2025. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7226312/
6. Ndugga N, Latoya Hill, Samantha Artiga. Racial Disparities in Health Status and Outcomes - Key Data on Health and Health Care by Race and Ethnicity. KFF. June 11, 2024. Accessed July 8, 2025. https://www.kff.org/key-data-on-health-and-health-care-by-race-and-ethnicity/?entry=health-status-and-outcomes-racial-disparities-in-health-status-and-outcomes
7. Office of Hawaiian Affairs, Research, Demography. Native Hawaiian Health Fact Sheet 2022. Volume IV: Native Hawaiian Health Status. Published online 2022.
8. Morisako AK, Tauali'i M, Ambrose AJH, Withy K. Beyond the Ability to Pay: The Health Status of Native Hawaiians and Other Pacific Islanders in Relationship to Health Insurance. Hawaii J Med Public Health. 2017;76(3 Suppl 1):36-41.
9. MOKUAU NOREEN, DELEON PATRICKH, KAHOLOKULA JOSEPHKEAWEAIMOKU, et al., editors. CHALLENGES AND PROMISE OF HEALTH EQUITY FOR NATIVE HAWAIIANS. In: National Academy of Medicine; Alexander C, Murry VMB, Bogard K, editors. Perspectives on Health Equity and Social Determinants of Health. Washington (DC): National Academies Press (US); 2017. 10. Available from: https://www.ncbi.nlm.nih.gov/books/NBK595255/
10. U.S. Department of Health and Human Services, Office of Minority Health. Mental and Behavioral Health – Native Hawaiians/Pacific Islanders. Published 2021. Accessed August 24, 2025.
11. Schumacher S, Hamel L, Artiga S, Hill L, Montalvo J. Health care experiences of Native Hawaiian or Pacific Islander adults. KFF. December 3, 2024. Accessed August 24, 2025. https://www.kff.org/racial-equity-and-health-policy/health-care-experiences-of-native-hawaiian-or-pacific-islander-adults/.
12. Climbing diabetes in Molokai. Diabetes.co.uk. October 9, 2007. Accessed August 31, 2025. https://www.diabetes.co.uk/news/2007/oct/climbing-diabetes-in-molokai.html.
13. Kennedy B. The Hawaiian Diet: Traditional native vs. "local" food - delishably. Delishably. March 6, 2025. Accessed August 31, 2025. https://delishably.com/Hawaiian-Food-Culture-The-Evolution-and-Effects-of-Local-Food.
14. Jara C, Phan N. Understanding Hawaiian Identity and Well-being to Improve Mental Health Outcomes for Hawaiian Young Adults. Hawaii J Health Soc Welf. 2024;83(5):124-131. doi:10.62547/HHGI9020
15. Tribes - native voices. U.S. National Library of Medicine. Accessed August 31, 2025. https://www.nlm.nih.gov/nativevoices/timeline/723.html#:~:text=The%20principle%20foods%20in%20the,revival%20of%20Native%20Hawaiian%20culture.
16. U.S. Government Accountability Office. Native Hawaiian Health Care: Information on the Native Hawaiian Health Care Systems and Their Services. GAO-24-106407. Published October 2023. Accessed August 24, 2025. https://www.gao.gov/assets/d24106407.pdf
17. U.S. Senate. Report on S. 702 – Native Hawaiian Health Care Improvement Reauthorization Act of 2003. S Rep No. 108-405. Washington, DC: Government Printing Office; 2004. https://www.govinfo.gov/content/pkg/CRPT-108srpt405/html/CRPT-108srpt405.htm
18. United States Code. Title 25, Chapter 18: Indian Health Care Improvement Act. Indian Health Service. Published n.d. Accessed September 5, 2025.
19. State of Hawai'i Department of Health. Primary Care Needs Assessment Data Book. Honolulu, HI: State of Hawai'i; 2021. Accessed August 24, 2025. https://health.hawaii.gov/opppd/files/2020/12/Primary-Care-Leg-Rept-2021.pdf
20. U.S. Congress. S. 2681 – Native Hawaiian Health Care Improvement Act Amendments of 1992. 102nd Cong. 1992. https://www.congress.gov/bill/102nd-congress/senate-bill/2681
21. U.S. Department of Health and Human Services, Health Resources and Services Administration. Fiscal Year 2025 (FY25) Native Hawaiian Health Care Improvement Act (NHHCIA) Non-Competing Continuation (NCC) Progress Report Instructions for FY24 Award Recipients. Published [if known: e.g., December 2024]. 17 pages. Accessed August 24, 2025. https://bphc.hrsa.gov/sites/default/files/bphc/funding/nh-ncc-instructions.pdf
22. U.S. Department of Health and Human Services, Indian Health Service. Indian Health Care Improvement Act Made Permanent. Press release; March 27, 2010. Updated March 27, 2010. Accessed August 24, 2025. https://www.ihs.gov/newsroom/pressreleases/2010pressreleases/indianhealthcareimprovementactmadepermanent/
23. McKeague ML. To Raise the Health Status of Native Hawaiians to the Highest Possible Level: An Expansive Reading of the Native Hawaiian Health Care Improvement Act. Asian-Pac Law Policy J. 2022;24(1):120-159. Accessed August 13, 2025. https://heinonline.org/HOL/P?h=hein.journals/aplpj24&i=122
24. Taparra K, Deville C. Native Hawaiian and Other Pacific Islander Representation Among US Allopathic Medical Schools, Residency Programs, and Faculty Physicians. JAMA Netw Open. 2021;4(9):e2125051. doi:10.1001/jamanetworkopen.2021.25051
25. Calac AJ, Taparra K. Attrition of Indigenous Medical Students Requires Swift Institutional Response. JAMA Intern Med. 2022;182(12):1330. doi:10.1001/jamainternmed.2022.4933
26. Connolly KK, Hong T, Buenconsejo-Lum LE. Addressing Physician Shortage in Hawai'i - Kaua'i Medical Training Opportunities. Hawaii J Health Soc Welf. 2024;83(11):306-308. doi:10.62547/GRQB2504

**RELEVANT AMA POLICY**

**H-350.976 Improving Health Care of American Indians and Alaska Natives**
Our AMA… (2) Our AMA recommends that the federal government provide sufficient funds to support needed health services for American Indians and Alaska Natives… (13) strongly supports those bills before Congressional committees that aim to improve the health of and health-related services provided to American Indians and Alaska Natives and further recommends that members of appropriate AMA councils and committees provide testimony in favor of effective legislation and proposed regulations. [CLRPD Rep. 3, I-98; Reaffirmed: Res. 221, A-07; Reaffirmation A-12; Reaffirmed: Res. 233, A-13; Reaffirmed: BOT Rep. 09, A-23; Modified: CMS Rep. 03, A-24; Reaffirmed: Res. 244, A-24]

**H-350.937 Improving Healthcare of Minority Communities in Rural Areas**
Our AMA… (2) Our AMA encourages enhanced understanding by federal, state and local governments of the unique health and health-related needs, including mental health, of minority communities in rural areas in an effort to improve their quality of life. [Res. 433, A-24; Modified: CSAPH Rep. 07, A-25]

**H-350.939 Health Care Access for American Indians and Alaska Natives**
Our American Medical Association supports (a) the federal government continuing to enhance and develop alternative pathways for American Indian and Alaska Native patients to access the full spectrum of health care, including within and outside of the established Indian Health Service (IHS) system; (b) collaborative research efforts to better understand the limitations of IHS health care, including barriers to access, disparities in treatment outcomes, and areas for improvement; (c) studies between the IHS and the CDC to better evaluate regional health outcomes, and potential treatment deficiencies among American Indian and Alaska Native populations, including with respect to cancer care; and (d) federal and other efforts to increase funding for and provide technical assistance to develop and expand accessible specialty care services at IHS, Tribal, and Urban Indian Health Programs and associated facilities, including by contracting with other physician practices. [Res. 242, A-24]

**H-350.977 Indian Health Service**
The policy of the American Medical Association is to support efforts in Congress to enable the Indian Health Service to meet its obligation to bring American Indian health up to the general population level. Our AMA specifically recommends… (a) In current education programs, and in the expansion of educational activities suggested below, special consideration be given to involving the American Indian and Alaska native population in training for the various health professions, in the expectation that such professionals, if provided with adequate professional resources, facilities, and income, will be more likely to serve the tribal areas permanently; (b) Exploration with American Indian leaders of the possibility of increased numbers of nonfederal American Indian health centers, under tribal sponsorship, to expand the American Indian role in its own health care; (c) Increased involvement of private practitioners and facilities in American Indian care, through such mechanisms as agreements with tribal leaders or Indian Health Service contracts, as well as normal private practice relationships; (d) Improvement in transportation to make access to existing private care easier for the American Indian population; (e) that those Indian Health Service facilities currently necessary for American Indian care be identified and that an immediate construction and modernization program be initiated to bring these facilities up to current standards of practice and accreditation; and (f) the removal of any requirement for competitive bidding in the Indian Health Service that compromises proper care for the American Indian population. [CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmation A-12; Reaffirmed: Res. 233, A-13; Appended: Res. 305, A-23; Reaffirmed: BOT Rep. 09, A-23; Reaffirmed: CMS Rep. 03, A-24; Reaffirmed: Res. 244, A-24; Reaffirmed: BOT Rep. 31, A-24; Modified: CMS Res. 305, A-24]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 229
(I-25)

Introduced by: Underrepresented in Medicine Advocacy Section

Subject: Protection of Medicaid Beneficiaries' Private Health Information from Immigration Enforcement

Referred to: Reference Committee B

---

Whereas, reporting by the Associated Press revealed that in July 2025, the Trump administration, through a Centers for Medicare & Medicaid Services – Department of Homeland Security (CMS–DHS) agreement, granted Immigration and Customs Enforcement (ICE) access to personal data, including names, home addresses, ethnicities, birth dates, and Social Security numbers, of approximately 79 million Medicaid enrollees, to enable enforcement actions;[1] and

Whereas, Reuters confirmed that the U.S. Department of Health and Human Services provided ICE with Medicaid recipients' personal data under the pretext of verifying eligibility and preventing misuse;[2] and

Whereas, Medicaid data contain highly sensitive health and demographic information protected as defined under the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule 45 CFR Part 164 and other federal privacy statutes, which are intended to prevent unauthorized disclosure;[3] and

Whereas, the use of Medicaid beneficiary information for immigration enforcement purposes is sure to discourage eligible individuals, including U.S. citizen children in mixed-status families, from enrolling in and/or using needed health services, thereby worsening health disparities; and

Whereas, the release of Medicaid information to ICE undermines the ethical duty of physicians to safeguard patient confidentiality and safety as defined by the Hippocratic Oath;[4] and

Whereas, this release of private information erodes trust between the general public, especially among immigrant communities, and our health system, undermining public health efforts such as immunizations, prenatal care, and treatment of communicable diseases; and

Whereas, state attorneys general, including California's, filed a lawsuit challenging the legal authority of CMS to share Medicaid data with ICE;[5] and

Whereas, a federal judge subsequently issued a preliminary injunction blocking this practice due to its potential to disrupt vital health programs and violate legal protections;[6] and

Whereas, AMA Policy H-440.876 ("Opposition to Criminalization of Medical Care Provided to Undocumented Immigrant Patients") affirms the AMA's commitment to oppose governmental actions that deter or penalize immigrants seeking medical care; and

Whereas, AMA Policy H-315.983 ("Patient Privacy and Confidentiality") supports the protection of patient information and opposes disclosure without consent except as required by law for public health purposes; therefore be it

RESOLVED, that our American Medical Association amend H-315.966 "Patient and Physician Rights Regarding Immigration Status" by addition and deletion to read as follows:

Our AMA supports protections that prohibit U.S. Immigration and Customs Enforcement, U.S. Customs and Border Protection, or other law enforcement agencies from utilizing information from medical records, Medicaid, Children's Health Insurance Program (CHIP), or other health program data, including but not limited to Emergency Medicaid and related immigrant-specific programs, ~~to pursue immigration enforcement actions against patients who are undocumented~~ for immigration enforcement purposes (Modify Current HOD Policy); and be it further

RESOLVED, that our AMA work with interested parties to educate physicians and patients about existing privacy protections and available legal remedies to safeguard confidential health information, particularly for immigrant and mixed-status families. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 09/29/25

**REFERENCES**

1. Kindy K, Seitz A. Trump administration hands over Medicaid recipients' personal data, including addresses, to ice. AP News. July 17, 2025. Accessed September 8, 2025. https://apnews.com/article/immigration-medicaid-trump-ice-ab9c2267ce596089410387bfcb40eeb7.
2. Aboulenein A, Singh K. US Health Department hands over Medicaid personal data to ice | reuters. Reuters. July 17, 2025. Accessed September 9, 2025. https://www.reuters.com/business/healthcare-pharmaceuticals/us-health-department-hands-over-medicaid-personal-data-ice-2025-07-17/.
3. Title 45, Subtitle A, Subchapter C, Part 164 - Security and Privacy. National Archives - Code of Federal Regulations. Accessed September 8, 2025. https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-C/part-164.
4. Moskop JC, Marco CA, Larkin GL, Geiderman JM, Derse AR. From Hippocrates to HIPAA: privacy and confidentiality in emergency medicine--Part I: conceptual, moral, and legal foundations. Ann Emerg Med. 2005;45(1):53-59. doi:10.1016/j.annemergmed.2004.08.008
5. Attorney general Bonta: Trump administration's unprecedented move to allow ice to access Medicaid database is violation of privacy, illegal, and horrifying. State of California - Department of Justice - Office of the Attorney General. July 17, 2025. Accessed September 8, 2025. https://oag.ca.gov/news/press-releases/attorney-general-bonta-trump-administration%E2%80%99s-unprecedented-move-allow-ice.
6. Alder S. Federal judge Blocks HHS from sharing Medicaid data with ice. The HIPAA Journal. August 18, 2025. Accessed September 9, 2025. https://www.hipaajournal.com/federal-judge-blocks-hhs-sharing-medicaid-data-ice/.

## RELEVANT AMA POLICY

**H-440.876 Opposition to Criminalization of Medical Care Provided to Undocumented Immigrant Patients**
Our AMA opposes;
any policies, regulations or legislation that would criminalize or punish physicians and other health care providers for the act of giving medical care to patients who are undocumented immigrants;
any policies, regulations, or legislation requiring physicians, other health care providers, and healthcare entities to collect and report data regarding an individual patient's legal resident status;
proof of citizenship as a condition of providing health care; and
withholding federal funds if health care institutions fail to comply with policies which mandate collection of a patient's immigration status.
Our AMA opposes any legislative proposals that would criminalize the provision of health care to undocumented residents. [Res. 920, I-06; Reaffirmed and Appended: Res. 140, A-07; Modified: CCB/CLRPD Rep. 2, A-14; Modified: BOT Rep. 09, A-24; Modified: Res. 011, A-25]

**H-315.966 Patient and Physician Rights Regarding Immigration Status**
Our AMA supports protections that prohibit U.S. Immigration and Customs Enforcement, U.S. Customs and Border Protection, or other law enforcement agencies from utilizing information from medical records to pursue immigration enforcement actions against patients who are undocumented. [Res. 018, A-17]

**Patient Privacy and Confidentiality H-315.983**
Our American Medical Association affirms the following key principles that should be consistently implemented to evaluate any proposal regarding patient privacy and the confidentiality of medical information:
that there exists a basic right of patients to privacy of their medical information and records, and that this right should be explicitly acknowledged;
that patients' privacy should be honored unless waived by the patient in a meaningful way or in rare instances when strong countervailing interests in public health or safety justify invasions of patient privacy or breaches of confidentiality, and then only when such invasions or breaches are subject to stringent safeguards enforced by appropriate standards of accountability;
that patients' privacy should be honored in the context of gathering and disclosing information for clinical research and quality improvement activities, and that any necessary departures from the preferred practices of obtaining patients' informed consent and of de-identifying all data be strictly controlled;
that any information disclosed should be limited to that information, portion of the medical record, or abstract necessary to fulfill the immediate and specific purpose of disclosure; and
that the Health Insurance Portability and Accountability Act of 1996 (HIPAA) be the minimal standard for protecting clinician-patient privilege, regardless of where care is received.
Our AMA affirms:
that physicians and medical students who are patients are entitled to the same right to privacy and confidentiality of personal medical information and medical records as other patients;
that when patients exercise their right to keep their personal medical histories confidential, such action should not be regarded as fraudulent or inappropriate concealment and;
that physicians and medical students should not be required to report any aspects of their patients' medical history to governmental agencies or other entities, beyond that which would be required by law.
Employers and insurers should be barred from unconsented access to identifiable medical information lest knowledge of sensitive facts form the basis of adverse decisions against individuals.
Release forms that authorize access should be explicit about to whom access is being granted and for what purpose, and should be as narrowly tailored as possible.
Patients, physicians, and medical students should be educated about the consequences of signing overly-broad consent forms.
Employers and insurers should adopt explicit and public policies to assure the security and confidentiality of patients' medical information.
A patient's ability to join or a physician's participation in an insurance plan should not be contingent on signing a broad and indefinite consent for release and disclosure.
Whenever possible, medical records should be de-identified for purposes of use in connection with utilization review, panel credentialing, quality assurance, and peer review.
The fundamental values and duties that guide the safekeeping of medical information should remain constant in this era of computerization. Whether they are in computerized or paper form, it is critical that medical information be accurate, secure, and free from unauthorized access and improper use.
Our AMA recommends that the confidentiality of data collected by race and ethnicity as part of the medical record, be maintained.
Genetic information should be kept confidential and should not be disclosed to third parties without the explicit informed consent of the tested individual.
When breaches of confidentiality are compelled by concerns for public health and safety, those breaches must be as narrow in scope and content as possible, must contain the least identifiable and sensitive information possible, and must be disclosed to the fewest possible to achieve the necessary end.
Law enforcement agencies requesting private medical information should be given access to such information only through a court order. This court order for disclosure should be granted only if the law enforcement entity has shown, by clear and convincing evidence, that the information sought is necessary to a legitimate law enforcement inquiry; that the needs of the law enforcement authority cannot be satisfied by non-identifiable health information or by any other information; and that the law enforcement need for the information outweighs the privacy interest of the individual to whom the information pertains. These records should be subject to stringent security measures.
Our AMA must guard against the imposition of unduly restrictive barriers to patient records that would impede or prevent access to data needed for medical or public health research or quality improvement and accreditation activities. Whenever possible, de-identified data should be used for these purposes. In those contexts where personal identification is essential for the collation of data, review of identifiable data should not take place without an institutional review board (IRB) approved justification for the

retention of identifiers and the consent of the patient. In those cases where obtaining patient consent for disclosure is impracticable, our AMA endorses the oversight and accountability provided by an IRB.
Marketing and commercial uses of identifiable patients' medical information may violate principles of informed consent and patient confidentiality. Patients divulge information to their physicians only for purposes of diagnosis and treatment. If other uses are to be made of the information, patients must first give their uncoerced permission after being fully informed about the purpose of such disclosures
Our AMA, in collaboration with other professional organizations, patient advocacy groups and the public health community, should continue its advocacy for privacy and confidentiality regulations, including:
the establishment of rules allocating liability for disclosure of identifiable patient medical information between physicians and the health plans of which they are a part, and securing appropriate physicians' control over the disposition of information from their patients' medical records;
the establishment of rules to prevent disclosure of identifiable patient medical information for commercial and marketing purposes;
the establishment of penalties for negligent or deliberate breach of confidentiality or violation of patient privacy rights.
Our AMA will pursue an aggressive agenda to educate patients, the public, physicians and policymakers at all levels of government about concerns and complexities of patient privacy and confidentiality in the variety of contexts mentioned.
Disclosure of personally identifiable patient information to public health physicians and departments is appropriate for the purpose of addressing public health emergencies or to comply with laws regarding public health reporting for the purpose of disease surveillance.
In the event of the sale or discontinuation of a medical practice, patients should be notified whenever possible and asked for authorization to transfer the medical record to a new physician or care provider.
Only de-identified and/or aggregate data should be used for "business decisions," including sales, mergers, and similar business transactions when ownership or control of medical records changes hands.
The most appropriate jurisdiction for considering physician breaches of patient confidentiality is the relevant state medical practice act. Knowing and intentional breaches of patient confidentiality, particularly under false pretenses, for malicious harm, or for monetary gain, represents a violation of the professional practice of medicine.
Our AMA Board of Trustees will actively monitor and support legislation at the federal level that will afford patients protection against discrimination on the basis of genetic testing.
Our AMA supports privacy standards that would require pharmacies to obtain a prior written and signed consent from patients to use their personal data for marketing purposes.
Our AMA supports privacy standards that require pharmacies and drug store chains to disclose the source of financial support for drug mailings or phone calls.
Our AMA supports privacy standards that would prohibit pharmacies from using prescription refill reminders or disease management programs as an opportunity for marketing purposes.
Our AMA will draft model state legislation requiring consent of all parties to the recording of a physician-patient conversation. [BOT Rep. 9, A-98; Reaffirmation I-98; Appended: Res. 4, and Reaffirmed: BOT Rep. 36, A-99; Appended: BOT Rep. 16 and Reaffirmed: CSA Rep. 13, I-99; Reaffirmation A-00; Reaffirmed: Res. 246 and 504 and Appended Res. 504 and 509, A-01; Reaffirmed: BOT Rep. 19, I-01; Appended: Res. 524, A-02; Reaffirmed: Sub. Res. 206, A-04; Reaffirmed: BOT Rep. 24, I-04; Reaffirmed: BOT Rep. 19, I-06; Reaffirmation A-07Reaffirmed: BOT Rep. 19, A-07; Reaffirmed: CEJA Rep. 6, A-11; Reaffirmed in lieu of Res. 705, A-12Reaffirmed: BOT Rep. 17, A-13; Modified: Res. 2, I-14; Reaffirmation: A-17; Modified: BOT Rep. 16, A-18; Appended: Res. 232, A-18; Reaffirmation: I-18; Reaffirmed: Res. 219, A-21; Reaffirmed: Res. 229, A-21; Reaffirmed: BOT Rep. 12, I-21; Reaffirmed: BOT Rep. 22, A-22; Reaffirmation: A-23; Reaffirmed: CSAPH Rep. 08, A-24]

**H-65.932 Reducing the Harmful Impacts of Immigration Status on Health**
Our AMA supports protecting the human right to seek asylum.
Our AMA supports pathways to citizenship for undocumented immigrants who entered the US as minors, including Deferred Action for Childhood Arrivals (DACA), temporary protected status (TPS) recipients, and Dreamers.
Our AMA supports family reunification pathways for children and adult immigrants from other countries if their parent/guardian, spouse, or child/dependent has documented status in the U.S.
Our AMA supports deferral of deportation (and if applicable, employment authorization, driver's licenses, and identification documents) for people with disabilities and significantly limiting chronic illness, people who work in healthcare and social care, and relatives of people with documented or DACA status, and people without violent felonies.

Our AMA supports federal and state efforts to remove immigration enforcement from workplaces and employment consideration, including the removal of E-Verify mandates. [Res. 004, A-25]

**H-65.958 Opposing Office of Refugee Resettlement's Use of Medical and Psychiatric Records for Evidence in Immigration Court**
Our AMA will: (1) advocate that healthcare services provided to minors in immigrant detention and border patrol stations focus solely on the health and well-being of the children; and (2) condemn the use of confidential medical and psychological records and social work case files as evidence in immigration courts without patient consent. [Res. 013, A-19]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 230
(I-25)

Introduced by: American College of Rheumatology, American College of Physicians, American Association of Geriatric Psychiatry, American Society for Gastrointestinal Endoscopy

Subject: Banning Non-compete Agreements in States

Referred to: Reference Committee B

---

Whereas, non-compete agreements are contract clauses that restrict an employee or independent contractor from working for a competitor or opening a competing business for a set time and within a geographic area; and

Whereas, non-compete agreements often prevent physicians and other healthcare workers from practicing within a radius of their former workplace for 1–2 years, which can force relocation or long commutes; and

Whereas, non-compete agreements leave physicians and other healthcare workers with less power to negotiate salary, call schedules, or resources; and

Whereas, non-compete agreements suppress wages, reduce job mobility, and stifle innovation; and

Whereas, non-compete agreements are particularly burdensome on physicians and other healthcare workers who provide care in rural and other underserved areas; and

Whereas, non-compete agreements compromise patient access to quality care by imposing longer wait times and reducing the number of specialists practicing in a certain area; and

Whereas, non-compete agreements often disrupt the continuity of care by forcing patients to abruptly switch providers; and

Whereas, the Federal Trade Commission's decision to not appeal the District Court's ruling in *Ryan, LLC v. FTC* puts the impetus on the states to enact legislation or regulation that either ban non-compete agreements or restrict their use; and

Whereas, only 4 states ban the use of non-compete agreements entirely and 34 states only partially restrict their use; and therefore be it

RESOLVED, that our American Medical Association will work with state medical societies, national specialty societies and/or other interested parties to advocate for legislation or regulation that would prohibit covenants not-to-compete for all physicians in clinical practice who hold employment contracts with for-profit or non-profit hospital, hospital system, or staffing company employers, across all states in which a ban on non-to-compete agreements is not in place. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/29/25

**RELEVANT AMA POLICY**

**Prohibiting Covenants Not-To-Compete in Physician Contracts D-265.988**
Our American Medical Association support policies, regulations, and legislation that prohibits covenants not-to-compete for all physicians in clinical practice who hold employment contracts with for-profit or non-profit hospital, hospital system, or staffing company employers. 1) Our AMA will oppose the use of restrictive covenants not-to-compete as a contingency of employment for any physician-in-training, regardless of the ACGME accreditation status of the residency/fellowship training program. 2) Our AMA will study and report back on current physician employment contract terms and trends with recommendations to address balancing legitimate business interests of physician employers while also protecting physician employment mobility and advancement, competition, and patient access to care - such recommendations to include the appropriate regulation or restriction of a) Covenants not to compete in physician contracts with independent physician groups that include time, scope, and geographic restrictions; and b) De facto non-compete restrictions that allow employers to recoup recruiting incentives upon contract termination.
Policy Timeline
Res. 237, A-23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 231
(I-25)

Introduced by: LGBTQ+ Section

Subject: Ensuring Equitable and Timely Medical Licensure for Physicians Providing Abortion and Gender-Affirming Care

Referred to: Reference Committee B

---

Whereas, physicians providing evidence-based medical care, including abortion and gender-affirming care, are increasingly targeted by state laws that criminalize or otherwise penalize such care, despite its adherence to widely accepted medical standards; and

Whereas, physicians may seek to relocate or obtain licensure in new states in response to legislative bans or professional risk, and unjust delays in licensure due to prior provision of legally and ethically appropriate care pose a barrier to physician mobility and access to care for patients; and

Whereas, the American Medical Association has policy supporting the protection of physicians who provide reproductive and gender-affirming care in accordance with established medical guidelines (e.g., AMA Policies H-160.915, H-65.963, and H-5.952); and

Whereas, discrimination against physicians in the licensure process based on their provision of abortion or gender-affirming care undermines the ethical obligations of the profession and patient access to essential healthcare services; therefore be it

RESOLVED, that our American Medical Association advocate that no physician be disqualified from medical licensure or subject to unnecessary delay in the licensure process solely due to having provided abortion care or gender-affirming care in accordance with then-current standards of medical practice and/or while such care was legal in their jurisdiction (Directive to Take Action); and be it further

RESOLVED, that our AMA support policies and legislation that prohibit discrimination by state medical boards or licensing authorities against applicants based on their provision of abortion or gender-affirming care (New HOD Policy); and be it further

RESOLVED, that our AMA work with relevant stakeholders, including state medical boards and specialty societies, to develop guidance ensuring that physicians seeking licensure are evaluated in a timely manner, equitably and without bias relating to reproductive or gender-affirming care practices. (Directive to Take Action)

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

Received: 9/29/25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 232
(I-25)

Introduced by: American Society for Reproductive Medicine

Subject: Safeguarding Access to IVF Amid Restorative Reproductive Medicine Legislation

Referred to: Reference Committee B

---

Whereas, “restorative reproductive medicine” (RRM), is a selective rebranding of certain medical practices in ways that mislead patients and threaten access to timely, effective fertility care including IVF; and

Whereas, some organizations suggest that RRM is a safer and more effective alternative to evidence-based infertility treatments; and

Whereas, the Arkansas legislature has passed[1], and the US government has introduced[2] legislation that would codify RRM coverage in statute and refers to IVF as “suppressive” or “circumventive” to natural fertility; and

Whereas, Board-certified physicians providing infertility assessment and treatment are trained to provide a comprehensive assessment of patients’ medical, surgical, and family histories and social determinants of health as the standard of care to optimize wellness and fertility and pregnancy outcomes; and

Whereas, while some symptoms of some infertility-associated conditions such as Polycystic Ovary Syndrome (PCOS), endometriosis, and erectile dysfunction, can be improved through attention to diet and lifestyle, medical and technological intervention may be necessary for successful pregnancy with these conditions; and

Whereas, other infertility-associated conditions such as azoospermia, bilateral tubal blockage, and uterine agenesis are treatable only with medical and technological intervention; and

Whereas, delays in accessing evidence-based fertility treatments such as IVF can further exacerbate age-related infertility; and

Whereas, our American Medical Association is committed to safeguarding public health infrastructure and maintaining the integrity of evidence-based medicine; therefore be it

RESOLVED, that our American Medical Association opposes any efforts to limit patient access to the full scope of evidence-based fertility treatments, including but not limited to: In Vitro Fertilization (IVF) (New HOD Policy); and be it further

RESOLVED, that our AMA should advocate for increased NIH funding for women's health, including reproductive health, so that we can expand research on the potential underlying causes of infertility (Directive to Take Action); and be it further

RESOLVED, that our AMA acknowledges that practices considered “restorative reproductive medicine” constitute part of what Reproductive Endocrinology and Infertility physicians, Urologists, and other fertility specialists provide in their daily practice through patient-centered evaluation and individualized treatment of underlying conditions (New HOD Policy); and be it further

RESOLVED, that our AMA acknowledges that IVF is an important part of the comprehensive, evidence-based infertility treatment options that should be offered to patients and is often the most successful option for many patients looking to grow or start their families. (New HOD Policy)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 09/30/25

**REFERENCES**

1. Act 859, 95th Gen. Assemb., Reg. Sess. (AR. 2025). https://arkleg.state.ar.us/Bills/Detail?id=hb1142&ddBienniumSession=2025%2F2025R
2. RESTORE Act, S. 1882, 119 Congress. (2025). https://www.congress.gov/bill/119th-congress/senate-bill/1882

**RELEVANT AMA POLICY**

**D-425.989 Protecting Access to IVF Treatment**
Our American Medical Association opposes any legislation or ballot measures that could criminalize in-vitro fertilization. Our AMA will work with other interested organizations to oppose any civil or criminal legislation or ballot measures or court rulings that would: (a) equate gametes (oocytes and sperm) or embryos with children; and/or (b) otherwise restrict or interfere with evidence-based care for Assisted Reproductive Technology (ART). Our AMA, through the AMA Task Force to Preserve the Patient-Physician Relationship, will report back at I-24, on the status of, and AMA’s activities surrounding, proposed ballot measures or legislation and pending court rulings, that would:
equate gametes or embryos with children; and/or otherwise restrict or interfere with evidence-based care for Assisted Reproductive Technology (ART). [Res. 217, A-24]

**D-440.905 Protecting Evidence-Based Medicine, Public Health Infrastructure and Biomedical Research**
Our AMA affirms that protecting science, clinical integrity, and the patient-physician relationship is central to the organization’s mission. Our AMA assertively and publicly leads the House of Medicine in collective, sustained advocacy for federal and state policies, proposals, and actions that safeguard public health infrastructure, advance biomedical research, improve vaccine confidence, and maintain the integrity of evidence-based medicine and decision-making processes. Our AMA will report back at the 2025 Interim Meeting of the AMA House of Delegates on the actions taken to implement this policy. [Res. 242, A-25]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 233
(I-25)

Introduced by: American Academy of Child and Adolescent Psychiatry

Subject: Renewing Mental Health Infrastructure in the School System

Referred to: Reference Committee B

---

Whereas, in May 2025 the U.S. Department of Education rescinded more than $1 billion in multiyear school-based mental health grants established under the Bipartisan Safer Communities Act, which had supported the training, placement, and diversification of school mental health professionals; and

Whereas, these rescissions disproportionately impact rural and underserved districts, disrupting continuity of care and destabilizing the workforce pipeline for counselors, psychologists, social workers, and physicians engaged in school-based health services; and

Whereas, existing AMA policy (H-60.991, H-60.900, H-60.947, H-60.902, H-60.943, H-60.937, H-95.932, H-345.977, H-515.952, H-345.984, H-200.955, D-200.982, H-450.935) demonstrates strong support for school-based health services, trauma-informed care, pediatric mental health screening, equitable workforce distribution, and evidence-based policy, but does not provide permanent funding or resilience mechanisms; and

Whereas, the Federal Medical Assistance Percentage (FMAP) is the longstanding federal–state cost-sharing formula for Medicaid, and provides a tested model for creating predictable, equitable, and sustainable financing structures; therefore be it

RESOLVED, that our American Medical Association advocate for federal legislation establishing a permanent School Mental Health Infrastructure Fund, modeled on a federal–state partnership such as the FMAP, to ensure stable and equitable financing for the training, placement, and retention of school-based mental health professionals, with priority given to rural and underserved communities (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for federal legislation incorporating automatic continuity protections (such as bridge funding or carryover authority) within school-based mental health programs, to prevent disruptions in student care and workforce stability when federal appropriations are delayed or rescinded. (Directive to Take Action)

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

Received: 9/30/25

**REFERENCES**

1. Rones, M., Hoagwood, K. School-Based Mental Health Services: A Research Review. Clin Child Fam Psychol Rev 3, 223-241 (2000). https://doi.org/10.1023/A:1026425104386
2. Brown C, Carrington NK. Increasing access to school-based mental health services for youth subsequent to the COVID-19 pandemic. Health Aff Sch. 2025 Apr 5;3(4):qxaf073. doi: 10.1093/haschl/qxaf073. PMID: 40264701; PMCID: PMC12013806.
3. Hoagwood, Kimberly, and Holly D. Erwin. "Effectiveness of school-based mental health services for children: A 10-year research review." Journal of Child and Family Studies 6.4 (1997): 435-451.

## RELEVANT AMA POLICY

### H-60.991 Providing Medical Services through School-Based Health Programs

1. Our American Medical Association supports further objective research into the potential benefits and problems associated with school-based health services by credible organizations in the public and private sectors.
2. Where school-based services exist, our AMA recommends that they meet the following minimum standards:
    a. Health services in schools must be supervised by a physician, preferably one who is experienced in the care of children and adolescents. Additionally, a physician should be accessible to administer care on a regular basis.
    b. On-site services should be provided by a professionally prepared school nurse or similarly qualified health professional. Expertise in child and adolescent development, psychosocial and behavioral problems, and emergency care is desirable. Responsibilities of this professional would include coordinating the health care of students with the student, the parents, the school and the student's personal physician and assisting with the development and presentation of health education programs in the classroom.
    c. There should be a written policy to govern provision of health services in the school. Such a policy should be developed by a school health council consisting of school and community-based physicians, nurses, school faculty and administrators, parents, and (as appropriate) students, community leaders and others. Health services and curricula should be carefully designed to reflect community standards and values, while emphasizing positive health practices in the school environment.
    d. Before patient services begin, policies on confidentiality should be established with the advice of expert legal advisors and the school health council.
    e. Policies for ongoing monitoring, quality assurance and evaluation should be established with the advice of expert legal advisors and the school health council.
    f. Health care services should be available during school hours. During other hours, an appropriate referral system should be instituted.
    g. School-based health programs should draw on outside resources for care, such as private practitioners, public health and mental health clinics, and mental health and neighborhood health programs.
    h. Services should be coordinated to ensure comprehensive care. Parents should be encouraged to be intimately involved in the health supervision and education of their children.

[CSA Rep. D, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: Res. 412, A-05; Reaffirmed in lieu of Res. 908, I-12; Reaffirmed: CSAPH Rep. 1, A-22]

### H-60.900 Student-Centered Approaches for Reforming School Disciplinary Policies

1. Our American Medical Association supports evidence-based frameworks in K-12 schools that focus on school-wide prevention and intervention strategies for student misbehavior.
2. Our AMA supports the consultation with school-based mental health professionals in the student discipline process.
3. Our AMA supports efforts to address physical and mental trauma experienced by children in K-12 education by reducing disproportionate punitive disciplinary actions and the involvement of law enforcement in student discipline.
4. Our AMA supports transitions to restorative approaches that individually address students' medical, social, and educational needs.
5. Our AMA supports ensuring that any law enforcement presence in K-12 schools focuses on maintaining student and staff safety and not on disciplining students.

6. Our AMA supports limiting the presence of law enforcement patrolling in schools to only those settings and times where student and staff safety is at active risk.

[Res. 008, A-22; Modified: CSAPH Rep. 04, A-23]

**H-60.947 Guns in School Settings**

Our American Medical Association recommends: (1) all children who take guns or other weapons to school should receive an evaluation by a psychiatrist or an appropriately trained mental health professional; and (2) that children who are determined by such evaluation to have a mental illness should receive appropriate treatment.

[Res. 402, I-98; Reaffirmed: CSAPH Rep. 2, A-08; Reaffirmed: CSAPH Rep. 01, A-18]

**H-60.902 School Resource Officer Qualifications and Training**

1. Our American Medical Association encourages:
    1. an evaluation of existing national standards (and legislation, if necessary) to have qualifications by virtue of training and certification that includes child and adolescent psychology and development, trauma-informed care, restorative justice, peer mediation, conflict resolution, crime awareness, implicit/explicit biases, how to work with children with disabilities and special needs, diversity inclusion, cultural humility competence of the distinct cultural groups represented at schools, de-escalation training, bullying and cyberbullying training, and individual and institutional safety and others deemed necessary for school resource officers.
    2. the development of policies that foster the best environment for learning through protecting the health and safety of those in school, including students, teachers, staff and visitors.
2. Our AMA encourages:
    1. school districts initiating SROs develop and those with existing SROs maintain an up-to-date Memorandum of Understanding (MOU) that clearly outlines processes for officer selection and assessment, defines roles and responsibilities of SROs and their scope relative to school personnel, identifies data to be collected, and establishes a mechanism for program evaluation and oversight.
    2. SROs to have access to local public health resources.
    3. schools with SRO programs to collect and report data to help evaluate the impact of SROs in schools;
    4. federal and state grant programs which provide funding for SRO programs, require collection and reporting of data to inform policymaking on these programs.
    5. adequate federal funding to the Bureau of Indian Education to develop and implement SRO programs in consultation with tribal leaders.
3. Our AMA acknowledges that:
    1. if a school chooses to utilize SROs, they are part of the school staff at large and their responsibilities should be defined within the context of the school team.
    2. community-based policing practices are essential for a successful SRO program.
4. Our AMA supports:
    1. efforts to address physical and mental trauma experienced by children in preschool-12th grade by eliminating disproportionate punitive disciplinary actions and the involvement of law enforcement in student discipline.
    2. transitions to restorative approaches that individually address students' medical, social, and educational needs.
    3. ensuring that any law enforcement presence in preschool-12th grade schools focuses on maintaining student and staff safety and not on disciplining students.

[Res. 926, I-19; Modified: CSAPH Rep. 04, A-23]

**H-60.943 Bullying Behaviors Among Children and Adolescents**

1. Our American Medical Association recognizes bullying as a complex and abusive behavior with potentially serious social and mental health consequences for children and adolescents. Bullying is defined as a pattern of repeated aggression; with deliberate intent to harm or disturb a victim despite apparent victim distress; and a real or perceived imbalance of power (e.g., due to age, strength, size), with the more powerful child or group attacking a physically or psychologically vulnerable victim.
2. Our AMA advocates for federal support of research:

   a. for the development and effectiveness testing of programs to prevent or reduce bullying behaviors, which should include rigorous program evaluation to determine long-term outcomes.
   b. for the development of effective clinical tools and protocols for the identification, treatment, and referral of children and adolescents at risk for and traumatized by bullying.
   c. to further elucidate biological, familial, and environmental underpinnings of aggressive and violent behaviors and the effects of such behaviors.
   d. to study the development of social and emotional competency and resiliency, and other factors that mitigate against violence and aggression in children and adolescents.
3. Our AMA urges physicians to
   a. be vigilant for signs and symptoms of bullying and other psychosocial trauma and distress in children and adolescents.
   b. enhance their awareness of the social and mental health consequences of bullying and other aggressive behaviors.
   c. screen for psychiatric comorbidities in at-risk patients.
   d. counsel affected patients and their families on effective intervention programs and coping strategies.
   e. advocate for family, school, and community programs and services for victims and perpetrators of bullying and other forms of violence and aggression.
4. Our AMA advocates for federal, state, and local resources to increase the capacity of schools to provide safe and effective educational programs by which students can learn to reduce and prevent violence. This includes:
   a. Programs to teach, as early as possible, respect and tolerance, sensitivity to diversity, and interpersonal problem-solving.
   b. Violence reduction curricula as part of education and training for teachers, administrators, school staff, and students.
   c. Age and developmentally appropriate educational materials about the effects of violence and aggression.
   d. Proactive steps and policies to eliminate bullying and other aggressive behaviors; and
   e. Parental involvement.
5. Our AMA advocates for expanded funding of comprehensive school-based programs to provide assessment, consultation, and intervention services for bullies and victimized students, as well as provide assistance to school staff, parents, and others with the development of programs and strategies to reduce bullying and other aggressive behaviors.
6. Our AMA urges parents and other caretakers of children and adolescents to:
   a. Be actively involved in their child's school and community activities.
   b. Teach children how to interact socially, resolve conflicts, deal with frustration, and cope with anger and stress.
   c. Build supportive home environments that demonstrate respect, tolerance, and caring and that do not tolerate bullying, harassment, intimidation, social isolation, and exclusion.

[CSA Rep. 1, A-02; Reaffirmed: CSAPH Rep. 1, A-12; Reaffirmed: CSAPH Rep. 1, A-22]

**H-60.937 Youth and Young Adult Suicide in the United States**

1. Our American Medical Association recognizes child, youth and young adult suicide as a serious health concern in the US.
2. Our AMA encourages the development and dissemination of educational resources and tools for physicians, especially those more likely to encounter child, youth or young adult patients, addressing effective suicide prevention, including screening tools, methods to identify risk factors and acuity, safety planning, and appropriate follow-up care including treatment and linkages to appropriate counseling resources.
3. Our AMA supports collaboration with federal agencies, relevant state and specialty societies, schools, public health agencies, community organizations, and other stakeholders to enhance awareness of the increase in child, youth and young adult suicide and to promote protective factors, raise awareness of risk factors, support evidence-based prevention strategies and interventions, encourage awareness of community mental health resources, and improve care for children, youth and young adults at risk of suicide.

4. Our AMA encourages efforts to provide children, youth and young adults better and more equitable access to treatment and care for depression, substance use disorder, and other disorders that contribute to suicide risk.
5. Our AMA encourages continued research to better understand suicide risk and effective prevention efforts in children, youth and young adults, especially in higher risk sub-populations such as those with a history of childhood trauma and adversity, Black, LGBTQ+, Hispanic/Latinx, Indigenous/Native Alaskan youth and young adult populations, and children in the welfare system.
6. Our AMA supports the development of novel technologies and therapeutics, along with improved utilization of existing medications to address acute suicidality and underlying risk factors in children, youth and young adults.
7. Our AMA supports research to identify evidence-based universal and targeted suicide prevention programs for implementation in middle schools and high schools.
8. Our AMA will publicly call attention to the escalating crisis in children, youth and young adult mental health in this country in the wake of the Covid-19 pandemic.
9. Our AMA will advocate at the state and national level for policies to prioritize children's, youth's, and young adult's mental, emotional, and behavioral health.
10. Our AMA will advocate for comprehensive system of care including prevention, management, and crisis care to address mental and behavioral health needs for children, youth, and young adults.
11. Our AMA will advocate for a comprehensive approach to the youth, and young adult mental and behavioral health crisis when such initiatives and opportunities are consistent with AMA policy.

[Res. 424, A-05; Reaffirmed: CSAPH Rep. 1, A-15; Reaffirmed in lieu of: Res. 001, I-16; Appended: CSAPH Rep. 3, A-21; Appended - BOT Action in response to referred for decision: CSAPH Rep. 3, A-21; Modified: Res. 419, A-23]

**H-95.932 Increasing Availability of Naloxone and Other Safe and Effective Overdose Reversal Medications**

1. Our American Medical Association supports legislative, regulatory, and national advocacy efforts to increase access to affordable naloxone and other safe and effective overdose reversal medications, including but not limited to collaborative practice agreements with pharmacists and standing orders for pharmacies and, where permitted by law, community-based organizations, law enforcement agencies, correctional settings, schools, and other locations that do not restrict the route of administration for naloxone and other safe and effective overdose reversal medications delivery.
2. Our AMA supports efforts that enable law enforcement agencies to carry and administer naloxone and other safe and effective overdose reversal medications .
3. Our AMA encourages physicians to co-prescribe naloxone and other safe and effective overdose reversal medications to patients at risk of overdose and, where permitted by law, to the friends and family members of such patients.
4. Our AMA encourages private and public payers to include all forms of naloxone and other safe and effective overdose reversal medications on their preferred drug lists and formularies with minimal or no cost sharing.
5. Our AMA supports liability protections for physicians and other healthcare professionals and others who are authorized to prescribe, dispense and/or administer naloxone and other safe and effective overdose reversal medications pursuant to state law.
6. Our AMA supports efforts to encourage individuals who are authorized to administer naloxone and other safe and effective overdose reversal medications to receive appropriate education to enable them to do so effectively.
7. Our AMA encourages manufacturers or other qualified sponsors to pursue the application process for over the counter approval of naloxone and other safe and effective overdose reversal medications with the Food and Drug Administration.
8. Our AMA supports the widespread implementation of easily accessible naloxone and other safe and effective overdose reversal medications rescue stations (public availability of naloxone and other safe and effective overdose reversal medications through wall-mounted display/storage units that also include instructions) throughout the country following distribution and legislative edicts similar to those for Automated External Defibrillators.
9. Our AMA supports the legal access to and use of naloxone and other safe and effective overdose reversal medications in all public spaces regardless of whether the individual holds a prescription.
10. Our AMA supports efforts to increase the availability, delivery, possession and use of mail-order overdose reversal medications, including naloxone, to help prevent opioid-related overdose,

especially in vulnerable populations, including but not limited to underserved communities and American Indian reservation populations.

11. Our AMA supports the expansion of naloxone availability through colocation of intranasal naloxone with AEDs in public locations.

[BOT Rep. 22, A-16; Modified: Res. 231, A-17; Modified: Speakers Rep. 01, A-17; Appended: Res. 909, I-17; Reaffirmed: BOT Rep. 17, A-18; Modified: Res. 524, A-19; Reaffirmed: BOT 09, I-19; Reaffirmed: Res. 219, A-21; Modified: Res. 505, A-23; Reaffirmed: BOT Rep. 11, A-24; Modified: Res. 512, A-24]

**H-345.977 Improving Pediatric Mental Health Screening**

Our AMA: (1) recognizes the importance of, and supports the inclusion of, mental health (including substance use, abuse, and addiction) screening in routine pediatric physicals; (2) will work with mental health organizations and relevant primary care organizations to disseminate recommended and validated tools for eliciting and addressing mental health (including substance use, abuse, and addiction) concerns in primary care settings; and (3) recognizes the importance of developing and implementing school-based mental health programs that ensure at-risk children/adolescents access to appropriate mental health screening and treatment services and supports efforts to accomplish these objectives.
[Res. 414, A-11; Appended: BOT Rep. 12, A-14; Reaffirmed: Res. 403, A-18]

**H-515.952 Adverse Childhood Experiences and Trauma-Informed Care**

1. Our American Medical Association recognizes trauma-informed care as a practice that recognizes the widespread impact of trauma on patients, identifies the signs and symptoms of trauma, and treats patients by fully integrating knowledge about trauma into policies, procedures, and practices and seeking to avoid re-traumatization.
2. Our AMA supports:
    a. evidence-based primary prevention strategies for Adverse Childhood Experiences (ACEs).
    b. evidence-based trauma-informed care in all medical settings that focuses on the prevention of poor health and life outcomes after ACEs or other trauma at any time in life occurs.
    c. efforts for data collection, research, and evaluation of cost-effective ACEs screening tools without additional burden for physicians.
    d. efforts to educate physicians about the facilitators, barriers and best practices for providers implementing ACEs screening and trauma-informed care approaches into a clinical setting.
    e. funding for schools, behavioral and mental health services, professional groups, community, and government agencies to support patients with ACEs or trauma at any time in life.
    f. increased screening for ACEs in medical settings, in recognition of the intersectionality of ACEs with significant increased risk for suicide, negative substance use-related outcomes including overdose, and a multitude of downstream negative health outcomes.
3. Our AMA supports the inclusion of ACEs and trauma-informed care into undergraduate and graduate medical education curricula.
4. Our AMA will collaborate with the CDC and other relevant interested parties to advocate for the inclusion of additional evidence-based categories to the currently existing Adverse Childhood Experiences (ACEs) categories for the purposes of continuing to improve research into the health impacts of ACEs and how to mitigate them.
5. Our AMA will work with the CDC and other relevant interested parties to advocate for resources to expand research into ACEs and efforts to operationalize those findings into effective and evidence-based clinical and public health interventions.
6. Our AMA will support the establishment of a national ACEs response team grant to dedicate federal resources towards supporting prevention and early intervention efforts aimed at diminishing the impacts ACEs have on the developing child.

[Res. 504, A-19; Appended: CSAPH Rep. 3, A-21; Appended: Res. 914, I-23]

**H-345.984 Awareness, Diagnosis and Treatment of Depression and other Mental Illnesses**

1. Our American Medical Association encourages:
    a. medical schools, primary care residencies, and other training programs as appropriate to include the appropriate knowledge and skills to enable graduates to recognize, diagnose,

and treat depression and other mental illnesses, either as the chief complaint or with another general medical condition.
b. all physicians providing clinical care to acquire the same knowledge and skills.
c. additional research into the course and outcomes of patients with depression and other mental illnesses who are seen in general medical settings and into the development of clinical and systems approaches designed to improve patient outcomes. Furthermore, any approaches designed to manage care by reduction in the demand for services should be based on scientifically sound outcomes research findings.

2. Our AMA will work with the National Institute on Mental Health and appropriate medical specialty and mental health advocacy groups to increase public awareness about depression and other mental illnesses, to reduce the stigma associated with depression and other mental illnesses, and to increase patient access to quality care for depression and other mental illnesses.
3. Our AMA:
   a. will advocate for the incorporation of integrated services for general medical care, mental health care, and substance use disorder care into existing psychiatry, addiction medicine and primary care training programs' clinical settings.
   b. encourages graduate medical education programs in primary care, psychiatry, and addiction medicine to create and expand opportunities for residents and fellows to obtain clinical experience working in an integrated behavioral health and primary care model, such as the collaborative care model.
   c. will advocate for appropriate reimbursement to support the practice of integrated physical and mental health care in clinical care settings.
4. Our AMA recognizes the impact of violence and social determinants on women's mental health.

[Res. 502, I-96; Reaffirm & Appended: CSA Rep. 7, I-97; Reaffirmation A-00; Modified: CSAPH Rep. 1, A-10; Modified: Res. 301, A-12; Appended: Res. 303, I-16; Appended: Res. 503, A-17; Reaffirmation: A-19; Reaffirmed: Res. 425, A-22]

**H-200.955 Revisions to AMA Policy on the Physician Workforce**

It is our American Medical Association policy that:

1. Any workforce planning efforts, done by our AMA or others, should utilize data on all aspects of the health care system, including projected demographics of both providers and patients, the number and roles of other health professionals in providing care, and practice environment changes. Planning should have as a goal appropriate physician numbers, specialty mix, and geographic distribution.
2. Our AMA encourages and collaborates in the collection of the data needed for workforce planning and in the conduct of national and regional research on physician supply and distribution. The AMA will independently and in collaboration with state and specialty societies, national medical organizations, and other public and private sector groups, compile and disseminate the results of the research.
3. The medical profession must be integrally involved in any workforce planning efforts sponsored by federal or state governments, or by the private sector.
4. In order to enhance access to care, our AMA collaborates with the public and private sectors to ensure an adequate supply of physicians in all specialties and to develop strategies to mitigate the current geographic maldistribution of physicians.
5. There is a need to enhance underrepresented minority representation in medical schools and in the physician workforce, as a means to ultimately improve access to care for minority and underserved groups.
6. There should be no decrease in the number of funded graduate medical education (GME) positions. Any increase in the number of funded GME positions, overall or in a given specialty, and in the number of US medical students should be based on a demonstrated regional or national need.
7. Our AMA will collect and disseminate information on market demands and workforce needs, so as to assist medical students and resident physicians in selecting a specialty and choosing a career.
8. Our AMA will encourage the Health Resources & Service Administration to collaborate with specialty societies to determine specific changes that would improve the agency's physician workforce projections process, to potentially include more detailed projection

inputs, with the goal of producing more accurate and detailed projections including specialty and subspecialty workforces.

9. Our AMA will consider physician retraining during all its deliberations on physician workforce planning.

[CME Rep. 2, I-03; Reaffirmation I-06; Reaffirmation I-07; Reaffirmed: CME Rep. 15, A-10; Reaffirmation: I-12; Reaffirmation A-13; Appended: Res. 324, A-17; Appended: CME Rep. 01, A-19; Reaffirmation: I-22; Reaffirmed in lieu of: Res. 218, A-25]

**D-200.982 Diversity in the Physician Workforce and Access to Care**

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

[CME Rep. 7, A-08; Reaffirmation A-13; Reaffirmation: A-16; Reaffirmed: CME Rep. 5, A-21; Reaffirmation: Res. 240, A-24]

**H-450.935 Health Care Standards**

Our AMA: (1) supports the ability of non-governmental organizations to evaluate appropriate medical diagnosis or therapy or current or new diagnostic or therapeutic tests, procedures, medications or other procedures that improve the quality of patient care; (2) supports the position that any practice guidelines, parameters, best practices models, or similar set of principles or clinical recommendations, whether developed or issued by government or non-government organizations, including those that result from any comparative effectiveness research or evidence-based medicine system, do not, and should expressly state that they do not, establish standard of care or create specific requirements for physicians that restrict the exercise of their clinical judgment; (3) urges any organization, whether governmental or non-governmental, promulgating any practice guidelines, parameters, best practices models, or similar set of principles or clinical recommendations, to include a statement that they are guidelines only; and (4) urges any organization, whether governmental or non-governmental, promulgating any practice guidelines, parameters, best practices models, or similar set of principles or clinical recommendations, to set and make publicly available a regular schedule for review and update and to include the level of evidence supporting the guidelines.

[Res. 205, A-10; Reaffirmation I-10; Reaffirmed: Res. 105, A-18]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 234
(I-25)

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

Subject: Study on Impact of Inflation Reduction Act on Oncology, Other Physician Practices

Referred to: Reference Committee B

---

Whereas, the Inflation Reduction Act (IRA) allows the Centers for Medicare & Medicaid Services to negotiate the prices of certain high-cost drugs under Medicare, beginning with Part D medications and expanding to Part B in 2029; and

Whereas, our American Medical Association (AMA) has existing policy supporting efforts to ensure patients have affordable access to medications and encourages all payers, both public and private, to establish a reasonable and affordable cap on patient out-of-pocket prescription drug spending; and

Whereas, our AMA Council on Medical Service released a report at A-25 on the enactment of the IRA and its health care sector impacts, including Medicare drug pricing; and

Whereas, the IRA has been lauded for its provision to cap out-of-pocket spending for Medicare Part D beneficiaries at $2,000 annually, a "milestone" that provides much-needed financial relief to patients with cancer; and

Whereas, despite these positive patient-facing provisions, the Association for Clinical Oncology (ASCO) and other medical organizations share concerns that the IRA's drug price negotiation program could negatively impact patient access, particularly to drugs covered under Medicare Part B which includes many infused and injectable oncology therapies; and

Whereas, ASCO has warned that the potential reimbursement reductions for provider-administered drugs under the IRA's negotiation program could threaten the sustainability of community-based cancer care practices; and

Whereas, Medicare drug negotiation is expected to expand to Part B plans in 2029, which is the primary payment mechanism for many physician-administered medications, including a substantial portion of cancer therapies; therefore be it

RESOLVED, that our American Medical Association will work with relevant stakeholders to conduct a comprehensive study on the impact of the Inflation Reduction Act's (IRA) drug price negotiation provisions, particularly for drugs covered under Medicare Part B and physician-administered drugs due to concerns it could jeopardize patient access to critical therapies as the IRA's potential for reimbursement reductions may lead to less availability of these medications in smaller, community-based clinics where a significant amount of care is provided (Directive to Take Action); and be it further

RESOLVED, that our AMA will specifically evaluate the potential impact on the sustainability of community-based physician practices, with a particular focus on oncology practices (Directive to Take Action); and be it further

RESOLVED, that our AMA will consider using the findings of this study to inform its advocacy efforts to ensure that any future drug pricing policies balance patient affordability with the stability of physician practices, patient access, and the continued advancement of drug innovation. (Directive to Take Action).

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

Received: 9/30/25

**REFERENCES**

1. AMA CMS Report 6-A-25 Prescription Medication Price Negotiation (Resolution 113-A-24)
2. FAQs about the Inflation Reduction Act's Medicare Drug Price Negotiation Program | KFF
3. ASCO Position Statement: Out-of-Pocket Costs for Cancer Care
4. Four Cancer Drugs Included in Next Round of Part D Drug Price Negotiation - ASCO

## RELEVANT AMA POLICY

**Prescription Medication Price Negotiation H-110.959**

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

**Prescription Drug Prices and Medicare D-330.954**

1. Our American Medical Association will support federal legislation which gives the Secretary of the Department of Health and Human Services the authority to negotiate contracts with manufacturers of covered Part D drugs.
2. Our AMA will work toward eliminating Medicare prohibition on drug price negotiation.
3. Our AMA will prioritize its support for the Centers for Medicare & Medicaid Services to negotiate pharmaceutical pricing for all applicable medications covered by CMS.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 236
(I-25)

Introduced by: College of American Pathologists

Subject: Deceptive Advertising in Accredited Allied Health Professional, Non-Physician Graduate Programs

Referred to: Reference Committee B

---

Whereas, our AMA advocates for 'Truth & Transparency' legislation to combat medical title misappropriation ensuring non-physicians clearly and accurately state their level of training, credentials, and board licensure in patient interactions, advertising, and marketing materials[1]; and

Whereas, the "Truth & Transparency" legislation currently advocated by our AMA, under current AMA policy, does not directly address deceptive advertising by accredited allied health professional, non-physician graduate programs; and

Whereas, Pathologists' Assistants serve an important role in the Pathologist-led laboratory healthcare team; and

Whereas, numerous universities offering NAACLS-accredited Pathologists' Assistants educational programs, are deceptively advertising the scope of practice of Pathologists' Assistants as independent practice to prospective students while dismissing and omitting physician supervision; and

Whereas, universities have inaccurately advertised that Pathologists' Assistants are 'advanced practitioners' and have claimed that Pathologists' Assistants can and will prospectively expand their scope of practice autonomy; and

Whereas, such misleading advertising can lead a potential student to select a career that may not reflect their talents and career goals, whereby other healthcare career choices may better serve the student, and ultimately the healthcare system; and

Whereas, deceptive advertising by universities to prospective students inaccurately characterize the appropriate, accepted, standard scope of practice for Pathologists' Assistants and thereby may lead to future lobbying efforts to permit independent practice of Pathologists' Assistants which is not in the best interest of patient diagnosis and care; and

Whereas, states such as Texas[3] have introduced legislation that states that a person who provides a post graduate health education program for a healing art that is regulated under this title may not use the term "residency" or fellowship" in the name of the program unless the program is intended for physicians, dentists, podiatrist or pharmacist; therefore be it

RESOLVED, that our AMA support state and national medical societies to advance "Truth & Transparency" legislation, inclusive of accredited allied health professional, non-physician graduate education programs to instill transparency in non-physicians' scope of practice and training under the direction of a licensed physician (New HOD Policy); and be it further

RESOLVED, that Our AMA advocate for legislation and refinements to "Truth & Transparency" laws to prohibit production and dissemination of deceptive advertising and marketing materials by accredited allied health professional, non-physician graduate programs. These requirements should:

1. Prohibit deceptive, misleading or false advertising inclusive of professional titles and scope of the allied health professional completing the program.
2. Require that the advertised course of study at such programs is clearly consistent with applicable state laws and well-established and widely accepted medical standards for allied health professionals' training, certification, and scope of practice.
3. Mandate all advertising materials include clear and unambiguous statements that clarify the requisite levels of physician supervision for non-physician, allied health professionals, that will complete the program. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/30/25

**REFERENCES**

1. https://policysearch.ama-assn.org/policyfinder/detail/truth in advertising?uri=%2FAMADoc%2Fdirectives.xml-D-405.974.xml
2. https://policysearch.ama-assn.org/policyfinder/detail/truth in advertising?uri=%2FAMADoc%2FHOD.xml-H-405.951.xml
3. https://capitol.texas.gov/BillLookup/History.aspx?LegSess=89R&Bill=SB2181

**RELEVANT AMA POLICY**

**H-175.992 Deceptive Health Care Advertising | AMA**
**D-405.974 Clarification of Healthcare Physician Identification: | AMA**
**H-405.951 Definition and Use of the Term Physician | AMA**

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 237
(I-25)

Introduced by: California, Idaho, New Mexico

Subject: Protecting and Improving Rural Health

Referred to: Reference Committee B

---

Whereas, rural communities already suffering from physician shortages, hospitals closures, less health insurance coverage, and thus, higher rates of chronic disease and age-adjusted mortality are at even greater risk with the significant $1 trillion in Medicaid and Affordable Care Act (ACA) funding cuts (CBO) recently imposed by Congress through the passage of HR 1; and

Whereas, to mitigate some of these cuts, Congress enacted the Rural Health Transformation Program that provides $50 billion to states to address rural health care challenges; and

Whereas, given that more than half of rural adults and children are either on Medicaid, the ACA or uninsured, and up to 14 million Medicaid and ACA enrollees could lose coverage nationwide under HR 1 (CBO), the need for AMA to provide leadership and assistance to rural physicians and communities is even greater; and

Whereas, while the AMA has extensive policy on improving rural health provider shortages, infrastructure, health care disparities, and access to care, this resolution includes additional specific policies that are warranted to augment AMA's rural health advocacy; and

Whereas, 54% of rural residents report that access to medical specialists is a problem in their community and telehealth has helped to address some physician shortages, provide access to specialty care, and reduce patient burden of traveling long distances to receive care;[2] and

Whereas, rural hospitals that have difficulty retaining subspecialists have developed telehealth programs in coordination with larger urban hospitals that allow them to consult on patient care as needed and treat complex patients at local facilities - helping patients avoid the cost and time associated with traveling long distances to larger medical centers;[3] and

Whereas, some patients cannot get the services they need via telehealth and need a variety of less costly transportation options to help them access physicians outside their communities - as rural residents, compared with urban residents who lack transportation feel that the distance to receive care (50% vs. 37%) is a significant barrier to obtaining care;[2] and

Whereas, a GAO analysis found that the availability of health care providers in counties with rural hospital closures was lower and declined more over time when compared to counties without rural hospital closures and a Health Affairs study found that the availability of physicians and the viability of hospitals are related which makes the argument that more should be done to sustain rural physician practices to protect the entire health care system in rural areas;[4] and

Whereas, there is evidence that administrative requirements, which are a challenge for physicians regardless of setting, can impose additional challenges for physicians in rural areas,

such as a 2018 GAO study of Medicare quality improvement programs that found small and rural practices were more likely to receive a negative payment adjustment citing lack of technology, financial resources to hire staff to manage the programs, and limited capacity to monitor program requirements which ultimately led to 18% of rural physician practices being penalized in the Medicare quality payment program in 2022;[5,6] and

Whereas, for example, a California Department of Health Services study found that providers in rural areas don't have access to basic health information technology or networks to engage in data exchange and while there is wide adoption of EHRs among physicians, physicians who had not adopted EHRs were more likely to be in rural or solo practice;[7] and

Whereas, while AMA is working to reduce the administrative burdens in the Medicare Merit-Based Incentive Payment System (MIPS), rural practices need more direct financial assistance to modernize; and

Whereas, counties that lack maternity care resources, have no hospitals or birth centers offering obstetric care, or have no obstetric providers, are called maternity care deserts, or "OB deserts; more than half of current rural hospitals in the United States lack a maternity ward and according to the Center for Healthcare Quality and Payment Reform (CHQPR), more than 700 rural hospitals in 2025 were at risk of closure due to financial problems;[9,10] and

Whereas, hospital administrators cite a number of reasons for the closures, including high costs, labor shortages, low public and private reimbursement, and declining birth rates. Labor and delivery units are one of the most expensive departments for hospitals to maintain, second only to emergency departments;[11,12] and

Whereas, a study by the American Journal of Public Health that looked at adverse maternal outcomes in rural and urban areas across the country found that pregnant individuals residing in rural areas experienced slightly increased rates of Intensive Care Unit admissions and maternal mortality rates almost twice the rate of individuals in urban areas;[13] and

Whereas, a CHQPR study shows that half of the patients in rural hospitals have private insurance and in most cases it is the amount that private insurance pays, not Medicaid that determines whether a rural hospital loses money. To preserve and enhance essential hospital services in rural areas, CHQPR recommends that small rural hospitals receive Standby Capacity Payments from both public and private payers to cover the hospital's fixed costs for maintaining essential services and access to necessary care;[14] and

Whereas, even states with high numbers of OB-GYNs have a geographic maldistribution within states. One opportunity to expand the number of physicians providing maternity care in rural areas is to increase the number of Family Practice Obstetricians which is a medical specialty that provides full obstetrical care as part of family practice. Family physicians complete a Family Practice Obstetrics fellowship and other requirements to become board certified in Family Medicine Obstetrics through the American Board of Physician Specialties (ABPS); and

Whereas, according to a 2024 National Public Radio (NPR) investigation, half of the active duty U.S. military installations are located in federally designated health professional shortage areas (HPSAs), including maternal care deserts and as the military has downsized and outsourced health care over the last decade to private physicians and hospitals, military personnel and their

families cannot find physicians accepting new patients, exacerbating the health care demands and access to care problems in rural areas;[15] and

Whereas, the military is also contracting with more people to provide services on military bases, such as janitorial cleaning staff, rather than hiring them as employees and many of these people are low-income, uninsured women who need maternal health care but can't obtain it on or near the base; and

Whereas, many states have examples of successful maternal care models, such as the California Maternal Quality Care Collaborative (CMQCC) created by Stanford University School of Medicine in partnership with the State of California and multiple stakeholder organizations that used research, data, toolkits and outreach to reduce maternal mortality by 65% from 2006-2016;[16] and

Whereas, there is a need to creatively engage in efforts to ensure that pregnant patients in rural regions have access to the care necessary to ensure healthy outcomes for both baby and mother; therefore be it

RESOLVED, that our American Medical Association assist state medical associations, specialty societies and physician practices with the implementation of HR 1, The One Big Beautiful Bill Act, to mitigate the negative impact of the Medicaid, ACA and student loan cuts to physicians and patients, particularly in rural areas (Directive to Take Action); and be it further

RESOLVED, that our AMA continue to assist state medical associations and physician practices with the HR 1 implementation of the Rural Transformation Program to ensure funding and assistance for physician practices (Directive to Take Action); and be it further

RESOLVED, that our AMA support the provision and payment of physician-to-physician virtual telehealth consultations as an option to increase access to primary and specialty care in rural communities, acknowledging that significant investments in rural telehealth broadband must be made in order to effectively deliver telehealth services (New HOD Policy); and be it further

RESOLVED, that our AMA encourage the development of programs and financial assistance models for rural physician practices in need of health information technology and other technological modernization and security, as well as access to specialty equipment to provide quality care (New HOD Policy); and be it further

RESOLVED, that our AMA support investments in and payment for a wide variety of medical transportation options to connect rural residents to primary and specialty care services and return to their communities (New HOD Policy); and be it further

RESOLVED, that our AMA continue to address the nation's obstetrics and gynecology training and workforce needs, including but not limited to increasing postgraduate positions in OB-GYN and family medicine OB fellowships, increasing ACGME funding, and evaluating other ways to increase physicians providing OB-GYN services in shortage areas (Directive to Take Action); and be it further

RESOLVED, that our AMA support expansion of Family Practice Obstetricians (FPOB) who are family practice physicians that are certified after completing an obstetrics fellowship (New HOD Policy); and be it further

RESOLVED, that our AMA urge the Centers for Medicare and Medicaid Services and others to provide funding for standby capacity payments to sustain obstetric services at hospitals at risk of closing access to maternity care (New HOD Policy); and be it further

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

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

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

Received: 9/30/25

**REFERENCES**

1. Access to Care [Issue Brief], AMERICAN MEDICAL ASSOCIATION (2024), available at https://www.ama-assn.org/system/files?check_logged_in=1&file=issue-brief-access-to-care.pdf.
2. Confronting Rural America's Health Care Crisis, BIPARTISAN POLICY CENTER RURAL HEALTH TASK FORCE (April 2020), available at https://bipartisanpolicy.org/report/confronting-rural-americas-health-care-crisis/.
3. Tate Hinkle, Telemedicine Filling Gap for Rural Community, AMERICAN ACADEMY OF FAMILY PHYSICIANS (September 10, 2019), available at https://www.aafp.org/news/blogs/freshperspectives/entry/20190910fp- telemedicine.html/.
4. Rural Hospital Closures: Affected Residents Had Reduced Access to Health Care Services, GOVERNMENT ACCOUNTABILITY OFFICE.
5. Small and Rural Practices' Experiences in Previous Programs and Expected Performance in the Merit-based Incentive Payment System, GOVERNMENT ACCOUNTABILITY OFFICE (December 22, 2020), available at https://www.gao.gov/assets/gao-18-428.pdf.
6. Tanya Albert Henry. It's time to revamp Medicare's broken MIPS program, AMERICAN MEDICAL ASSOCIATION (July 8, 2024), available at https://www.ama-assn.org/practice-management/payment-delivery-models/it-s-time- revamp-medicare-s-broken-mips-program.
7. California Data Exchange Landscape, CALIFORNIA HEALTH AND HUMAN SERVICES (July 1, 2022), available at https://www.cdii.ca.gov/wp-content/uploads/2023/01/3_CalHHS_DxF_California-Data-Exchange- Landscape_Final_v1_07-01-2022.pdf.
8. Beatty, K., Heffernan, M., Hale, N., & Meit, M. (2020). Funding and service delivery in rural and urban local US health departments in 2010 and 2016. American Journal of Public Health, 110, 1293-1299. https://doi.org/10.2105/AJPH.2020.305757.
9. Maternity Care Deserts" March of Dimes, September 5, 2024. https://www.marchofdimes.org/peristats/data?top=23
10. Tony Leys. Rural Hospitals Built During Baby Boom Are Now Face a Baby Bust. California Healthline. July 15, 2024.Rural Hospitals Built During Baby Boom Now Face Baby Bust - California Healthline.
11. Tony Leys. Rural Hospitals Built During Baby Boom Are Now Face a Baby Bust. California Healthline. July 15, 2024. Rural Hospitals Built During Baby Boom Now Face Baby Bust - California Healthline.
12. Kristen Hwang, Ana B. Ibarra, & Erica Yee. Vast Stretches of California Lose Maternity Care as Dozens of Hospitals Shut Labor Wards, CALMATTERS. November 15, 2023. https://calmatters.org/health/2023/11/california-hospitals-close-maternity-wards/
13. Kristen Hwang, Ana B. Ibarra, & Erica Yee. Vast Stretches of California Lose Maternity Care as Dozens of Hospitals Shut Labor Wards, CALMATTERS. November 15, 2023. https://calmatters.org/health/2023/11/california-hospitals-close-maternity-wards/
14. Gamble, Molly. 703 Hospitals at Risk of Closure, State by State. Becker's Hospital Review. August 5, 2024. 703 hospitals at risk of closure, state by state (beckershospitalreview.com).
15. https://www.npr.org/2024/06/17/nx-s1-4991098/50-of-u-s-military-bases-are-in-a-health-care-desert-npr-probe-finds#:~:text=Transcript-,An%20ongoing%20NPR%20investigation%20into%20military%20health%20care%20reveals%20that,this%20map%20at%20npr.org.;
16. Toolkits. California Maternal Quality Care Collaborative. https://www.cmqcc.org/resources-tool-kits/toolkits.

**RELEVANT AMA POLICY**

**D-190-969 Rural Hospital Payment Models**
1. Our American Medical Association supports and encourages efforts to develop and implement proposals for improving payment models to rural hospitals.
2. Our AMA will report back no later than the 2026 Annual Meeting on data analysis and appropriate recommendations for improved rural hospital payments based on innovative payment models such as the Pennsylvania Rural H
ealth Model (PARHM).

**D-465.994 New Reimbursement System Needed for Rural Hospital Survival**
Our AMA will study the issue and report back the best options for achieving a new reimbursement system for rural hospital survival in our country.

**H-130-954 Non-Emergent Patient Transportation Systems**
Our AMA: (1) supports the education of physicians, first responders, and the public about the costs associated with inappropriate use of emergency patient transportation systems; and (2) encourages the development of non-emergency patient transportation systems that are affordable to the patient, thereby ensuring cost effective and accessible health care for all patients.

**H-160.885 Impact of Integration and Consolidation on Patients and Physicians**
3. Our American Medical Association will continue to monitor the impact of **hospital**-physician practice and **hospital**-**hospital** mergers and **acquisitions** on health care prices and spending, patient access to care, potential changes in patient quality outcomes, and physician wages and labor.
4. Our AMA will continue to monitor how provider mix may change following mergers and **acquisitions** and how non-compete clauses may impact patients and physicians.
5. Our AMA will support efforts to collect relevant information regarding **hospital**-physician practice and **hospital**-**hospital** mergers and **acquisitions** in states or regions that may fall below the Federal Trade Commission (FTC)/Department of Justice review threshold.
6. Our AMA will encourage state and local medical associations, state specialty societies, and physicians to contact their state attorney general with concerns of anticompetitive behavior.
7. Our AMA will encourage physicians to share their experiences with mergers and **acquisitions**, such as those between hospitals and/or those between hospitals and physician practices, with the FTC via their online submission form.

**H-200.949 Principles & Actions to Address Primary Care Workforce**
1. Our patients require a sufficient, well-trained supply of primary care physicians--family physicians, general internists, general pediatricians, and obstetricians/gynecologists--to meet the nation's current and projected demand for health care services.
2. To help accomplish this critical goal, our American Medical Association (AMA) will work with a variety of key stakeholders, to include federal and state legislators and regulatory bodies; national and state specialty societies and medical associations, including those representing primary care fields; and accreditation, certification, licensing, and regulatory bodies from across the continuum of medical education (undergraduate, graduate, and continuing medical education).
3. Through its work with these stakeholders, our AMA will encourage development and dissemination of innovative models to recruit medical students interested in primary care, train primary care physicians, and enhance both the perception and the reality of primary care practice, to encompass the following components: a) Changes to medical school admissions and recruitment of medical students to primary care specialties, including counseling of medical students as they develop their career plans; b) Curriculum changes throughout the medical education continuum; c) Expanded financial aid and debt relief options; d) Financial and logistical support for primary care practice, including adequate reimbursement, and enhancements to the practice environment to ensure professional satisfaction and practice sustainability; and e) Support for research and advocacy related to primary care.
4. Admissions and recruitment: The medical school admissions process should reflect the specific institution's mission. Those schools with missions that include primary care should consider those predictor variables among applicants that are associated with choice of these specialties.
5. Medical schools, through continued and expanded recruitment and outreach activities into secondary schools, colleges, and universities, should develop and increase the pool of applicants likely to practice

primary care by seeking out those students whose profiles indicate a likelihood of practicing in primary care and underserved areas, while establishing strict guidelines to preclude discrimination.
6. Career counseling and exposure to primary care: Medical schools should provide to students career counseling related to the choice of a primary care specialty, and ensure that primary care physicians are well-represented as teachers, mentors, and role models to future physicians.
7. Financial assistance programs should be created to provide students with primary care experiences in ambulatory settings, especially in underserved areas. These could include funded preceptorships or summer work/study opportunities.
8. Curriculum: Voluntary efforts to develop and expand both undergraduate and graduate medical education programs to educate primary care physicians in increasing numbers should be continued. The establishment of appropriate administrative units for all primary care specialties should be encouraged.
9. Medical schools with an explicit commitment to primary care should structure the curriculum to support this objective. At the same time, all medical schools should be encouraged to continue to change their curriculum to put more emphasis on primary care.
10. All four years of the curriculum in every medical school should provide primary care experiences for all students, to feature increasing levels of student responsibility and use of ambulatory and community-based settings.
11. Federal funding, without coercive terms, should be available to institutions needing financial support to expand resources for both undergraduate and graduate medical education programs designed to increase the number of primary care physicians. Our AMA will advocate for public (federal and state) and private payers to a) develop enhanced funding and related incentives from all sources to provide education for medical students and resident/fellow physicians, respectively, in progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model) to enhance primary care as a career choice; b) fund and foster innovative pilot programs that change the current approaches to primary care in undergraduate and graduate medical education, especially in urban and rural underserved areas; and c) evaluate these efforts for their effectiveness in increasing the number of students choosing primary care careers and helping facilitate the elimination of geographic, racial, and other health care disparities.
12. Medical schools and teaching hospitals in underserved areas should promote medical student and resident/fellow physician rotations through local family health clinics for the underserved, with financial assistance to the clinics to compensate their teaching efforts.
13. The curriculum in primary care residency programs and training sites should be consistent with the objective of training generalist physicians. Our AMA will encourage the Accreditation Council for Graduate Medical Education to (a) support primary care residency programs, including community hospital-based programs, and (b) develop an accreditation environment and novel pathways that promote innovations in graduate medical education, using progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model).
14. The visibility of primary care faculty members should be enhanced within the medical school, and positive attitudes toward primary care among all faculty members should be encouraged.
15. Support for practicing primary care physicians: Administrative support mechanisms should be developed to assist primary care physicians in the logistics of their practices, along with enhanced efforts to reduce administrative activities unrelated to patient care, to help ensure professional satisfaction and practice sustainability.
16. There should be increased financial incentives for physicians practicing primary care, especially those in rural and urban underserved areas, to include scholarship or loan repayment programs, relief of professional liability burdens, and Medicaid case management programs, among others. Our AMA will advocate to state and federal legislative and regulatory bodies, among others, for development of public and/or private incentive programs, and expansion and increased funding for existing programs, to further encourage practice in underserved areas and decrease the debt load of primary care physicians. The imposition of specific outcome targets should be resisted, especially in the absence of additional support to the schools.
17. Our AMA will continue to advocate, in collaboration with relevant specialty societies, for the recommendations from the AMA/Specialty Society RVS Update Committee (RUC) related to reimbursement for E&M services and coverage of services related to care coordination, including patient education, counseling, team meetings and other functions; and work to ensure that private payers fully recognize the value of E&M services, incorporating the RUC-recommended increases adopted for the most current Medicare RBRVS.

18. Our AMA will advocate for public (federal and state) and private payers to develop physician reimbursement systems to promote primary care and specialty practices in progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model consistent with current AMA Policies H-160.918 and H-160.919.
19. There should be educational support systems for primary care physicians, especially those practicing in underserved areas.
20. Our AMA will urge urban hospitals, medical centers, state medical associations, and specialty societies to consider the expanded use of mobile health care capabilities.
21. Our AMA will encourage the Centers for Medicare & Medicaid Services to explore the use of telemedicine to improve access to and support for urban primary care practices in underserved settings.
22. Accredited continuing medical education providers should promote and establish continuing medical education courses in performing, prescribing, interpreting and reinforcing primary care services.
23. Practicing physicians in other specialties--particularly those practicing in underserved urban or rural areas--should be provided the opportunity to gain specific primary care competencies through short-term preceptorships or postgraduate fellowships offered by departments of family medicine, internal medicine, pediatrics, etc., at medical schools or teaching hospitals. In addition, part-time training should be encouraged, to allow physicians in these programs to practice concurrently, and further research into these concepts should be encouraged.
24. Our AMA supports continued funding of Public Health Service Act, Title VII, Section 747, and encourages advocacy in this regard by AMA members and the public.
25. Research: Analysis of state and federal financial assistance programs should be undertaken, to determine if these programs are having the desired workforce effects, particularly for students from disadvantaged groups and those that are underrepresented in medicine, and to gauge the impact of these programs on elimination of geographic, racial, and other health care disparities. Additional research should identify the factors that deter students and physicians from choosing and remaining in primary care disciplines. Further, our AMA should continue to monitor trends in the choice of a primary care specialty and the availability of primary care graduate medical education positions. The results of these and related research endeavors should support and further refine AMA policy to enhance primary care as a career choice.

**H-200.954 U.S. Physician Shortages**
1. Our AMA explicitly recognizes the existing shortage of physicians in many specialties and areas of the US.
2. Our AMA supports efforts to quantify the geographic maldistribution and physician shortage in many specialties.
3. Our AMA supports current programs to alleviate the shortages in many specialties and the maldistribution of physicians in the US.
4. Our AMA encourages medical schools and residency programs to consider developing admissions policies and practices and targeted educational efforts aimed at attracting physicians to practice in underserved areas and to provide care to underserved populations.
5. Our AMA encourages medical schools and residency programs to continue to provide courses, clerkships, and longitudinal experiences in rural and other underserved areas as a means to support educational program objectives and to influence choice of graduates' practice locations.
6. Our AMA encourages medical schools to include criteria and processes in admission of medical students that are predictive of graduates' eventual practice in underserved areas and with underserved populations.
7. Our AMA will continue to advocate for funding from public and private payers for educational programs that provide experiences for medical students in rural and other underserved areas.
8. Our AMA will continue to advocate for funding from all payers (public and private sector) to increase the number of graduate medical education positions in specialties leading to first certification.
9. Our AMA will work with other groups to explore additional innovative strategies for funding graduate medical education positions, including positions tied to geographic or specialty need.
10. Our AMA continues to work with the Association of American Medical Colleges (AAMC) and other relevant groups to monitor the outcomes of the National Resident Matching Program; and
11. Our AMA continues to work with the AAMC and other relevant groups to develop strategies to address the current and potential shortages in clinical training sites for medical students.
12. Our AMA will:

a. promote greater awareness and implementation of the Project ECHO (Extension for Community Healthcare Outcomes) and Child Psychiatry Access Project models among academic health centers and community-based primary care physicians;
b. work with stakeholders to identify and mitigate barriers to broader implementation of these models in the United States; and
c. monitor whether health care payers offer additional payment or incentive payments for physicians who engage in clinical practice improvement activities as a result of their participation in programs such as Project ECHO and the Child Psychiatry Access Project; and if confirmed, promote awareness of these benefits among physicians.

13. Our AMA will work to augment the impact of initiatives to address rural physician workforce shortages.
14. Our AMA supports opportunities to incentivize physicians to select specialties and practice settings which involve delivery of health services to populations experiencing a shortage of providers, such as women, LGBTQ+ patients, children, elder adults, and patients with disabilities, including populations of such patients who do not live in underserved geographic areas.

**H-200.955 Revision to AMA Policy on Physician Workforce**
It is our American Medical Association policy that:
1. Any workforce planning efforts, done by our AMA or others, should utilize data on all aspects of the health care system, including projected demographics of both providers and patients, the number and roles of other health professionals in providing care, and practice environment changes. Planning should have as a goal appropriate physician numbers, specialty mix, and geographic distribution.
2. Our AMA encourages and collaborates in the collection of the data needed for workforce planning and in the conduct of national and regional research on physician supply and distribution. The AMA will independently and in collaboration with state and specialty societies, national medical organizations, and other public and private sector groups, compile and disseminate the results of the research.
3. The medical profession must be integrally involved in any workforce planning efforts sponsored by federal or state governments, or by the private sector.
4. In order to enhance access to care, our AMA collaborates with the public and private sectors to ensure an adequate supply of physicians in all specialties and to develop strategies to mitigate the current geographic maldistribution of physicians.
5. There is a need to enhance underrepresented minority representation in medical schools and in the physician workforce, as a means to ultimately improve access to care for minority and underserved groups.
6. There should be no decrease in the number of funded graduate medical education (GME) positions. Any increase in the number of funded GME positions, overall or in a given specialty, and in the number of US medical students should be based on a demonstrated regional or national need.
7. Our AMA will collect and disseminate information on market demands and workforce needs, so as to assist medical students and resident physicians in selecting a specialty and choosing a career.
8. Our AMA will encourage the Health Resources & Service Administration to collaborate with specialty societies to determine specific changes that would improve the agencys physician workforce projections process, to potentially include more detailed projection inputs, with the goal of producing more accurate and detailed projections including specialty and subspecialty workforces.
9. Our AMA will consider physician retraining during all its deliberations on physician workforce planning.

**H-200.972 Primary Care Providers in Underserved Areas**
1. Our American Medical Association should pursue the following plan to improve the recruitment and retention of physicians in underserved areas:
a. encourage the creation and pilot-testing of school-based, faith-based, and community-based urban/rural family health clinics, with an emphasis on health education, prevention, primary care, and prenatal care;
b. encourage the affiliation of these family health clinics with local medical schools and teaching hospitals;
c. advocate for the implementation of AMA policy that supports extension of the rural health clinic concept to urban areas with appropriate federal agencies;
d. encourage the AMA Senior Physicians Section to consider the involvement of retired physicians in underserved settings, with appropriate mechanisms to ensure their competence;
e. urge hospitals and medical societies to develop opportunities for physicians to work part-time to staff health clinics that help meet the needs of underserved patient populations;

f. encourage the AMA and state medical associations to incorporate into state and federal health system reform legislative relief or immunity from professional liability for senior, part-time, or other physicians who help meet the needs of underserved patient populations and

g. urge hospitals and medical centers to seek out the use of available military health care resources and personnel, which can be used to help meet the needs of underserved patient populations.

2. Our AMA supports efforts to:

a. expand opportunities to retain international medical graduates after the expiration of allocated periods under current law; and

b. increase the recruitment and retention of physicians practicing in federally designated health professional shortage areas.

**H-215.960 Hospital Consolidation**

1. Our American Medical Association affirms that:

a. Health care entity mergers should be examined individually, taking into account case-specific variables of market power and patient needs.

b. The AMA strongly supports and encourages competition in all health care markets.

c. The AMA supports rigorous review and scrutiny of proposed mergers to determine their effects on patients and providers.

d. Antitrust relief for physicians remains a top AMA priority.

2. Our AMA will continue to support actions that promote competition and choice, including:

a. Eliminating state certificate of need laws.

b. Repealing the ban on physician-owned hospitals.

c. Reducing administrative burdens that make it difficult for physician practices to compete.

d. Achieving meaningful price transparency.

3. Our AMA will work with interested state medical associations to monitor hospital markets, including rural, state, and regional markets, and review the impact of horizontal and vertical health system integration on patients, physicians and hospital prices.

**H-215.969 Hospital Merger Study**

1. It is the policy of the AMA that, in the event of a **hospital** merger, acquisition, consolidation, or affiliation, a joint committee with merging medical staffs should be established to resolve at least the following issues:

(A) medical staff representation on the board of directors;
(B) clinical services to be offered by the institutions;
(C) process for approving and amending medical staff bylaws;
(D) selection of the medical staff officers, medical executive committee, and clinical department chairs;
(E) credentialing and recredentialing of physicians and limited licensed providers;
(F) quality improvement;
(G) utilization and peer review activities;
(H) presence of exclusive contracts for physician services and their impact on physicians' clinical privileges;
(I) conflict resolution mechanisms;
(J) the role, if any, of medical directors and physicians in joint ventures;
(K) control of medical staff funds;
(L) successor-in-interest rights;
(M) that the medical staff bylaws be viewed as binding contracts between the medical staffs and the hospitals; and

3. Our AMA will work to ensure, through appropriate state oversight agencies, that where **hospital** mergers and **acquisitions** may lead to restrictions on reproductive health care services, the merging entity shall be responsible for ensuring continuing community access to these services.

**H-350.937 Improving Health Care of Minority Communities in Rural Areas**

1. Our AMA encourages health promotion, access to care, and disease prevention through educational efforts and publications specifically tailored to **minority communities in rural areas**.

2. Our AMA encourages enhanced understanding by federal, state and local governments **of** the unique health and health-related needs, including mental health, **of minority communities in rural areas in** an effort to improve their quality **of** life.

3. Our AMA encourages the collection **of** vital statistics and other relevant demographic data **of minority communities in rural areas**.
4. Our AMA will advise organizations **of** the importance **of minority** health **in rural areas**.
5. Our AMA will channel existing policy for telehealth to support improved broadband internet access **in minority communities in rural areas** to increase the availability **of** telemedicine where clinically appropriate.
6. Our AMA supports **minority** health **in rural areas** through programming, equity initiatives, and other representation efforts.
7. Our AMA encourages the development **of** strategies and mechanisms for **communities** to share resources and best practices to serve their **rural minority** populations.

**H-420.946 Advancing Evidence-Based Strategies to Improve Rural Obstetrical Health Care and Access**
8. Our American Medical Association strongly supports federal legislation that provides funding for the creation and implementation of a national obstetric emergency training program for rural health care facilities with and without a dedicated labor and delivery unit.
9. Our AMA supports the expansion and implementation of innovative obstetric telementoring/teleconsultation models to address perinatal health disparities and improve access to evidence-informed perinatal care in rural communities.
10. Our AMA encourages academic medical centers and health systems to actively participate in obstetric telementoring/teleconsultation models to support rural physicians and nonphysician practitioners who provide obstetric care as part of a physician-led team and improve perinatal health outcomes in rural communities.
11. Our AMA supports ongoing research to evaluate the effectiveness of national implementation of obstetric telementoring/teleconsultation models to improve rural perinatal health outcomes and reduce rural-urban health disparities.

**H-465-977 FQHCs and Rural Health Clinic Care**
1. Our American Medical Association supports certification requirements and other policies that reduce the administrative burden for physicians practicing in Federally Qualified Health Center (FQHCs).
2. Our AMA supports sufficient federal funding to maintain the operation and costs associated with establishing and operating a FQHC, FQHC “Look- Alike”, or Outpatient Tribal Facility.
3. Our AMA advocates for regular updates to the Medicaid FQHC Prospective Payment System that at least keep pace with inflation.

**H-465-981 Enhancing Rural Physician Practices**
1. Our American Medical Association supports legislation to extend the 10% Medicare payment bonus to physicians practicing in rural counties and other areas where the poverty rate exceeds a certain threshold, regardless of the areas' Health Professional Shortage Area (HPSA) status.
2. Our AMA encourages federal and state governments to make available low interest loans and other financial assistance to assist physicians with shortage area practices in defraying their costs of compliance with requirements of the Occupational Safety and Health Administration, Americans with Disabilities Act and other national or state regulatory requirements.
3. Our AMA will explore the feasibility of supporting the legislative and/or regulatory changes necessary to establish a waiver process through which shortage area practices can seek exemption from specific elements of regulatory requirements when improved access, without significant detriment to quality, will result.
4. Our AMA supports legislation that would allow shortage area physician practices to qualify as Rural Health Clinics without the need to employ one or more physician extenders.
5. Our AMA will undertake a study of structural urbanism, federal payment polices, and the impact on rural workforce disparities.

**H-465.988 Educational Strategies for Meetings Rural Health Physician Shortages**
1. In light of the data available from the current literature as well as ongoing studies being conducted by staff, our American Medical Association recommends that:
    a. Our AMA encourage medical schools and residency programs to develop educationally sound rural clinical preceptorships and rotations consistent with educational and training requirements,

and to provide early and continuing exposure to those programs for medical students and residents.

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

2. Our AMA will work with state and specialty societies, medical schools, teaching hospitals, the Accreditation Council for Graduate Medical Education (ACGME), the Centers for Medicare and Medicaid Services (CMS) and other interested stakeholders to identify, encourage and incentivize qualified rural physicians to serve as preceptors and volunteer faculty for rural rotations in residency.
3. Our AMA will:

m. work with interested stakeholders to identify strategies to increase residency training opportunities in rural areas with a report back to the House of Delegates; and
n. work with interested stakeholders to formulate an actionable plan of advocacy with the goal of increasing residency training in rural areas.

4. Our AMA will encourage ACGME review committees to consider adding exposure to rural medicine as appropriate, to encourage the development of rural program tracks in training programs and increase physician awareness of the conditions that pose challenges and lack of resources in rural areas.
5. Our AMA will encourage adding educational webinars, workshops and other didactics via remote learning formats to enhance the educational needs of smaller training programs.

**H-465.994 Improving Rural Health**

1. Our American Medical Association:
   a. supports continued and intensified efforts to develop and implement proposals for improving rural health care and public health,
   b. urges physicians practicing in rural areas to be actively involved in these efforts, and
   c. advocates widely publicizing AMA's policies and proposals for improving rural health care and public health to the profession, other concerned groups, and the public.
2. Our AMA will work with other entities and organizations interested in public health to:
   a. Encourage more research to identify the unique needs and models for delivering public health and health care services in rural communities.
   b. Identify and disseminate concrete examples of administrative leadership and funding structures that support and optimize local, community-based rural public health.
   c. Develop an actionable advocacy plan to positively impact local, community-based rural public health including but not limited to the development of rural public health networks, training of current and future rural physicians and public health professionals in core public health techniques and novel

funding mechanisms to support public health initiatives that are led and managed by local public health authorities.

d. Advocate for adequate and sustained funding for public health staffing and programs

3. Our American Medical Association will work with relevant stakeholders to develop a national strategy to eliminate rural cancer disparities in screening, treatment, and outcomes and achieve health equity in cancer outcomes across all geographic regions.

4. Our AMA calls for increased federal and state funding to support research on rural cancer disparities and equity in care, access, and outcomes and development of interventions to address those disparities.

5. Our AMA advocates for evidence-based collaborative models for innovative telementoring/ teleconsultation between health care systems, academic medical centers, and community physicians to improve access to cancer screening, diagnosis, treatment, rehabilitation, and patient services in rural areas.

**H-465.997 Access to Quality Rural Health Care**

1. Our American Medical Association believes that solutions to access problems in rural areas should be developed through the efforts of voluntary local health planning groups, coordinated at the regional or state level by a similar voluntary health planning entity. Regional or statewide coordination of local efforts will not only help to remedy a particular community's problems, but will also help to avoid and, if necessary, resolve existing duplication of health care resources.

2. In addition to local solutions, our AMA believes that on a national level, the implementation of Association policy for providing the uninsured and underinsured with adequate protection against health care expense would be an effective way to help maintain and improve access to care for residents of economically depressed rural areas who lack adequate health insurance coverage. Efforts to place National Health Service Corps physicians in underserved areas of the country should also be continued.

**H-465.998 Addressing Payment & Delivery in Rural Hospitals**

1. Our American Medical Association will advocate that public and private payers take the following actions to ensure payment to rural hospitals is adequate and appropriate:

a. Create a capacity payment to support the minimum fixed costs of essential services, including surge capacity, regardless of volume.

b. Provide adequate service-based payments to cover the costs of services delivered in small communities.

c. Adequately compensate physicians for standby and on-call time to enable very small rural hospitals to deliver quality services in a timely manner.

d. Use only relevant quality measures for rural hospitals and set minimum volume thresholds for measures to ensure statistical reliability.

e. Hold rural hospitals harmless from financial penalties for quality metrics that cannot be assessed due to low statistical reliability.

f. Create voluntary monthly payments for primary care that would give physicians the flexibility to deliver services in the most effective manner with an expectation that some services will be provided via telehealth or telephone.

2. Our AMA encourages transparency among rural hospitals regarding their costs and quality outcomes.

3. Our AMA supports better coordination of care between rural hospitals and networks of providers where services are not able to be appropriately provided at a particular rural hospital.

4. Our AMA encourages employers and rural residents to choose health plans that adequately and appropriately reimburse rural hospitals and physicians.

**H-478.980 Increasing Access to Broadband**

Our American Medical Association will advocate for the expansion of broadband and wireless connectivity to all rural and underserved areas of the United States while at all times taking care to protecting existing federally licensed radio services from harmful interference that can be caused by broadband and wireless services.

## Reference Committee C

**Report(s) of the Council on Medical Education**

01 Additional Pathways for International Medical Graduates

**Resolutions**

301 Preventing Sleep Deprivation and Supporting Medical Student Wellness

304 Systemic Exclusion of IMGs from Residency Programs

305 Paid Sick Leave and Flexible Work Arrangements for Caregivers of Individuals with Special Needs, Chronic Illness, or Elderly Parents

306 Support for Paid Prenatal Leave

307 Integrating Artificial Intelligence (AI) Literacy Into UME, GME, and CME

308 Enhancing the Pathway for Black Male Medical Students

311 Gender and URiM Disparities in Surgical Training Volumes

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 1-I-25

Subject: Additional Pathways for International Medical Graduates

Presented by: Kelly J. Caverzagie, MD, FACP, FHM

Referred to: Reference Committee C

---

American Medical Association (AMA) Policy D-255.971, "Alternative Pathways for International Medical Graduates," adopted at the 2024 Interim Meeting of the AMA House of Delegates (HOD) asks the following:

1. Our American Medical Association will provide an informational report about the ongoing work around alternate licensing pathways and currently introduced laws and regulations being introduced around the country and their status during the I-25 meeting.
2. Our AMA, following the conclusion of the work of the Advisory Commission on Alternate Licensing Models, will develop educational resources related to alternate licensing models for the AMA HOD and other interested parties.
3. Our AMA will widely distribute the Commission's report and relevant educational content to all AMA members.

This report is submitted to the HOD in response to the directive in the first clause. Since the 2024 Interim Meeting, the Advisory Commission changed its name from "Alternate" to "Additional" Licensing Models. For the purposes of this report, it will be referred to as the "Commission."

BACKGROUND

*Inception and convening*

On March 27, 2024, The Federation of State Medical Boards (FSMB), Intealth™, and the Accreditation Council for Graduate Medical Education (ACGME) announced the establishment of a new Advisory Commission on Alternate Licensing Models "to provide guidance on alternative pathways for state licensure of physicians who have completed training and/or practiced outside of the United States. These are physicians who have graduated from medical school in another country, have completed a post graduate training program substantially similar to those in the U.S., and (in most state requirements) have practiced for a certain period of time. The Commission uses the term "internationally trained physicians." Many of these physicians are international medical graduates (IMGs), encompassing both foreign nationals and U.S. citizens who completed their medical education and training outside the United States and Canada."[1] The intent was to create recommendations to guide state medical boards, legislatures, and policymakers considering state legislation to create additional pathways to licensure or those responsible for implementing legislation that has been enacted. These founding organizations held their first meeting on April 5, 2024, in Washington, D.C. The Commission convened as state legislative activity creating additional pathways to licensure is gaining momentum.

© 2025 American Medical Association. All rights reserved.

This Commission convened a one-day symposium on June 18, 2024, in Washington D.C., attended by more than 175 individuals representing members of the public, state medical licensing boards, and organizations involved with medical education, accreditation, and certification. The symposium "provided a forum for attendees to exchange ideas and discuss considerations for legislative, regulatory, and procedural implementation of such alternative pathways for medical licensure."[2]

A meeting on September 16, 2024, discussed a first set of recommendations. Those draft preliminary recommendations were then released on October 1, 2024, with a focus on eligibility requirements with an open comment period through December 6, 2024, via online survey.[3] The AMA provided comments, which are available on the AMA's Federal and State Correspondence Finder.

*Commission Recommendations*

On February 4, 2025, the Commission released its first set of nine recommendations informed by the feedback from the open comment period; the full document with recommendations is available on the FSMB website:

1. "Rulemaking authority should be delegated, and resources allocated, to the state medical board for implementing and evaluating any additional licensure pathways.
2. An offer of employment should be required for pathway eligibility. State medical boards should be authorized to define what is an appropriate clinical facility for the supervision and assessment of internationally trained physicians (ITPs) for their provisional licensure period.
3. Educational Commission for Foreign Medical Graduates (ECFMG) Certification and graduation from a duly recognized medical school should be required for pathway eligibility.
4. Completion of postgraduate training (graduate medical education) outside the United States should be required for pathway eligibility.
5. Possession of authorization from another country or jurisdiction to lawfully practice medicine in that country or jurisdiction, and at least three years of experience in medical practice should be required for pathway eligibility.
6. A limit on the physician's time "out of practice" that is consistent with that state's existing re-entry to practice requirements should be considered.
7. A successfully completed period of supervision and assessment by an employer should be required of ITPs to transition from provisional licensure to full licensure.
8. State medical boards should preserve their authority to assess each candidate for full and unrestricted licensure.
9. State medical boards implementing additional licensure pathways should collect and share data to evaluate the program's effectiveness."[4]

Following the publication of these recommendations, the Commission announced on May 22, 2025, a call for comments on new draft guidance recommendations specifically regarding the assessment and supervision of internationally-trained physicians seeking licensure in the U.S.[5,6] This second call for comment, open until July 11, 2025, offered eight recommendations addressing specific guidance for the consideration of state medical boards and other relevant parties. The feedback was collected via a survey tool. The AMA appreciates the Commission's efforts to ensure safe, structured pathways for internationally trained physicians. AMA feedback supported the intent of each recommendation while also addressing concerns (e.g., additional burdens put upon rural health care systems, supervising physicians, and small practices; lack of uniform standards

and institutional oversight; unintended consequences) and offering suggestions for improvement to best execute these recommendations.

In July 2025, the Annals of Internal Medicine published an opinion from the leaders of the Commission's founding organizations entitled "Licensing Internationally Trained Physicians: Advisory Commission Leaders Share Initial Progress."[7] An August 2025 press release provided the latest recommendations as well as a toolkit to inform the assessment and supervision of ITPs.[8]

Of note, these are recommendations and do not carry the force of law.

DISCUSSION

*Founders of the Commission*

The FSMB supports state medical boards within the U.S., its territories, and the District of Columbia in protection of the public's health, safety, and welfare. This involves oversight of proper medical regulation, licensing, and disciplining of physicians (as well as physician assistants and other health care professionals). This includes issues and concerns related to internationally trained physicians. As such, the FSMB serves as the primary convener for the Commission.

The Educational Commission for Foreign Medical Graduates (ECFMG) Certification assures the readiness of internationally trained physicians to enter graduate medical education in the U.S. Foundation for Advancement of International Medical Education (FAIMER®) promotes excellence in international health professions education through programmatic and research activities. They partner with other leaders in U.S. medical education to analyze data, develop policies, and create new tools for this audience. In 2021, ECFMG and FAIMER® were joined under the umbrella of Intealth.

The ACGME establishes and oversees the voluntary professional educational standards that are essential to preparing physicians (including those internationally trained) to provide safe and high-quality medical care. They also oversee the accreditation of residency and fellowship programs in the U.S.

*AMA engagement*

The AMA has been actively engaged in the Commission as an adviser since its inception. In addition, the AMA Advocacy and Medical Education business units, in collaboration with the Council on Medical Education and the International Medical Graduates (IMG) Section, has responded to each open comment period provided by the Commission.

The Council on Medical Education (CME) actively monitors issues related to IMGs and authors reports as directed by the House of Delegates. They have included:

- Challenges to Primary Source Verification of International Medical Graduates Resulting from International Conflict (CME 8-A-23)
- Financial Burdens and Exam Fees for International Medical Graduates (CME 3-A-23)
- Expediting Entry of Qualified IMG Physicians to U.S. Medical Practice (CME 4-JUN-21)
- Licensure for International Medical Graduates Practicing in U.S. Institutions with Restricted Medical Licenses (CME 2-JUN-21)

Reports from all Councils are made available to members via the Council Report Finder. The Medical Education unit publishes issue briefs on a variety of timely topics. In 2022, an issue brief was released entitled "Support for IMGs practicing in the U.S."

The Advocacy unit closely monitors any communications or actions by the current Administration as it relates to IMGs. For example:

- They have issued letters of support for the Conrad 30 Waiver Program and the recent Doctors in our Borders Act, which would expand the number of Conrad 30 waivers a state or regional commission can receive from 30 to 100. Such letters and statements are made available to members in the AMA Federal and State Correspondence Finder.
- AMA's Advocacy Update e-newsletter provides timely information which may contain news relevant to IMGs.
- Advocacy also monitors state legislative activity to create additional pathways to licensure for internationally trained physicians. This activity is summarized in a recently updated AMA issue brief entitled "Additional State Licensure Pathways for Internationally Trained Physicians."

Federal immigration issues are not discussed in this report, given ongoing changes by the current administration.

The AMA's IMG Section addresses and advocates for issues that impact international medical graduate physicians. To help IMGs navigate the process of practicing medicine in the United States, the section recently developed a toolkit. The latest information and resources from the IMG Section are available on the AMA website.

News articles and podcasts related to IMGs are also available on the AMA website. Examples of information from as recent as April 2025 include:

- Immigration issues: Visas and green cards
- Starting physician residency as an IMG? 6 tips to ease transition
- Meet Your Match: Tips for IMGs entering U.S. residency with Ricardo Correa, MD

## RELEVANT AMA POLICY

The following policies, available in the AMA Policy Finder, are of relevance to this report. Full policies are listed in the Appendix.

- Abolish Discrimination in Licensure of IMGs H-255.966
- Licensure for International Medical Graduates Practicing in U.S. Institutions with Restricted Medical Licenses D-255.977
- AMA Principles on International Medical Graduates H-255.988
- Alternatives to the Federation of State Medical Boards Recommendations on Licensure H-275.934
- International Medical Graduate Employment H-255.965
- Unfair Discrimination Against International Medical Graduates H-255.978

## CONCLUSION

The AMA will continue to (1) participate in the Advisory Commission on Additional Licensing Models, (2) provide comment on future recommendations, and (3) engage with relevant parties in support of internationally trained physicians.

RECOMMENDATION

The Council on Medical Education recommends that the following be adopted and the remainder of the report be filed.

1. That the first clause of AMA Policy D-255.971, "Alternative Pathways for International Medical Graduates," be rescinded as having been accomplished by this report. (Rescind AMA Policy)

Fiscal note: Minimal

APPENDIX – RELEVANT AMA POLICIES

Abolish Discrimination in Licensure of IMGs H-255.966

1. Our American Medical Association supports the following principles related to medical licensure of international medical graduates (IMGs):
    a. State medical boards should ensure uniformity of licensure requirements for IMGs and graduates of U.S. and Canadian medical schools, including eliminating any disparity in the years of graduate medical education (GME) required for licensure and a uniform standard for the allowed number of administrations of licensure examinations.
    b. All physicians seeking licensure should be evaluated on the basis of their individual education, training, qualifications, skills, character, ethics, experience and past practice.
    c. Discrimination against physicians solely on the basis of national origin and/or the country in which they completed their medical education is inappropriate.
    d. U.S. states and territories retain the right and responsibility to determine the qualifications of individuals applying for licensure to practice medicine within their respective jurisdictions.
    e. State medical boards should be discouraged from a) using arbitrary and non-criteria-based lists of approved or unapproved foreign medical schools for licensure decisions and b) requiring an interview or oral examination prior to licensure endorsement. More effective methods for evaluating the quality of IMGs' undergraduate medical education should be pursued with the Federation of State Medical Boards (FSMB) and other relevant organizations. When available, the results should be a part of the determination of eligibility for licensure.
2. Our AMA will continue to work with the FSMB to encourage parity in licensure requirements for all physicians, whether U.S. medical school graduates or international medical graduates.
3. Our AMA will continue to work with the Educational Commission for Foreign Medical Graduates and other appropriate organizations in developing effective methods to evaluate the clinical skills of IMGs.
4. Our AMA will work with state medical societies in states with discriminatory licensure requirements between IMGs and graduates of U.S. and Canadian medical schools to advocate for parity in licensure requirements, using the AMA International Medical Graduate Section licensure parity model resolution as a resource.
5. Our AMA will:
    a. encourage states to study existing strategies to improve policies and processes to assist IMGs with credentialing and licensure to enable them to care for patients in underserved areas.
    b. encourage the FSMB and state medical boards to evaluate the progress of programs aimed at reducing barriers to licensure--including successes, failures, and barriers to implementation.

Licensure for International Medical Graduates Practicing in U.S. Institutions with Restricted Medical Licenses D-255.977

Our American Medical Association will advocate that qualified international medical graduates have a pathway for licensure by encouraging state medical licensing boards and the member boards of the American Board of Medical Specialties to develop criteria that allow:

1. Completion of medical school and residency training outside the U.S.
2. Extensive U.S. medical practice.
3. Evidence of good standing within the local medical community to serve as a substitute for U.S. graduate medical education requirement for physicians seeking full unrestricted licensure and board certification.

AMA Principles on International Medical Graduates H-255.988

1. Our American Medical Association supports current U.S. visa and immigration requirements applicable to foreign national physicians who are graduates of medical schools other than those in the United States and Canada.
2. Our AMA supports current regulations governing the issuance of exchange visitor visas to foreign national IMGs, including the requirements for successful completion of the USMLE.
3. Our AMA reaffirms its policy that the U.S. and Canada medical schools be accredited by a nongovernmental accrediting body.
4. Our AMA supports cooperation in the collection and analysis of information on medical schools in nations other than the U.S. and Canada.
5. Our AMA supports continued cooperation with the ECFMG and other appropriate organizations to disseminate information to prospective and current students in foreign medical schools. An AMA member, who is an IMG, should be appointed regularly as one of the AMA's representatives to the ECFMG Board of Trustees.
6. Our AMA supports working with the Accreditation Council for Graduate Medical Education (ACGME) and the Federation of State Medical Boards (FSMB) to assure that institutions offering accredited residencies, residency program directors, and U.S. licensing authorities do not deviate from established standards when evaluating graduates of foreign medical schools.
7. In cooperation with the ACGME and the FSMB, our AMA supports only those modifications in established graduate medical education or licensing standards designed to enhance the quality of medical education and patient care.
8. Our AMA continues to support the activities of the ECFMG related to verification of education credentials and testing of IMGs.
9. Our AMA supports that special consideration be given to the limited number of IMGs who are refugees from foreign governments that refuse to provide pertinent information usually required to establish eligibility for residency training or licensure.
10. Our AMA supports that accreditation standards enhance the quality of patient care and medical education and not be used for purposes of regulating physician manpower.
11. Our AMA representatives to the ACGME, residency review committees and to the ECFMG should support AMA policy opposing discrimination. Medical school admissions officers and directors of residency programs should select applicants on the basis of merit, without considering status as an IMG or an ethnic name as a negative factor.
12. Our AMA supports the requirement that all medical school graduates complete at least one year of graduate medical education in an accredited U.S. program in order to qualify for full and unrestricted licensure. State medical licensing boards are encouraged to allow an alternate set of criteria for granting licensure in lieu of this requirement:
    a. completion of medical school and residency training outside the U.S.;
    b. extensive U.S. medical practice; and
    c. evidence of good standing within the local medical community.
13. Our AMA supports publicizing existing policy concerning the granting of staff and clinical privileges in hospitals and other health facilities.
14. Our AMA supports the participation of all physicians, including graduates of foreign as well as U.S. and Canadian medical schools, in organized medicine. Our AMA offers encouragement and assistance to state, county, and specialty medical societies in fostering greater membership among

IMGs and their participation in leadership positions at all levels of organized medicine, including AMA committees and councils, the Accreditation Council for Graduate Medical Education and its review committees, the American Board of Medical Specialties and its specialty boards, and state boards of medicine, by providing guidelines and non-financial incentives, such as recognition for outstanding achievements by either individuals or organizations in promoting leadership among IMGs.

15. Our AMA supports studying the feasibility of conducting peer-to-peer membership recruitment efforts aimed at IMGs who are not AMA members.
16. Our AMA membership outreach to IMGs to include
    a. using its existing publications to highlight policies and activities of interest to IMGs, stressing the common concerns of all physicians;
    b. publicizing its many relevant resources to all physicians, especially to nonmember IMGs;
    c. identifying and publicizing AMA resources to respond to inquiries from IMGs; and
    d. expansion of its efforts to prepare and disseminate information about requirements for admission to accredited residency programs, the availability of positions, and the problems of becoming licensed and entering full and unrestricted medical practice in the U.S. that face IMGs. This information should be addressed to college students, high school and college advisors, and students in foreign medical schools.
17. Our AMA supports recognition of the common aims and goals of all physicians, particularly those practicing in the U.S., and support for including all physicians who are permanent residents of the U.S. in the mainstream of American medicine.
18. Our AMA supports its leadership role to promote the international exchange of medical knowledge as well as cultural understanding between the U.S. and other nations.
19. Our AMA supports institutions that sponsor exchange visitor programs in medical education, clinical medicine and public health to tailor programs for the individual visiting scholar that will meet the needs of the scholar, the institution, and the nation to which he will return.
20. Our AMA supports informing foreign national IMGs that the availability of training and practice opportunities in the U.S. is limited by the availability of fiscal and human resources to maintain the quality of medical education and patient care in the U.S., and that those IMGs who plan to return to their country of origin have the opportunity to obtain GME in the United States.
21. Our AMA supports U.S. medical schools offering admission with advanced standing, within the capabilities determined by each institution, to international medical students who satisfy the requirements of the institution for matriculation.
22. Our AMA supports the Federation of State Medical Boards, its member boards, and the ECFMG in their willingness to adjust their administrative procedures in processing IMG applications so that original documents do not have to be recertified in home countries when physicians apply for licenses in a second state.
23. Our AMA supports continued efforts to protect the rights and privileges of all physicians duly licensed in the U.S. regardless of ethnic or educational background and opposes any legislative efforts to discriminate against duly licensed physicians on the basis of ethnic or educational background.
24. Our AMA supports continued study of challenges and issues pertinent to IMGs as they affect our country's health care system and our physician workforce.
25. Our AMA supports advocacy to Congress to fund studies through appropriate agencies, such as the Department of Health and Human Services, to examine issues and experiences of IMGs and make recommendations for improvements.

Alternatives to the Federation of State Medical Boards Recommendations on Licensure H-275.934

Our American Medical Association adopts the following principles:

1. Ideally, all medical students should successfully complete Steps 1 and 2 of the United States Medical Licensing Examination (USMLE) or Levels 1 and 2 of the Comprehensive Osteopathic Medical Licensing Examination (COMLEX USA) prior to entry into residency training. At a minimum, individuals entering residency training must have successfully completed Step 1 of the USMLE or Level 1 of COMLEX USA. There should be provision made for students who have not completed Step 2 of the USMLE or Level 2 of the COMLEX USA to do so during the first year of residency training.

2. All applicants for full and unrestricted licensure, whether graduates of U.S. medical schools or international medical graduates, must have completed one year of accredited graduate medical education (GME) in the U.S., have passed all state-required licensing examinations (USMLE or COMLEX USA), and must be certified by their residency program director as ready to advance to the next year of GME and to obtain a full and unrestricted license to practice medicine. State medical licensing boards are encouraged to allow an alternate set of criteria for granting licensure in lieu of this requirement for completing one year of accredited GME in the U.S.: (a) completion of medical school and residency training outside the U.S.; (b) extensive U.S. medical practice; and (c) evidence of good standing within the local medical community.
3. There should be a training permit/educational license for all resident physicians who do not yet have a full and unrestricted license to practice medicine. To be eligible for an initial training permit/educational license, the resident must have completed Step 1 of the USMLE or Level 1 of COMLEX USA.
4. Residency program directors shall report only those actions to state medical licensing boards that are reported for all licensed physicians.
5. Residency program directors should receive training to ensure that they understand the process for taking disciplinary action against resident physicians, and are aware of procedures for dismissal of residents and for due process. This requirement for residency program directors should be enforced through Accreditation Council for Graduate Medical Education accreditation requirements.
6. There should be no reporting of actions against medical students to state medical licensing boards.
7. Medical schools are responsible for identifying and remediating and/or disciplining medical student unprofessional behavior, problems with substance abuse, and other behavioral problems. as well as gaps in student knowledge and skills.
8. The Dean's Letter of Evaluation should be strengthened and standardized, to serve as a better source of information to residency programs about applicants.

International Medical Graduate Employment H-255.965
Our American Medical Association will support federal legislation that reduces the administrative burden and streamlines the process of hiring International Medical Graduates.

Unfair Discrimination Against International Medical Graduates H-255.978
It is the policy of the AMA to take appropriate action, legal or legislative, against implementation of Section 4752(d) of the OBRA of 1990 that requires international medical graduates, in order to obtain a Medicaid UPN number, to have held a license in one or more states continuously since 1958, or pass the Foreign Medical Graduate Examination in Medical Sciences (FMGEMS), or pass the Educational Commission for Foreign Medical Graduates (ECFMG) Examination, or be certified by ECFMG.

REFERENCES

1. Accreditation Council for Graduate Medical Education (ACGME). FSMB, Intealth, ACGME Establish Advisory Commission to Guide Alternate Pathways for State Licensure of International Medical Graduates. March 27, 2024. Accessed March 12, 2025. https://www.acgme.org/newsroom/2024/3/fsmb-intealth-acgme-establish-advisory-commission-to-guide-alternate-pathways-for-state-licensure-of-international-medical-graduates/

2. Accreditation Council for Graduate Medical Education (ACGME). Advisory Commission on Alternate Licensing Models Hosts Symposium to Discuss Pathways to Licensure for Fully-Trained International Physicians. June 21, 2024. Accessed March 13, 2025. https://www.acgme.org/newsroom/2024/6/advisory-commission-on-alternate-licensing-models-hosts-symposium-to-discuss-pathways-to-licensure-for-fully-trained-international-physicians/

3. Federation of State Medical Boards (FSMB). Advisory Commission Opens Public Comment Period on Draft Recommendations. Accessed March 13, 2025. https://www.fsmb.org/advisory-commission-on-additional-licensing-models/

4. Federation of State Medical Boards (FSMB). Advisory Commission Releases Recommendations to Inform Legislation on Licensing Internationally-Trained Physicians. February 4, 2025. Accessed March 3, 2025. https://www.fsmb.org/advocacy/news-releases/advisory-commission-releases-recommendations/

5. Federation of State Medical Boards (FSMB). Advisory Commission on Additional Licensing Models Releases Second Set of Draft Preliminary Recommendations for Public Comment. Accessed May 24, 2025. https://www.fsmb.org/advisory-commission-comment-period/

6. Accreditation Council for Graduate Medical Education (ACGME). Advisory Commission on Additional Licensing Models Releases Second Set of Draft Recommendations. May 22, 2025. Accessed May 29, 2025. https://www.acgme.org/newsroom/2025/5/advisory-commission-on-additional-licensing-models-releases-second-set-of-recommendations/

7. Chaudhry HJ, Combes JR, Holmboe ES, et al. Licensing Internationally Trained Physicians: Advisory Commission Leaders Share Initial Progress. *Ann Intern Med*. 2025;178:1187-1189. [Epub 1 July 2025]. doi:10.7326/ANNALS-25-00936

8. Federation of State Medical Boards (FSMB). Advisory Commission Releases Recommendations and Toolkit to Inform Assessment and Supervision of Internationally Trained Physicians. Accessed August 29, 2025. https://www.fsmb.org/advocacy/news-releases/advisory-commission-releases-recommendations-and-toolkit/

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 301
(I-25)

Introduced by: Michigan

Subject: Preventing Sleep Deprivation and Supporting Medical Student Wellness

Referred to: Reference Committee C

---

Whereas, state studies recommend how much sleep adults need to function well. Experts recommend that adults receive 7-9 hours of sleep per night; and

Whereas, studies have found that sleeping less than 7 hours can lead to adverse health outcomes such as impaired immune function, increased pain, decreased performance, and an increased risk of accidents; and

Whereas, medical students and residents who receive less than 7 hours of sleep per night experience higher rates of burnout, decreased motivation for learning, and increased risk of anxiety, depression, and alcohol abuse; and

Whereas, sleep deprivation and extended wakefulness can lead to impaired attention, slowed response time, and increased risk of errors, accidents, and injuries. In addition, studies show that cognitive function is most impaired during the first night of night shift work; and

Whereas, sleep deprivation and its negative effects on performance cannot be overcome by willing oneself to stay awake, nor by motivation, training, or experience. Thus, adequate rest is a necessary prerequisite for effective medical training; and

Whereas, research from the National Heart, Lung and Blood Institute underscores that sleep deprivation cannot simply be repaid through short sleeping periods. Multiple studies have shown that a full night of sleep (7-9 hours) is needed to restore memory and hippocampal-memory association function after one night of total sleep loss; and

Whereas, the Liaison Committee on Medical Education (LCME) works to ensure that every medical school has an effective system of counseling services to encourage medical student wellness; however, there are no guidelines in the LCME Functions and Structure of a Medical School: Standards for Accreditation of Medical Education Programs Leading to the MD Degree on how medical schools should manage student working hours and prevent sleep deprivation; and

Whereas, the Accreditation Council for Graduate Medical Education (ACGME) limits residents work hours to 80 hours per week (averaged over a 4-week period); and

Whereas, duty hour limits include at least 10 hours of rest between duty periods and no more than 24 hours of continuous scheduled clinical assignments (Note: 6-hour extension is permitted for patient continuity and education.); and

Whereas, ACGME also states that residents must have at least 14 hours free of clinical work and education after 24 hours of in-house call; therefore be it

RESOLVED, that our American Medical Association support the development of national standards to act as the official guideline for medical student work-hour limits, time off after a 24-hour shift, and work-hour guidelines. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 9/3/25

**REFERENCES**

1. 2025-26-Functions-and-Structure_2024-08-01. (n.d.). https://lcme.org/publications/ ACGME Common Program Requirements (Residency). (n.d.). Retrieved February 24, 2025, from https://www.acgme.org/globalassets/pfassets/programrequirements/2025-prs/cprresidency_2025.pdf
2. Ahmed, N., Sadat, M., & Cukor, D. (2017). Sleep Knowledge and Behaviors in Medical Students: Results of a Single Center Survey. Academic psychiatry : the journal of the American Association of Directors of Psychiatric Residency Training and the Association for Academic Psychiatry, 41(5), 674â€“678. https://doi.org/10.1007/s40596-016-0655-3
3. Caruso CC. Negative impacts of shiftwork and long work hours. Rehabil Nurs. 2014 Jan-Feb;39(1):16-25. doi: 10.1002/rnj.107. Epub 2013 Jun 18. PMID: 23780784; PMCID: PMC4629843.
4. Chai, Y., Fang, Z., Yang, F.N. et al. Two nights of recovery sleep restores hippocampal connectivity but not episodic memory after total sleep deprivation. Sci Rep 10, 8774 (2020). https://doi.org/10.1038/s41598-020-65086-x
5. Kalkanis, A., Demolder, S., Papadopoulos, D., Testelmans, D., & Buyse, B. (2023). Recovery from shift work. Frontiers in neurology, 14, 1270043. https://doi.org/10.3389/fneur.2023.1270043
6. Lamond, N. and Dawson, D. (1999), Quantifying the performance impairment associated with fatigue. Journal of Sleep Research, 8: 255-262. https://doi.org/10.1046/j.1365-2869.1999.00167.x
7. Santhi N, Horowitz TS, Duffy JF, Czeisler CA (2007) Acute Sleep Deprivation and Circadian Misalignment Associated with Transition onto the First Night of Work Impairs Visual Selective Attention. PLoS ONE 2(11): e1233. https://doi.org/10.1371/journal.pone.0001233
8. Watson, N. F., Badr, M. S., Belenky, G., Bliwise, D. L., Buxton, O. M., Buysse, D., Dinges, D. F., Gangwisch, J., Grandner, M. A., Kushida, C., Malhotra, R. K., Martin, J. L., Patel, S. R., Quan, S. F., & Tasali, E. (2015). Recommended Amount of Sleep for a Healthy Adult: A Joint Consensus Statement of the American Academy of Sleep Medicine and Sleep Research Society. Sleep, 38(6), 843â€“844. https://doi.org/10.5665/sleep.4716
9. Wilson MR. The New ACGME Resident Duty Hours: Big Changes, Bigger Challenges. Ochsner J. 2003 Spring;5(2):3-5. PMID: 22826676; PMCID: PMC3399327.

## RELEVANT AMA POLICY

**Factors Causing Burnout H-405.948**
Our American Medical Association recognizes that medical students, resident physicians, and fellows face unique challenges that contribute to burnout during medical school and residency training, such as debt burden, inequitable compensation, discrimination, limited organizational or institutional support, stress, depression, suicide, childcare needs, mistreatment, long work and study hours, among others, and that such factors be included as metrics when measuring physician well-being, particularly for this population of physicians.

**Resident/Fellow Clinical and Educational Work Hours H-310.907**
Our American Medical Association adopts the following Principles of Resident/Fellow Clinical and Educational Work Hours, Patient Safety, and Quality of Physician Training:

1. Our AMA supports the 2017 Accreditation Council for Graduate Medical Education (ACGME) standards for clinical and educational work hours (previously referred to as “duty hours”).
2. Our AMA will continue to monitor the enforcement and impact of clinical and educational work hour standards, in the context of the larger issues of patient safety and the optimal learning environment for residents.
3. Our AMA encourages publication and supports dissemination of studies in peer-reviewed publications and educational sessions about all aspects of clinical and educational work hours, to include such topics as extended work shifts, handoffs, in-house call and at-home call, level of supervision by attending physicians, workload and growing service demands, moonlighting, protected sleep periods, sleep deprivation and fatigue, patient safety, medical error, continuity of care, resident well-being and burnout, development of professionalism, resident learning outcomes, and preparation for independent practice.
4. Our AMA endorses the study of innovative models of clinical and educational work hour requirements and, pending the outcomes of ongoing and future research, should consider the evolution of

specialty- and rotation-specific requirements that are evidence-based and will optimize patient safety and competency-based learning opportunities.

5. Our AMA encourages the ACGME to:
   a. Decrease the barriers to reporting of both clinical and educational work hour violations and resident intimidation.
   b. Ensure that readily accessible, timely and accurate information about clinical and educational work hours is not constrained by the cycle of ACGME survey visits.
   c. Use, where possible, recommendations from respective specialty societies and evidence-based approaches to any future revision or introduction of clinical and educational work hour rules.
   d. Broadly disseminate aggregate data from the annual ACGME survey on the educational environment of resident physicians, encompassing all aspects of clinical and educational work hours.
6. Our AMA recognizes the ACGME for its work in ensuring an appropriate balance between resident education and patient safety, and encourages the ACGME to continue to:
   a. Offer incentives to programs/institutions to ensure compliance with clinical and educational work hour standards.
   b. Ensure that site visits include meetings with peer-selected or randomly selected residents and that residents who are not interviewed during site visits have the opportunity to provide information directly to the site visitor.
   c. Collect data on at-home call from both program directors and resident/fellow physicians; release these aggregate data annually; and develop standards to ensure that appropriate education and supervision are maintained, whether the setting is in-house or at-home.
   d. Ensure that resident/fellow physicians receive education on sleep deprivation and fatigue.
7. Our AMA supports the following statements related to clinical and educational work hours:
   a. Total clinical and educational work hours must not exceed 80 hours per week, averaged over a four-week period (Note: “Total clinical and educational work hours” includes providing direct patient care or supervised patient care that contributes to meeting educational goals; participating in formal educational activities; providing administrative and patient care services of limited or no educational value; and time needed to transfer the care of patients).
   b. Scheduled on-call assignments should not exceed 24 hours. Residents may remain on-duty for an additional 4 hours to complete the transfer of care, patient follow-up, and education; however, residents may not be assigned new patients, cross-coverage of other providers’ patients, or continuity clinic during that time.
   c. Time spent in the hospital by residents on at-home call must count towards the 80-hour maximum weekly hour limit, and on-call frequency must not exceed every third night averaged over four weeks. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks.
   d. At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.
   e. Residents are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new “off-duty period.”
   f. Given the different education and patient care needs of the various specialties and changes in resident responsibility as training progresses, clinical and educational work hour requirements should allow for flexibility for different disciplines and different training levels to ensure appropriate resident education and patient safety; for example, allowing exceptions for certain disciplines, as appropriate, or allowing a limited increase to the total number of clinical and educational work hours when need is demonstrated.
   g. Resident physicians should be ensured a sufficient duty-free interval prior to returning to duty.
   h. Clinical and educational work hour limits must not adversely impact resident physician participation in organized educational activities. Formal educational activities must be scheduled and available within total clinical and educational work hour limits for all resident physicians.
   i. Scheduled time providing patient care services of limited or no educational value should be minimized.
   j. Accurate, honest, and complete reporting of clinical and educational work hours is an essential element of medical professionalism and ethics.
   k. The medical profession maintains the right and responsibility for self-regulation (one of the key tenets of professionalism) through the ACGME and its purview over graduate medical education,

and categorically rejects involvement by the Centers for Medicare & Medicaid Services, The Joint Commission, Occupational Safety and Health Administration, and any other federal or state government bodies in the monitoring and enforcement of clinical and educational work hour regulations, and opposes any regulatory or legislative proposals to limit the work hours of practicing physicians.

l. Increased financial assistance for residents/fellows, such as subsidized child care, loan deferment, debt forgiveness, and tax credits, may help mitigate the need for moonlighting. At the same time, resident/fellow physicians in good standing with their programs should be afforded the opportunity for internal and external moonlighting that complies with ACGME policy.

m. Program directors should establish guidelines for scheduled work outside of the residency program, such as moonlighting, and must approve and monitor that work such that it does not interfere with the ability of the resident to achieve the goals and objectives of the educational program.

n. The costs of clinical and educational work hour limits should be borne by all health care payers. Individual resident compensation and benefits must not be compromised or decreased as a result of changes in the graduate medical education system.

o. The general public should be made aware of the many contributions of resident/fellow physicians to high-quality patient care and the importance of trainees' realizing their limits (under proper supervision) so that they will be able to competently and independently practice under real-world medical situations.

8. Our AMA is in full support of the collaborative partnership between allopathic and osteopathic professional and accrediting bodies in developing a unified system of residency/fellowship accreditation for all residents and fellows, with the overall goal of ensuring patient safety.

9. Our AMA will actively participate in ongoing efforts to monitor the impact of clinical and educational work hour limitations to ensure that patient safety and physician well-being are not jeopardized by excessive demands on post-residency physicians, including program directors and attending physicians.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 304
(I-25)

Introduced by: International Medical Graduates Section

Subject: Systemic Exclusion of IMGs from Residency Programs

Referred to: Reference Committee C

---

Whereas, international medical graduates (IMGs) represent nearly 25% of the U.S. physician workforce and provide essential care in primary care, rural, and underserved communities; and

Whereas, categorical exclusion of IMGs from residency application processes persists despite longstanding AMA policy opposing discrimination in medical education and training, including AMA Policy H-255.988 (“Support for International Medical Graduates”), which affirms that IMGs should be evaluated on the basis of individual merit rather than place of medical education; and

Whereas, AMA policy also opposes discrimination in graduate medical education based on school of graduation, citizenship, or immigration status, yet some programs continue to employ blanket exclusions; and

Whereas, such exclusion limits workforce diversity, exacerbates physician shortages, and denies patients access to qualified physicians trained and certified through rigorous international and U.S. standards; and

Whereas, many residency programs fail to provide transparent information about IMG eligibility, leading applicants to waste limited financial and personal resources while discouraging participation in the Match process; and

Whereas, fair, competency-based evaluation of residency applicants, rather than categorical exclusion, aligns with the principles of equity, diversity, and inclusion and strengthens the physician workforce; and

Whereas, graduate medical education (GME) positions are funded substantially by federal and state tax dollars, and programs receiving public funds should adhere to non-discrimination principles in admitting qualified applicants; therefore be it

RESOLVED, that our American Medical Association reaffirm its commitment to opposing discrimination against IMGs in all aspects of medical education and training (New HOD Policy); and be it further

RESOLVED, that our AMA, through its Council on Medical Education, work with the Accreditation Council for Graduate Medical Education, the National Resident Matching Program, and Intealth to prohibit categorical exclusion of IMGs from residency applications; (Directive to Take Action); and be it further

RESOLVED, that our AMA, through its Council on Medical Education, advocate for mandatory transparency in residency program eligibility requirements, including IMG eligibility, published in a standardized and accessible format. (Directive to Take Action)

Fiscal Note: Minimal – less than $1,000

Received: 9/25/25

**RELEVANT AMA POLICY**

**AMA Principles on International Medical Graduates – H-255.988**

1. Our AMA supports current U.S. visa and immigration requirements applicable to foreign national physicians who are graduates of medical schools other than those in the United States and Canada.
2. Our AMA supports current regulations governing the issuance of exchange visitor visas to foreign national IMGs, including the requirements for successful completion of the USMLE.
3. Our AMA reaffirms its policy that the U.S. and Canada medical schools be accredited by a nongovernmental accrediting body.
4. Our AMA supports cooperation in the collection and analysis of information on medical schools in nations other than the U.S. and Canada.
5. Our AMA supports continued cooperation with the ECFMG and other appropriate organizations to disseminate information to prospective and current students in foreign medical schools. An AMA member, who is an IMG, should be appointed regularly as one of the AMA's representatives to the ECFMG Board of Trustees.
6. Our AMA supports working with the Accreditation Council for Graduate Medical Education (ACGME) and the Federation of State Medical Boards (FSMB) to assure that institutions offering accredited residencies, residency program directors, and U.S. licensing authorities do not deviate from established standards when evaluating graduates of foreign medical schools.
7. In cooperation with the ACGME and the FSMB, our AMA supports only those modifications in established graduate medical education or licensing standards designed to enhance the quality of medical education and patient care.
8. Our AMA continues to support the activities of the ECFMG related to verification of education credentials and testing of IMGs.
9. Our AMA supports that special consideration be given to the limited number of IMGs who are refugees from foreign governments that refuse to provide pertinent information usually required to establish eligibility for residency training or licensure.
10. Our AMA supports that accreditation standards enhance the quality of patient care and medical education and not be used for purposes of regulating physician manpower.
11. Our AMA representatives to the ACGME, residency review committees and to the ECFMG should support AMA policy opposing discrimination. Medical school admissions officers and directors of residency programs should select applicants on the basis of merit, without considering status as an IMG or an ethnic name as a negative factor.
12. Our AMA supports the requirement that all medical school graduates complete at least one year of graduate medical education in an accredited U.S. program in order to qualify for full and unrestricted licensure. State medical licensing boards are encouraged to allow an alternate set of criteria for granting licensure in lieu of this requirement:
    a. completion of medical school and residency training outside the U.S.;
    b. extensive U.S. medical practice; and
    c. evidence of good standing within the local medical community.
13. Our AMA supports publicizing existing policy concerning the granting of staff and clinical privileges in hospitals and other health facilities.
14. Our AMA supports the participation of all physicians, including graduates of foreign as well as U.S. and Canadian medical schools, in organized medicine. Our AMA offers encouragement and assistance to state, county, and specialty medical societies in fostering greater membership among IMGs and their participation in leadership positions at all levels of organized medicine, including AMA committees and councils, the Accreditation Council for Graduate Medical Education and its review committees, the American Board of Medical Specialties and its specialty boards, and state boards of medicine, by providing guidelines and non-financial incentives, such

as recognition for outstanding achievements by either individuals or organizations in promoting leadership among IMGs.

15. Our AMA supports studying the feasibility of conducting peer-to-peer membership recruitment efforts aimed at IMGs who are not AMA members.
16. Our AMA membership outreach to IMGs to include
    a. using its existing publications to highlight policies and activities of interest to IMGs, stressing the common concerns of all physicians;
    b. publicizing its many relevant resources to all physicians, especially to nonmember IMGs;
    c. identifying and publicizing AMA resources to respond to inquiries from IMGs; and
    d. expansion of its efforts to prepare and disseminate information about requirements for admission to accredited residency programs, the availability of positions, and the problems of becoming licensed and entering full and unrestricted medical practice in the U.S. that face IMGs. This information should be addressed to college students, high school and college advisors, and students in foreign medical schools.
17. Our AMA supports recognition of the common aims and goals of all physicians, particularly those practicing in the U.S., and support for including all physicians who are permanent residents of the U.S. in the mainstream of American medicine.
18. Our AMA supports its leadership role to promote the international exchange of medical knowledge as well as cultural understanding between the U.S. and other nations.
19. Our AMA supports institutions that sponsor exchange visitor programs in medical education, clinical medicine and public health to tailor programs for the individual visiting scholar that will meet the needs of the scholar, the institution, and the nation to which he will return.
20. Our AMA supports informing foreign national IMGs that the availability of training and practice opportunities in the U.S. is limited by the availability of fiscal and human resources to maintain the quality of medical education and patient care in the U.S., and that those IMGs who plan to return to their country of origin have the opportunity to obtain GME in the United States.
21. Our AMA supports U.S. medical schools offering admission with advanced standing, within the capabilities determined by each institution, to international medical students who satisfy the requirements of the institution for matriculation.
22. Our AMA supports the Federation of State Medical Boards, its member boards, and the ECFMG in their willingness to adjust their administrative procedures in processing IMG applications so that original documents do not have to be recertified in home countries when physicians apply for licenses in a second state.
23. Our AMA supports continued efforts to protect the rights and privileges of all physicians duly licensed in the U.S. regardless of ethnic or educational background and opposes any legislative efforts to discriminate against duly licensed physicians on the basis of ethnic or educational background.
24. Our AMA supports continued study of challenges and issues pertinent to IMGs as they affect our country's health care system and our physician workforce.
25. Our AMA supports advocacy to Congress to fund studies through appropriate agencies, such as the Department of Health and Human Services, to examine issues and experiences of IMGs and make recommendations for improvements.

BOT Rep. Z, A-8 Reaffirmed: Res. 312, I-93 Modified: CME Rep. 2, A-03 Reaffirmation I-11 Reaffirmed: CME Rep. 1, I-1 3 Modified: BOT Rep. 25, A-15 Modified: CME Rep. 01, A-16 Appended: Res. 304, A-17 Modified: CME Rep. 01, I-17 Reaffirmation: A-19 Modified: CME Rep. 2, A-21 Modified: CME Rep. 1, A-22 Modified: CCB/CLRPD Rep. 1, A-22 Reaffirmed: CME Rep. 03, A-23 Reaffirmed: Res. 312, A-25 Reaffirmed in lieu of the first resolve: Res. 234, A-2  Reaffirmed: Res. 241, A-25

**Impact of Immigration Barriers on the Nation's Health D-255.980**

1. Our American Medical Association recognizes the valuable contributions and affirms our support of international medical students and international medical graduates and their participation in U.S. medical schools, residency and fellowship training programs and in the practice of medicine.
2. Our AMA will oppose laws and regulations that would broadly deny entry or re-entry to the United States of persons who currently have legal visas, including permanent resident status (green card) and student visas, based on their country of origin and/or religion.

3. Our AMA will oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion.
4. Our AMA will advocate for the immediate reinstatement of premium processing of H-1B visas for physicians and trainees to prevent any negative impact on patient care.
5. Our AMA will advocate for the timely processing of visas for all physicians, including residents, fellows, and physicians in independent practice.
6. Our AMA will work with other stakeholders to study the current impact of immigration reform efforts on residency and fellowship programs, physician supply, and timely access of patients to health care throughout the U.S.

Alt. Res. 308, A-17 Modified: CME Rep. 01, A-18 Reaffirmation: A-19 Reaffirmed: CME Rep. 4, A-21 Reaffirmed: Res. 234, A-22 Reaffirmed: Res. 210, A-23

**Filtering International Medical Graduates During Residency or Fellowship Applications H-255.963**
1. Our American Medical Association recognizes the exclusion of certain residency applicants from consideration, such as international medical graduates.
2. Our AMA opposes discriminatory use of filters designed to inequitably screen applicants, including international medical graduates, using the Electronic Residency Application Service® (ERAS®) system.
Res. 313, A-23

**National Resident Matching Program Reform D-310.977**
1. Our AMA will work with the National Resident Matching Program (NRMP) to develop and distribute educational programs to better inform applicants about the NRMP matching process, including the existing NRMP waiver and violations review policies.
2. Our AMA will actively participate in the evaluation of, and provide timely comments about, all proposals to modify the NRMP Match.
3. Our AMA will request that the NRMP explore the possibility of including the Osteopathic Match in the NRMP Match.
4. Our AMA will continue to review the NRMP's policies and procedures and make recommendations for improvements as the need arises, to include making the conditions of the Match agreement more transparent while assuring the confidentiality of the match.
5. Our AMA will work with the Accreditation Council for Graduate Medical Education (ACGME) and other appropriate agencies to assure that the terms of employment for resident physicians are fair and equitable and reflect the unique and extensive amount of education and experience acquired by physicians.
6. Our AMA does not support the current the "All-In" policy for the Main Residency Match to the extent that it eliminates flexibility within the match process.
7. Our AMA will work with the NRMP, and other residency match programs, in revising Match policy, including the secondary match or scramble process to create more standardized rules for all candidates including application timelines and requirements.
8. Our AMA will work with the NRMP and other external bodies to develop mechanisms that limit disparities within the residency application process and allow both flexibility and standard rules for applicants.
9. Our AMA encourages the National Resident Matching Program to study and publish the effects of implementation of the Supplemental Offer and Acceptance Program on the number of residency spots not filled through the Main Residency Match and include stratified analysis by specialty and other relevant areas.
10. Our AMA will work with the NRMP and ACGME to evaluate the challenges in moving from a time-based education framework toward a competency-based system, including:
    a. Analysis of time-based implications of the ACGME milestones for residency programs.
    b. The impact on the NRMP and entry into residency programs if medical education programs offer variable time lengths based on acquisition of competencies.
    c. The impact on financial aid for medical students with variable time lengths of medical education programs.
    d. The implications for interprofessional education and rewarding teamwork.
    e. The implications for residents and students who achieve milestones earlier or later than their peers.

11. Our AMA will work with the Association of American Medical Colleges (AAMC), American Osteopathic Association (AOA), American Association of Colleges of Osteopathic Medicine (AACOM), and National Resident Matching Program (NRMP) to evaluate the current available data or propose new studies that would help us learn how many students graduating from US medical schools each year do not enter into a US residency program; how many never enter into a US residency program; whether there is disproportionate impact on individuals of minority racial and ethnic groups; and what careers are pursued by those with an MD or DO degree who do not enter residency programs.
12. Our AMA will work with the AAMC, AOA, AACOM and appropriate licensing boards to study whether US medical school graduates and international medical graduates who do not enter residency programs may be able to serve unmet national health care needs;
13. Our AMA will work with the AAMC, AOA, AACOM and the NRMP to evaluate the feasibility of a national tracking system for US medical students who do not initially match into a categorical residency program.
14. Our AMA will discuss with the National Resident Matching Program, Association of American Medical Colleges, American Osteopathic Association, Liaison Committee on Medical Education, Accreditation Council for Graduate Medical Education, and other interested bodies potential pathways for reengagement in medicine following an unsuccessful match and report back on the results of those discussions.
15. Our AMA encourages the Association of American Medical Colleges to work with U.S. medical schools to identify best practices, including career counseling, used by medical schools to facilitate successful matches for medical school seniors, and reduce the number who do not match.
16. Our AMA supports the movement toward a unified and standardized residency application and match system for all non-military residencies.
17. Our AMA encourages the Educational Commission for Foreign Medical Graduates (ECFMG) and other interested stakeholders to study the personal and financial consequences of ECFMG-certified U.S. IMGs who do not match in the National Resident Matching Program and are therefore unable to get a residency or practice medicine.
18. Our AMA encourages the AAMC, AACOM, NRMP, and other key stakeholders to jointly create a no-fee, easily accessible clearinghouse of reliable and valid advice and tools for residency program applicants seeking cost-effective methods for applying to and successfully matching into residency.
19. Our AMA will work with appropriate stakeholders to study options for improving transparency in the resident application process.
20. Our AMA encourages the piloting of innovations to the residency application process with aims to reduce application numbers per applicant, focus applicants on programs with reciprocal interest, and maximize residency placement. With support from the medical education community, successful pilots should be expanded to enhance the standardized process.
21. Our AMA will continue to engage the National Resident Matching Program® (NRMP®) and other matching organizations on behalf of residents and medical students to further develop ongoing relationships, improve communications, and seek additional opportunities to collaborate including the submission of suitable nominees for their governing bodies as appropriate.

CME Rep. 4, A-05 Appended: Res. 330, A-11Appended: Res. 920, I-11Appended: Res. 311, A-14Appended: Res. 312, A-14 Appended: Res. 304, A-15 Appended: CME Rep. 03, A-16 Reaffirmation: A-16 Appended: CME Rep. 06, A-17Appended: Res. 306, A-17 Modified: Speakers Rep. 01, A-17 Appended: CME Rep. 3, A-21Modified: CME Rep. 1, A-22 Appended: Res. 328, A-22 Modified: CME Rep. 02, A-24 Reaffirmed: CME Rep. 03, A-25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 305
(I-25)

Introduced by: Women Physicians Section

Subject: Paid Sick Leave and Flexible Work Arrangements for Caregivers of Individuals with Special Needs, Chronic Illness, or Elderly Parents

Referred to: Reference Committee C

---

Whereas, there is no standardized or universal structure in place for laws related to paid sick leave across the United States[1,2]; and

Whereas, as more than 14 million children in the U.S. have been reported to have special needs, it is essential to expand on sick leave and flexible work arrangements for physician mothers who are also caregivers[3,4]; and

Whereas, in a 2019 JAMA Internal Medicine survey, 45% of physician mothers as caregivers reported being burnout and 40% of physician mothers with reported extra caregiving obligations also identified with having mood and anxiety disorder[5]; and

Whereas, physician mothers with caregiving obligations can reduce higher physician burnout, secondary traumatic stress, and compassion fatigue if their sick child or elderly sick parent receives prompt and timely care[6]; and

Whereas, the American with Disabilities Act (ADA) requires reasonable accommodations for employees with disabilities but does not mandate accommodations for caregivers, therefore accommodation for physician mothers who are also caregivers of child(ren) with special needs, disability, chronic illness or elderly sick parent(s) should be provided[7]; and

Whereas, the Family Medical Leave Act (FMLA) provides at least 12 weeks of unpaid leave for family/medical reasons, it does not mandate paid leave, hence it would be beneficial to provide financial compensation (partial or complete) for employee medical leave which can help to reduce the financial and mental distress of the employee (physician mother)[8,9] and

Whereas, the implementation and addition of backup child-care and elderly-care such as hospital based employer-provided care facilities or community-based respite programs, especially for situations where an elderly or child may be sick or require special in-person assisted care can benefit both the caregiver by reducing work disruptions and stress as well as having necessary support for their child or elderly parent; and

Whereas, provision of well-trained and well-equipped daycare centers that can provide care for children (with special needs or chronic health issues) or elderly parents (with health issues) can improve the work-life balance of physician mothers and reduce caregiver responsibilities; and

Whereas, flexible work arrangements such as flexible work hours, remote telework, or adjusted work schedules can help accommodate physician mothers who are also caregivers and may need to be physically present to attend the needs of their child(ren) (with special needs, disability, or chronic illness) or their elderly sick parent(s)[10,11,12]; therefore be it

RESOLVED, that our American Medical Association amend H-420.979, "AMA Statement on Family, Medical, and Safe Leave", by addition as follows:

Our American Medical Association supports policies that provide employees with reasonable job security and continued availability of health plan benefits in the event leave by an employee becomes necessary due to documented medical conditions, caregiving obligations, or reasons related to personal safety. Such policies should provide for reasonable periods of paid or unpaid:

1. Medical leave for the employee, including pregnancy, abortion, and stillbirth.
2. Maternity and paternity leave for the employee.
3. Leave if medically appropriate to care for a member of the employee's immediate family, i.e., a spouse, children, or elderly parents
4. Leave for adoption or for foster care leading to adoption.
5. Safe leave provisions for those experiencing any instances of violence, including but not limited to intimate partner violence, sexual violence or coercion, and stalking.
6. Flexible work arrangements such as flexible work hours and the ability to work remotely,

Such periods of leave may differ with respect to each of the foregoing classifications and may vary with reasonable categories of employers. Such policies should encourage voluntary programs by employers and may provide for appropriate legislation (with or without financial assistance from government). Any legislative proposals will be reviewed through the Association's normal legislative process for appropriateness, taking into consideration all elements therein, including classifications of employees and employers, reasons for the leave, periods of leave recognized (whether paid or unpaid), obligations on return from leave, and other factors involved in order to achieve reasonable objectives recognizing the legitimate needs of employees and employers. Our AMA recognizes the positive impact of paid safe leave on public health outcomes and supports legislation that offers safe leave;

(Modify Current HOD Policy); and be it further

RESOLVED, that our AMA supports physician mothers who are caregivers to alleviate physician burnout. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 9/25/25

**REFERENCES**

1. Mitchell, Sophia. *STATE PAID SICK LEAVE LAWS* . Department of Labor- Women's Bureau, Sept. 2024.
2. U.S Bureau of Labor Statistics. "Paid Sick Leave: What Is Available to Workers?" *Www.bls.gov*, 19 Sept. 2024, www.bls.gov/ebs/factsheets/paid-sick-leave.htm.
3. *Children and Youth with Special Health Care Needs* . Health Resources and Services Administration Maternal and Child Health Bureau, 2022.
4. Child and Adolescent Health Measurement Initiative. 2021-2022 National Survey of Children's Health (NSCH) data query. Data Resource Center for Child and Adolescent Health supported by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). Retrieved [mm/dd/yy] from [www.childhealthdata.org]
5. Yank, Veronica, et al. "Behavioral Health and Burnout among Physician Mothers Who Care for a Person with a Serious Health Problem, Long-Term Illness, or Disability." *JAMA Internal Medicine*, vol. 179, no. 4, 1 Apr. 2019, p. 571, https://doi.org/10.1001/jamainternmed.2018.6411. Accessed 1 Feb. 2022.
6. Albert Henry, Tanya. "Higher Physician Burnout Risk for Moms in "Sandwich Generation."" *American Medical Association*, 3 June 2019, www.ama-assn.org/practice-management/physician-health/higher-physician-burnout-risk-moms-sandwich-generation.

7. *The ADA and Caregivers: Frequently Asked Questions*. ADA National Network, 2015, adata.org/factsheet/ada-and-caregivers.
8. U.S. Department of Labor. “Fact Sheet #28: The Family and Medical Leave Act.” *Www.dol.gov*, U.S Department of Labor, Feb. 2023, www.dol.gov/agencies/whd/fact-sheets/28-fmla.
9. “Paid Family and Medical Leave (PFML) Overview and Benefits.” *Mass.gov*, Department of Family and Medical Leave, 2024, www.mass.gov/info-details/paid-family-and-medical-leave-pfml-overview-and-benefits?_gl=1. Accessed 18 Sept. 2025.
10. Semere W, Ponce AN, Linos E, Jagsi R, Mangurian C, Halley MC. "Learning from those who know the system inside and out": Experiences of physician mothers who are informal caregivers. Fam Syst Health. 2025 Jun;43(2):386-393. doi: 10.1037/fsh0000945. Epub 2024 Dec 12. PMID: 39666478; PMCID: PMC12159254.
11. Minkove, Judy F. *Addressing Caregiver Strain among Faculty*. Johns Hopkins Medicine, 4 Oct. 2021, www.hopkinsmedicine.org/news/articles/2021/10/addressing-caregiver-strain-among-faculty. Accessed 18 Sept. 2025.
12. Wisenberg Brin, Dinah. *Working Mom, MD: Always on Call*. AAMC, 2017, www.aamc.org/news/working-mom-md-always-call. Accessed 18 Sept. 2025.

## RELEVANT AMA POLICY

### H-405.960 Increasing Practice Viability for Physicians Through Increased Employer And Employee Awareness of Protected Leave Policies

Our American Medical Association adopts as policy the following guidelines for, and encourages the implementation of, Parental, Family and Medical Necessity Leave for Medical Students and Physicians:

1. Our AMA urges residency training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage development of leave policies, including parental, family, and medical leave policies, as part of the physician's standard benefit agreement.
2. Recommended components of parental leave policies for physicians include:
    a. duration of leave allowed before and after delivery;
    b. category of leave credited;
    c. whether leave is paid or unpaid;
    d. whether provision is made for continuation of insurance benefits during leave, and who pays the premium;
    e. whether sick leave and vacation time may be accrued from year to year or used in advance;
    f. how much time must be made up in order to be considered board eligible;
    g. whether make-up time will be paid;
    h. whether schedule accommodations are allowed; and
    i. leave policy for adoption.
3. Our AMA policy is expanded to include physicians in practice, reading as follows:
    a. residency program directors and group practice administrators should review federal law concerning maternity leave for guidance in developing policies to assure that pregnant physicians are allowed the same sick leave or disability benefits as those physicians who are ill or disabled;
    b. staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in other physicians' workloads, particularly in residency programs; and
    c. physicians should be able to return to their practices or training programs after taking parental leave without the loss of status.
4. Our AMA recommends that medical practices, departments and training programs strive to provide 12 weeks of paid parental, family and medical necessity leave in a 12-month period for their attending and trainee physicians as needed, with the understanding that no parent be required to take a minimum leave, and with eligibility beginning at the start of employment without a waiting period.
5. Residency program directors should review federal and state law for guidance in developing policies for parental, family, and medical leave.
6. Medical students and physicians who are unable to work because of pregnancy, childbirth, abortion or stillbirth, and other related medical conditions should be entitled to such leave and other benefits on the same basis as other physicians who are temporarily unable to work for other medical reasons.

7. Residency programs should develop written policies on leave for physicians. Such written policies should include the following elements:
    a. leave policy for birth or adoption;
    b. duration of leave allowed before and after delivery;
    c. duration of leave allowed after abortion or stillbirth;
    d. category of leave credited (e.g., sick, vacation, parental, unpaid leave, short term disability);
    e. whether leave is paid or unpaid;
    f. whether provision is made for continuation of insurance benefits during leave and who pays for premiums; (g) whether sick leave and vacation time may be accrued from year to year or used in advance;
    g. extended leave for resident physicians with extraordinary and long-term personal or family medical tragedies for periods of up to one year, without loss of previously accepted residency positions, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life;
    h. how time can be made up in order for a resident physician to be considered board eligible;
    i. what period of leave would result in a resident physician being required to complete an extra or delayed year of training;
    j. whether time spent in making up a leave will be paid; and
    k. whether schedule accommodations are allowed, such as reduced hours, no night call, modified rotation schedules, and permanent part-time scheduling.
8. Medical schools should develop written policies on parental leave, family leave, and medical leave for medical students. Such written policies should include the following elements:
    a. leave policy for birth or adoption;
    b. duration of leave allowed before and after delivery;
    c. extended leave for medical students with extraordinary and long-term personal or family medical tragedies, without loss of previously accepted medical school seats, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life;
    d. how time can be made up in order for a medical students to be eligible for graduation with minimal or no delays;
    e. what period of leave would result in a medical student being required to complete an extra or delayed year of training; and
    f. whether schedule accommodations are allowed, such as modified rotation schedules, no night duties, and flexibility with academic testing schedules.
9. Our AMA endorses the concept of equal parental leave for birth and adoption as a benefit for resident physicians, medical students, and physicians in practice regardless of gender or gender identity.
10. Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in the workloads of other physicians, particularly those in residency programs.
11. Physicians should be able to return to their practices or training programs after taking parental leave, family leave, or medical leave without the loss of status.
12. Residency program directors must assist residents in identifying their specific requirements (for example, the number of months to be made up) because of leave for eligibility for board certification and must notify residents on leave if they are in danger of falling below minimal requirements for board eligibility. Program directors must give these residents a complete list of requirements to be completed in order to retain board eligibility.
13. Our AMA encourages flexibility in residency programs and medical schools incorporating parental leave and alternative schedules for pregnant trainees.
14. In order to accommodate leave protected by the federal Family and Medical Leave Act, our AMA encourages all specialties within the American Board of Medical Specialties (ABMS) to allow graduating residents to extend training after the traditional residency completion date while still maintaining board eligibility, in the event of leave beyond six weeks. Our AMA encourages specialty boards to develop flexible policies for board certification for those physicians who take leave beyond the minimum of six weeks of family or medical leave (per ABMS policy) and

whose residency programs are able to certify that residents meet appropriate competencies for program completion.

15. Our AMA will work with appropriate stakeholders to encourage that residency programs annually publish and share with FREIDA and other appropriate stakeholders, self-identified and other demographic data, including but not limited to the composition of their program over the last 5 years by age; historically marginalized, minoritized, or excluded status; sexual orientation and gender identity.
16. Our AMA will encourage the Accreditation Council for Graduate Medical Education and other relevant stakeholders to annually collect data on childbirth and parenthood from all accredited US residency programs and publish this data with disaggregation by gender identity and specialty.
17. These policies as above should be freely available online through FREIDA and in writing to all current trainees and applicants to medical school, residency or fellowship.
18. Medical schools are encouraged to develop clear, equitable parental leave policies and determine how a 12-week parental, family, or medical leave may be incorporated with alternative, timely means of completing missed curriculum while still meeting competency requirements necessary to complete a medical degree.
19. Our AMA opposes any discrimination related to physicians taking protected leave during training and/or medical practice for medical, religious, and/or family reasons.
20. Our AMA will encourage relevant stakeholders to survey physicians and medical students who have taken family leave, in an effort to learn about the experiences of various demographic groups and identify potential disparities in career progression trends. [CCB/CLRPD Rep. 4, A-13; Modified: Res. 305, A-14; Modified: Res. 904, I-14; Modified: Res. 307, A-22; Modified: Res. 302, I-22; Modified: Res. 312, I-22; Modified: CME Rep. 01 and Res. 306, I-23; Modified: Res. 302, I-24]

**H-405.947 Compassionate Leave for Physicians, Medical Students, Medical Trainees, and Physician Residents and Fellows**

1. Our American Medical Association urges:
    a. medical schools, and the Liaison Committee on Medical Education and Commission on Osteopathic College Accreditation to incorporate and/or encourage development of compassionate leave policies. Such compassionate leave policies should consider inclusion of extensive travel and events impacting family planning, pregnancy, or fertility (including pregnancy loss, an unsuccessful round of intrauterine insemination or of an assisted reproductive technology procedure, a failed adoption arrangement, or a failed surrogacy arrangement). These policies should determine how compassionate leave may be incorporated with alternative, timely means of achieving curricular goals when absent from curricular components and to meet competency requirements necessary to complete a medical degree.
    b. residency and fellowship training programs, their sponsoring institutions, and Accreditation Council for Graduate Medical Education to incorporate and/or encourage development of compassionate leave policies as part of the physician's standard benefit agreement. Such compassionate leave policies should consider appropriateness of coverage during extensive travel and events impacting family planning, pregnancy, or fertility (including pregnancy loss, an unsuccessful round of intrauterine insemination or of an assisted reproductive technology procedure, a failed adoption arrangement, or a failed surrogacy arrangement). These policies should also include whether the leave is paid or unpaid, outline what obligations and absences must be made up, and determine how compassionate leave may be incorporated with alternative, timely means of achieving curricular goals when absent from curricular components and to meet competency requirements necessary to achieve independent practice and board eligibility for their specialty.
    c. medical group practices to incorporate and/or encourage development of compassionate leave policies as part of the physician's standard benefit agreement. Such compassionate leave policies should consider appropriateness of coverage during extensive travel and events impacting family planning, pregnancy, or fertility (including pregnancy loss, an unsuccessful round of intrauterine insemination or of an assisted

reproductive technology procedure, a failed adoption arrangement, or a failed surrogacy arrangement). These policies should also include whether the leave is paid or unpaid and what obligations and absences must be made up.

2. Our AMA encourages medical schools, residency and fellowship programs, specialty boards, specialty societies and medical group practices to incorporate into their compassionate leave policies a three-day minimum leave, with the understanding that no medical student or physician should be required to take a minimum leave.
3. Medical students and physicians who are unable to work beyond the defined compassionate leave period because of physical or psychological stress, medical complications of pregnancy loss, or another related reason should refer to their institution's sick leave policy, family and medical leave policy, and other benefits on the same basis as other physicians who are temporarily unable to work for other reasons.
4. Our AMA supports the concept of equal compassionate leave for bereavement due to death or loss (e.g., pregnancy loss and other such events impacting fertility in a physician or their partner) as a benefit for physicians, medical students, medical trainees, and physician residents and fellows, regardless of gender or gender identity.
5. Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in the workloads of other physicians, particularly those in residency programs.
6. These guidelines as above should be freely available online and in writing to all applicants to medical school, residency, or fellowship. [Res. 309, I-22; Modified: CME Rep. 01, I-23]

**H-405.954 Parental Leave**
Our American Medical Association encourages the study of the health implications among patients if the United States were to modify one or more of the following aspects of the Family and Medical Leave Act (FMLA): a reduction in the number of employees from 50 employees; an increase in the number of covered weeks from 12 weeks; and creating a new benefit of paid parental leave.

1. Our AMA will study the effects of FMLA expansion on physicians in varied practice environments.
2. Our AMA:
    a. encourages employers to offer and/or expand paid parental leave policies.
    b. encourages state medical associations to work with their state legislatures to establish and promote paid parental leave policies.
    c. advocates for improved social and economic support for paid family leave to care for newborns, infants and young children.
    d. advocates for federal tax incentives to support early child care and unpaid child care by extended family members.
3. Our AMA:
    a. encourages key stakeholders to implement policies and programs that help protect against parental discrimination and promote work-life integration for physician parents, which should encompass prenatal parental care, equal parental leave for birthing and non-birthing parents, and flexibility for childcare.
    b. urges key stakeholders to include physicians and frontline workers in legislation that provides protections and considerations for paid parental leave for issues of health and childcare. [Res. 215, I-16; Appended BOT Rep. 11, A-19; Appended: Res. 403, A-22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 306
(I-25)

Introduced by: Women Physicians Section

Subject: Support for Paid Prenatal Leave

Referred to: Reference Committee C

---

Whereas, prenatal care utilization is significantly associated with maternal and infant health outcomes, with lower utilization associated with increased maternal morbidity and mortality[1–7]; and

Whereas, lower socioeconomic status is associated with higher risk of severe maternal morbidity and lower utilization of prenatal care[8–14]; and

Whereas, pregnant people working low wage jobs are less likely to access prenatal care than pregnant people working high wage jobs and pregnant people in two-income households, with financial strain often cited as a reason for missing prenatal care appointments[10,15–21]; and

Whereas, on January 1, 2025 New York became the first state to enact paid prenatal leave, which guarantees an additional 20 hours of paid sick leave for prenatal care in addition to existing sick leave for all privately-employed pregnant workers in New York[22]; and

Whereas, many people can't afford to take unpaid leave, and about 44% of U.S. workers don't qualify for benefits through FMLA, which excludes smaller employers and many part-time workers[23]; and

Whereas, Americans who currently have access to paid leave are much more likely to be affluent, well-educated, and white[24–26], and

Whereas, people who currently do not have access to paid leave would likely experience the most improved outcomes from gaining access to paid prenatal leave, including fewer preterm births, lower infant mortality, decreased risk of poverty, and reduced intimate partner violence[23,27–30]; therefore be it

RESOLVED, that our American Medical Association supports policies that provide employees, particularly larger organizations and those with the capacity and resources, with paid leave for prenatal care or any medical care related to pregnancy in addition to other existing forms of leave (New HOD Policy); and be it further

RESOLVED, that our AMA supports the creation of state sponsored programs that cover family and medical leave. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Date Received: 9/25/25

**REFERENCES**

1. Perez MT, Bucholz E, Asimacopoulos E, et al. Impact of maternal social vulnerability and timing of prenatal care on outcome of prenatally detected congenital heart disease. *Ultrasound Obstet Gynecol*. 2022;60(3):346-358. doi:10.1002/uog.24863
2. Champion ML, Bushman ET, Martin KD, et al. Reevaluating Associations between Prenatal Care Utilization and Current Trends in Preterm Birth. *Am J Perinatol*. 2024;41(13):1880-1886. doi:10.1055/a-2295-6524
3. Yan J. The Effects of Prenatal Care Utilization on Maternal Health and Health Behaviors. *Health Econ*. 2017;26(8):1001-1018. doi:10.1002/hec.3380
4. Peahl AF, Pennathur H, Zacharek N, et al. Retrospective Use of Patients' Characteristics to Assess Variation in Prenatal Care Utilization. *Am J Perinatol*. 2024;41(S 01):e2529-e2538. doi:10.1055/s-0043-1771505
5. Castelló A, Río I, Martinez E, et al. Differences in Preterm and Low Birth Weight Deliveries Between Spanish and Immigrant Women: Influence of the Prenatal Care Received. *Ann Epidemiol*. 2012;22(3):175-182. doi:10.1016/j.annepidem.2011.12.005
6. Coley SL, Aronson RE. Exploring Birth Outcome Disparities and the Impact of Prenatal Care Utilization Among North Carolina Teen Mothers. *Womens Health Issues*. 2013;23(5):e287-e294. doi:10.1016/j.whi.2013.06.004
7. Gadson A, Akpovi E, Mehta PK. Exploring the social determinants of racial/ethnic disparities in prenatal care utilization and maternal outcome. *Semin Perinatol*. 2017;41(5):308-317. doi:10.1053/j.semperi.2017.04.008
8. Wolf ER, Donahue E, Sabo RT, Nelson BB, Krist AH. Barriers to Attendance of Prenatal and Well-Child Visits. *Acad Pediatr*. 2021;21(6):955-960. doi:10.1016/j.acap.2020.11.025
9. Bellerose M, Collin L, Daw JR. The ACA Medicaid Expansion And Perinatal Insurance, Health Care Use, And Health Outcomes: A Systematic Review. *Health Aff (Millwood)*. 2022;41(1):60-68. doi:10.1377/hlthaff.2021.01150
10. Bellerose M, Rodriguez M, Vivier PM. A systematic review of the qualitative literature on barriers to high-quality prenatal and postpartum care among low-income women. *Health Serv Res*. 2022;57(4):775-785. doi:10.1111/1475-6773.14008
11. Yapundich M, Jeffries RS, Moore JB, Mayfield AM, Namak SY. Evaluating Prenatal Care Compliance and Barriers to Prenatal Care Among Pregnant Individuals in Forsyth County, North Carolina. *N C Med J*. 2024;85(6). doi:10.18043/001c.121419
12. Kaur A, Hornberger LK, Fruitman D, Ngwezi D, Eckersley LG. Impact of rural residence and low socioeconomic status on rate and timing of prenatal detection of major congenital heart disease in a jurisdiction of universal health coverage. *Ultrasound Obstet Gynecol*. 2022;60(3):359-366. doi:10.1002/uog.26030
13. Krishnan A, Jacobs MB, Morris SA, et al. Impact of Socioeconomic Status, Race and Ethnicity, and Geography on Prenatal Detection of Hypoplastic Left Heart Syndrome and Transposition of the Great Arteries. *Circulation*. 2021;143(21):2049-2060. doi:10.1161/CIRCULATIONAHA.120.053062
14. Wang E, Glazer KB, Howell EA, Janevic TM. Social Determinants of Pregnancy-Related Mortality and Morbidity in the United States: A Systematic Review. *Obstet Gynecol*. 2020;135(4):896-915. doi:10.1097/AOG.0000000000003762
15. Testa A, Jackson DB. Incarceration Exposure and Barriers to Prenatal Care in the United States: Findings from the Pregnancy Risk Assessment Monitoring System. *Int J Environ Res Public Health*. 2020;17(19):7331. doi:10.3390/ijerph17197331
16. Testa A, Jackson DB. Barriers to Prenatal Care Among Food-Insufficient Women: Findings from the Pregnancy Risk Assessment Monitoring System. *J Womens Health*. 2021;30(9):1268-1277. doi:10.1089/jwh.2020.8712
17. Testa A, Lee J, Semenza DC, Jackson DB, Ganson KT, Nagata JM. Intimate partner violence and barriers to prenatal care. *Soc Sci Med*. 2023;320:115700. doi:10.1016/j.socscimed.2023.115700
18. Care I of M (US) C to SO for P, Brown SS. Barriers to the Use of Prenatal Care. In: *Prenatal Care: Reaching Mothers, Reaching Infants*. National Academies Press (US); 1988. Accessed January 19, 2025. https://www.ncbi.nlm.nih.gov/books/NBK217704/
19. Fryer K, Munoz MC, Rahangdale L, Stuebe AM. Multiparous Black and Latinx Women Face More Barriers to Prenatal Care than White Women. *J Racial Ethn Health Disparities*. 2021;8(1):80-87. doi:10.1007/s40615-020-00759-x
20. Bebbington M. Barriers to accessing care: challenges in early prenatal diagnosis of congenital anomalies. *Ultrasound Obstet Gynecol*. 2022;60(3):307-308. doi:10.1002/uog.26040
21. Campbell MJ, Lorch S, Rychik J, Quartermain MD, Passarella M, Groeneveld PW. Socioeconomic barriers to prenatal diagnosis of critical congenital heart disease. *Prenat Diagn*. 2021;41(3):341-346. doi:10.1002/pd.5864
22. New York State Paid Prenatal Leave. Accessed January 19, 2025. https://www.ny.gov/programs/new-york-state-paid-prenatal-leave
23. The urgent necessity for paid parental leave. https://www.apa.org. Accessed January 19, 2025. https://www.apa.org/monitor/2022/04/feature-parental-leave
24. A National Paid Leave Program Would Help Workers, Families | Center on Budget and Policy Priorities. April 27, 2021. Accessed January 19, 2025. https://www.cbpp.org/research/economy/a-national-paid-leave-program-would-help-workers-families
25. J.;Waldfogel,Jane B Ann P ;Kim,Soohyun;Nam,Jaehyun;Rossin Slater,Maya;Ruhm,Christopher. Racial and ethnic disparities in access to and use of paid family and medical leave: evidence from four nationally representative datasets. Bureau of Labor Statistics. Accessed January 19, 2025. https://www.bls.gov/opub/mlr/2019/article/racial-and-ethnic-disparities-in-access-to-and-use-of-paid-family-and-medical-leave.htm
26. Goodman JM, Williams C, Dow WH. Racial/Ethnic Inequities in Paid Parental Leave Access. *Health Equity*. 2021;5(1):738-749. doi:10.1089/heq.2021.0001
27. Khan MS. Paid family leave and children health outcomes in OECD countries. *Child Youth Serv Rev*. 2020;116:105259. doi:10.1016/j.childyouth.2020.105259
28. D'Inverno AS, Reidy DE, Kearns MC. Preventing intimate partner violence through paid parental leave policies. *Prev Med*. 2018;114:18-23. doi:10.1016/j.ypmed.2018.05.024
29. Stanczyk AB. Does Paid Family Leave Improve Household Economic Security Following a Birth? Evidence from

California. *Soc Serv Rev*. 2019;93(2):262-304. doi:10.1086/703138
30. Stearns J. The effects of paid maternity leave: Evidence from Temporary Disability Insurance. *J Health Econ*. 2015;43:85-102. doi:10.1016/j.jhealeco.2015.04.005

**RELEVANT AMA POLICY**

**AMA Statement on Family, Medical, and Safe Leave H-420.979**

Our American Medical Association supports policies that provide employees with reasonable job security and continued availability of health plan benefits in the event leave by an employee becomes necessary due to documented medical conditions. Such policies should provide for reasonable periods of paid or unpaid:

1. Medical leave for the employee, including pregnancy, abortion, and stillbirth.
2. Maternity leave for the employee-mother.
3. Leave if medically appropriate to care for a member of the employee's immediate family, i.e., a spouse or children.
4. Leave for adoption or for foster care leading to adoption.
5. Safe leave provisions for those experiencing any instances of violence, including but not limited to intimate partner violence, sexual violence or coercion, and stalking.

Such periods of leave may differ with respect to each of the foregoing classifications and may vary with reasonable categories of employers. Such policies should encourage voluntary programs by employers and may provide for appropriate legislation (with or without financial assistance from government). Any legislative proposals will be reviewed through the Association's normal legislative process for appropriateness, taking into consideration all elements therein, including classifications of employees and employers, reasons for the leave, periods of leave recognized (whether paid or unpaid), obligations on return from leave, and other factors involved in order to achieve reasonable objectives recognizing the legitimate needs of employees and employers.

Our AMA recognizes the positive impact of paid safe leave on public health outcomes and supports legislation that offers safe leave

[BOT Rep. A, A-88 Reaffirmed: Sunset Report, I-98 Reaffirmed: CLRPD Rep. 1, A-08 Reaffirmation A-12 Reaffirmed: CMS Rep.03, A-16 Modified: Res. 302, I-22 Appended: Res. 413, A-23 Modified: Res. 424, A-23 Modified: Speakers Rep. 01, I-24]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 307
(I-25)

Introduced by: New Jersey

Subject: Integrating Artificial Intelligence (AI) Literacy Into UME, GME, and CME

Referred to: Reference Committee C

---

Whereas, the American Medical Association (AMA) has established policy on Augmented Intelligence in Health Care and has issued principles to guide trustworthy AI development, deployment, and use in clinical settings, including calls for education of physicians and trainees about AI's promises and limits; and

Whereas, peer-reviewed studies and surveys across specialties show trainees are already using AI tools, believe AI will play a current/future role in care, and desire formal training that includes ethics, equity, bias mitigation, evaluation, and safe workflow integration; and

Whereas, medical schools in New Jersey currently lack standardized AI curricula, despite the integration of AI-driven tools in affiliated teaching hospitals; and

Whereas, New Jersey's leading health systems are already deploying AI in radiology, oncology, cardiology, and predictive analytics for patient flow, demonstrating that resident physicians in NJ are encountering AI-enabled environments without structured training; and

Whereas, the State of New Jersey has recently launched initiatives positioning NJ as a hub for AI and life sciences innovation, further underscoring the importance of preparing NJ's physician workforce with AI literacy to align with state priorities; therefore be it

RESOLVED, that our American Medical Association support developing and disseminating model AI learning objectives and curricular toolkits aligned with existing AMA policy and AAMC principles (New HOD Policy); and be it further

RESOLVED, that our AMA collaborate with LCME and ACGME to recognize AI literacy elements within accreditation and program requirements where appropriate (Directive to Take Action); and be it further

RESOLVED, that our AMA support CME offerings to upskill the current workforce (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for funding and faculty-development resources to implement and evaluate such training initiatives (Directive to Take Action); and be it further

RESOLVED, that our AMA report back on progress, including uptake metrics, learner outcomes, and best practices for equitable implementation across diverse institutions. (Directive to Take Action)

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

Received: 9/26/25

**REFERENCES**

1. University of Miami, Cincinnati, Minnesota, UC Irvine AI curricula pilots (AAMC News).
   RSNA Imaging AI Certificate Program; ACR AI-LAB residency modules.
2. STFM AiM-PC (Artificial Intelligence & Machine Learning for Primary Care) Curriculum.
   Surveys of resident/faculty attitudes toward AI education (Academic Radiology, 2024).
   Rowan University AI resources and Edison Patent Award recognition (Rowan News, Rowan SOM LibGuide).
3. Rutgers NJMS Distinction in AI in Medicine.
4. Hackensack Meridian Health AI innovations (Google Cloud AI deployment, AI-powered primary care, AI-driven cardiology tools).
5. NJ Economic Development Authority & Governor Murphy's AI research/innovation hub initiatives (NJ Business Magazine).

**RELEVANT AMA POLICY**

AMA Policy on Augmented Intelligence in Health Care (H-480.940).
AMA Principles for AI in Healthcare (2023-2025 updates).
AAMC Principles for Responsible AI in Academic Medicine.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 308
(I-25)

Introduced by: New York

Subject: Enhancing the Pathway for Black Male Medical Students

Referred to: Reference Committee C

---

Whereas, the rate of Black male medical student matriculation rate is decreasing; and

Whereas, systemic barriers, including implicit bias, lack of mentorship, financial constraints, and institutional policies, contribute to the academic challenges faced by Black male medical students; and

Whereas, increasing diversity in the physician workforce has been linked to improved patient outcomes, particularly in underserved communities where Black physicians play a critical role in reducing health disparities; and therefore; therefore be it

RESOLVED, that, consistent with applicable laws, our American Medical Association support the development and funding of comprehensive mentorship programs connecting Black male pre-medical students with physician mentors, guiding academic preparation, MCAT preparation, the medical school application process, and career development (New HOD Policy); and be it further

RESOLVED, that, consistent with applicable laws, our AMA promote the expansion of loan repayment programs specifically designed to incentivize physicians to practice in underserved communities, where Black male populations are often concentrated (Directive to Take Action); and be it further

RESOLVED, that, consistent with applicable laws, our AMA develop faculty to promote unbiased assessment of the performance of medical learners to reduce disparities in medical school matriculation (Directive to Take Action); and be it further

RESOLVED, that, consistent with applicable laws, our AMA support the development of leadership training programs for Black male physicians, equipping them with the skills and knowledge to assume leadership roles in academic medicine, healthcare administration, and public health (New HOD Policy); and be it further

RESOLVED, that our AMA encourage collaboration between our AMA, medical schools, HBCUs, and community organizations. (New HOD Policy)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/26/25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 311
(I-25)

Introduced by: American Academy of Ophthalmology

Subject: Gender and URiM Disparities in Surgical Training Volumes

Referred to: Reference Committee C

---

Whereas, a 2018-2019 retrospective review of case logs from 133 vitreoretinal surgery fellows found a consistent trend for female fellows to report fewer total procedures than male fellows at the completion of training, with significantly fewer key procedures including endolaser (P = .018), internal limiting membrane peel (P = .042); and cyroretinopexy (P = .002); and

Whereas, a longitudinal analysis of 1,271 ophthalmology resident from 24 U.S. programs (2005-2017) found that female residents performed 15 fewer cataract surgeries and 58 fewer total procedures on average than men (P<.001), with disparities widening over time despite increases in overall surgical volume; and

Whereas, a national cohort study of 4,811 ophthalmology residents (2014–2023) confirmed these patterns, showing women performed 4.4% fewer cataract surgeries and 7.4% fewer total procedures than men (P < .001), and URiM residents performed 5.3% fewer total procedures than non-URiM peers (P = .02), disparities consistent across a decade of training data; and

Whereas, a cohort study of 2,544 graduating otolaryngology residents (2009–2017) found consistent gender-based differences in operative case volume, with male residents performing on average 34.8 more key indicator cases per year than female residents (P < .001), and 41.3 more cases when serving as primary surgeon or supervisor (P < .001), highlighting disparities in both operative exposure and leadership opportunities; and

Whereas, a multi-institutional study of 1,343 categorical general surgery graduates (2010–2020) from 20 ACGME-accredited programs found persistent gender disparities in operative experience, with female residents performing fewer total cases (1,140 vs. 1,177; P < .01) and less likely to be high-volume residents (27% vs. 36%, P < .01), though the gap showed signs of narrowing over time; and

Whereas, an analysis of orthopaedic surgery residency case logs from 2013–2022 demonstrated both gender- and race/ethnicity-based disparities, with early cohorts showing women reporting 33 fewer cases and URiM residents 29 fewer cases than peers, and while overall differences narrowed in later years, women continued to lag in several key case categories including anterior cruciate ligament reconstruction and total joint arthroplasty; and

Whereas, a national study of 3,335 urology residents from 145 ACGME-accredited programs (2013–2023) found persistent gender disparities, with women logging significantly fewer cases than men overall (1,374 vs. 1,423; P < .001), and men consistently performing more general urology, endoscopy, and oncology procedures; and

Whereas, the disparities in case distribution raise concerns about equity of opportunity, access to complex surgical experiences, and potential barriers to professional development; therefore be it

RESOLVED, that our American Medical Association recognize gender- and URiM-based disparities in surgical training volumes as an equity issue in graduate medical education, distinct from resident competency (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for the Accreditation Council for Graduate Medical Education (ACGME) and specialty boards to collect and publish aggregate, de-identified surgical case volume data stratified by gender and URiM status (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate that surgical residency and fellowship programs implement monitoring mechanisms to promote equitable case allocation, while reaffirming that all graduates meet established training requirements (Directive to Take Action); and be it further

RESOLVED, that our AMA support the development and dissemination of best practices—including mentorship initiatives, equitable case distribution systems, and supportive leave policies—to ensure fairness in operative experience across all surgical specialties (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 9/30/25

**REFERENCES**

1. Maffei JB, Johny A, Park YS, Holmboe E, Hogan SO, Badalato GM, Kraft KH, Mayer WA. The Effect of Gender on Case Log Volumes for Urology Residents: An 11 Year National Study. J Surg Educ. 2025 Jun;82(6):103515. doi: 10.1016/j.jsurg.2025.103515. Epub 2025 May 2. PMID: 40318562. https://www.sciencedirect.com/science/article/abs/pii/S1931720425000959?via%3Dihub
2. Culican SM, Syed MF, Park YS, Hogan SO. Gender Differences in Case Volume Among Ophthalmology Resident Graduates, 2014-2023. JAMA Ophthalmol. 2025 Jun 1;143(6):490-497. doi: 10.1001/jamaophthalmol.2025.0935. PMID: 40310612; PMCID: PMC12046517. https://jamanetwork.com/journals/jamaophthalmology/fullarticle/2833393
3. Shoga P, Van Heest A, Ames SE, Hogan SO, Holmboe E, Klingensmith M, Park YS, Parker C, Solberg E, Templeton K. Does Resident Gender or Race/Ethnicity Affect Orthopaedic Surgery Case Volume During Residency Training? JB JS Open Access. 2025 Feb 3;10(1):e24.00146. doi: 10.2106/JBJS.OA.24.00146. PMID: 39901939; PMCID: PMC11778099. https://pmc.ncbi.nlm.nih.gov/articles/PMC11778099/
4. Shoga P, Van Heest A, Ames SE, Hogan SO, Holmboe E, Klingensmith M, Park YS, Parker C, Solberg E, Templeton K. Does Resident Gender or Race/Ethnicity Affect Orthopaedic Surgery Case Volume During Residency Training? JB JS Open Access. 2025 Feb 3;10(1):e24.00146. doi: 10.2106/JBJS.OA.24.00146. PMID: 39901939; PMCID: PMC11778099. https://pmc.ncbi.nlm.nih.gov/articles/PMC11778099/
5. Winer LK, Kader S, Abelson JS, Hammaker AC, Eruchalu CN, Etheridge JC, Cho NL, Foote DC, Ivascu FA, Smith S, Postlewait LM, Greenwell K, Meister KM, Montgomery KB, Zmijewski P, Byrd SE, Kimbrough MK, Stopenski SJ, Nahmias JT, Harvey J, Farr D, Callahan ZM, Marks JA, Stahl CC, Al Yafi M, Sutton JM, Elsaadi A, Campbell SJ, Dodwad SM, Adams SD, Woeste MR, Martin RCG, Patel P, Anstadt MJ, Nasim BW, Willis RE, Patel JA, Newcomb MR, George BC, Quillin RC 3rd, Cortez AR. Disparities in the Operative Experience Between Female and Male General Surgery Residents: A Multi-institutional Study From the US ROPE Consortium. Ann Surg. 2023 Jul 1;278(1):1-7. doi: 10.1097/SLA.0000000000005847. Epub 2023 Mar 30. PMID: 36994704; PMCID: PMC10896185. https://pmc.ncbi.nlm.nih.gov/articles/PMC10896185/
6. Reyes-Capo DP, Yannuzzi NA, Chan RVP, Murray TG, Berrocal AM, Sridhar J. GENDER DIFFERENCES IN SELF-REPORTED PROCEDURAL VOLUME AMONG VITREORETINAL FELLOWS. Retina. 2021 Apr 1;41(4):867-871. doi: 10.1097/IAE.0000000000002942. PMID: 32796443. https://journals.lww.com/retinajournal/abstract/2021/04000/gender_differences_in_self_reported_procedural.27.aspx
7. Gurgel RK, Cardon BR, Allen CM, Presson AP, Kelly BC, Hopf HW, Choi SS, Miller RH. Evaluating gender parity in operative experience for otolaryngology residencies in the United States. Laryngoscope. 2020 Jul;130(7):1651-1656. doi: 10.1002/lary.28306. Epub 2019 Sep 18. PMID: 31532842. https://onlinelibrary.wiley.com/doi/10.1002/lary.28306
8. Gong D, Winn BJ, Beal CJ, Blomquist PH, Chen RW, Culican SM, Dagi Glass LR, Domeracki GF, Goshe JM, Jones JK, Khouri AS, Legault GL, Martin TJ, Mitchell KT, Naseri A, Oetting TA, Olson JH, Pettey JH, Reinoso MA, Reynolds AL, Siatkowski RM, SooHoo JR, Sun G, Syed MF, Tao JP, Taravati P, WuDunn D, Al-Aswad LA. Gender Differences in Case Volume Among Ophthalmology Residents. JAMA Ophthalmol. 2019 Sep 1;137(9):1015-1020. doi: 10.1001/jamaophthalmol.2019.2427. PMID: 31318390; PMCID: PMC6646997. https://jamanetwork.com/journals/jamaophthalmology/fullarticle/2738409

**RELEVANT AMA POLICY**

**D-295.963 Continued Support for Diversity in Medical Education**
Our American Medical Association will publicly state and reaffirm its support for diversity in medical education and acknowledge the incorporation of DEI efforts as a vital aspect of medical training.
1. Our AMA will request that the Liaison Committee on Medical Education regularly share statistics related to compliance with accreditation standards IS-16 and MS-8 with medical schools and with other stakeholder groups.
2. Our AMA will work with appropriate stakeholders to commission and enact the recommendations of a forward-looking, cross-continuum, external study of 21st century medical education focused on reimagining the future of health equity and racial justice in medical education, improving the diversity of the health workforce, and ameliorating inequitable outcomes among minoritized and marginalized patient populations.
3. Our AMA will advocate for funding to support the creation and sustainability of Historically Black College and University (HBCU), Hispanic-Serving Institution (HSI), and Tribal College and University (TCU) affiliated medical schools and residency programs, with the goal of achieving a physician workforce that is proportional to the racial, ethnic, and gender composition of the United States population.
4. Our AMA will directly oppose any local, state, or federal actions that aim to limit diversity, equity, and inclusion initiatives, curriculum requirements, or funding in medical education.
5. Our AMA will advocate for resources to establish and maintain DEI offices at medical schools that are staff-managed and student- and physician-guided as well as committed to longitudinal community engagement.
6. Our AMA will investigate the impacts of state legislation regarding DEI-related efforts on the education and careers of students, trainees, and faculty.
7. Our AMA will recognize the disproportionate efforts by and additional responsibilities placed on minoritized individuals to engage in diversity, equity, and inclusion efforts.
8. Our AMA will collaborate with the Association of American Medical Colleges, the Liaison Committee on Medical Education, and relevant stakeholders to encourage academic institutions to utilize Diversity, Equity, and Inclusion activities and community engagement as criteria for faculty and staff promotion and tenure. [Res. 325, A-03 Appended CME Rep. 6, A-11 Modified: CME Rep. 3, A-13; Appended: CME Rep. 5, A-21; Modified: CME Rep.02, I-22; Appended: Res 319, A-22; Modified: Res. 319, A-23; reaffirmed: BOT Rep. 31, A-24]

**H-295.969 Nondiscrimination Toward Residency Applicants**
Our American Medical Association urges the Accreditation Council for Graduate Medical Education to amend its Institutional Requirements to read: "In assessing and selecting applicants for residency/fellowship programs, ACGME-accredited programs must not discriminate on the basis of sex, age, race, creed, national origin, gender identity, or sexual orientation."
Our AMA:
1. opposes questioning residency or fellowship applicants regarding marital status, dependents, plans for marriage or children, sexual orientation, gender identity, age, race, national origin, and religion;
2. will work with the Accreditation Council for Graduate Medical Education, the National Residency Matching Program, and other interested parties to eliminate questioning about or discrimination based on marital and dependent status, future plans for marriage or children, sexual orientation, age, race, national origin, and religion during the residency and fellowship application process;
3. will continue to support efforts to enhance racial and ethnic diversity in medicine. Information regarding race and ethnicity may be voluntarily provided by residency and fellowship applicants;
4, encourages the Association of American Medical Colleges (AAMC) and its Electronic Residency Application Service (ERAS) Advisory Committee to develop steps to minimize bias in the ERAS and the residency training selection process; and
5. will advocate that modifications in the ERAS Residency Application to minimize bias consider the effects these changes may have on efforts to increase diversity in residency programs. [Res 12, A-89; Reaffirmed Sunset Report, A-00; Modified: Bot Rep. 11, A-07; Reaffirmed: CCB/CLRPD Rep. 1, A-14; Modified: CME Rep. 01, A-16]

**H-310.919 Eliminating Questions Regarding Marital Status, Dependents, Plans for Marriage or** Children, Sexual Orientation, Gender Identity, Age, Race, National Origin and Religion During the Residency and Fellowship Application Process
Our AMA:
1. opposes questioning residency or fellowship applicants regarding marital status, dependents, plans for marriage or children, sexual orientation, gender identity, age, race, national origin, and religion;
2. will work with the Accreditation Council for Graduate Medical Education, the National Residency Matching Program, and other interested parties to eliminate questioning about or discrimination based on marital and dependent status, future plans for marriage or children, sexual orientation, age, race, national origin, and religion during the residency and fellowship application process;
3. will continue to support efforts to enhance racial and ethnic diversity in medicine. Information regarding race and ethnicity may be voluntarily provided by residency and fellowship applicants;
4. encourages the Association of American Medical Colleges (AAMC) and its Electronic Residency Application Service (ERAS) Advisory Committee to develop steps to minimize bias in the ERAS and the residency training selection process; and
5. will advocate that modifications in the ERAS Residency Application to minimize bias consider the effects these changes may have on efforts to increase diversity in residency programs. [Res 307, A-09; Appended: Res 955, I-17]

**H-310.976 Gender-Based Questioning in Residency Interviews**
Our American Medical Association opposes gender-based questioning during residency interviews in both public and private institutions for the purpose of sexual discrimination. [Res.124, I-88; Reaffirmed: Sunset Report, I-98; Modified and Reaffirmed: CME Rep. 2, A-08; Reaffirmed: CCB/CLRPD Rep. 3. A-13; Modified: CME Rep. 01, A-23]

## Reference Committee F

**Report(s) of the Council on Long Range Planning and Development**

01 Private Practice Physicians Section Five-Year Review
02 Evaluation of the Structure of the AMA House of Delegates

**Report(s) of the HOD Committee on Compensation of the Officers**

01 Report of the House of Delegates Committee on the Compensation of the Officers

**Report(s) of the Speakers**

01 Online Reference Committees
02 Election Committee Review of Election Rules for Clarification

**Resolutions**

601 Reimagining and Modernizing the U.S. Healthcare Delivery System
602 Standardizing the Appointment Process for AMA Councils

REPORT OF THE COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT

CLRPD Report 1-I-25

Subject: Private Practice Physicians Section Five-Year Review

Presented by: Jan Kief, MD, Chair

Referred to: Reference Committee F

---

The Council on Long Range Planning and Development (CLRPD) analyzed information from a letter of application submitted before November 2024 from the Private Practice Physicians Section (PPPS) for renewal of delineated section status and representation in the American Medical Association (AMA) House of Delegates (HOD). The letter focuses on activities beginning in November 2020 special meeting of the HOD, when the Private Practice Physicians Caucus became the PPPS.

AMA Bylaw 7.0.9 states, "A delineated section must reconfirm its qualifications for continued delineated section status and associated representation in the House of Delegates by demonstrating at least every 5 years that it continues to meet the criteria adopted by the House of Delegates." AMA Bylaw 6.6.1.5 states that one function of the Council on Long Range Planning and Development (CLRPD) is "to evaluate and make recommendations to the House of Delegates, through the Board of Trustees, with respect to the formation and/or change in status of any section. The Council will apply criteria adopted by the House of Delegates."

APPLICATION OF CRITERIA

Criterion 1: Issue of Concern – Focus will relate to concerns that are distinctive to the subset within the broader, general issues that face medicine. A demonstrated need exists to deal with these matters, as they are not currently being addressed through an existing AMA group.

During its first five years the PPPS placed particular focus on the following issues:

*Leveling the Economic Playing Field*

PPPS advanced a resolution calling for a report illustrating the decades of fiscal losses and inequities that practices without facility fees have endured because of the site of service differential. The AMA produced and posted this analysis on its website for 18 months, increasing awareness of the inequities in reimbursement structures and providing a visual advocacy tool for policymakers and the public.

*Pharmacy Benefit Manager Control of Treating Disease States*

In response to growing concern over pharmacy benefits managers (PBMs) diverting patients to designated care teams, PPPS led development of AMA policy opposing this practice and called for immediate legal and policy measures to prevent it. Outcomes included AMA advocacy for network adequacy standards that prevent steerage of patients to certain physicians or other providers, the

© 2025 American Medical Association. All rights reserved.

development of "any willing provider" state model legislation and recognizing the need for federal oversight of relationships between PBMs and insurers. This issue remains a cross-sectional priority shared with the Organized Medical Staff Section (OMSS) and the Integrated Physician Practice Section (IPPS).

*Prior Authorization and Patient Autonomy*

PPPS successfully introduced a resolution directing the AMA to advocate for electronic prior authorization systems with transparent monitoring capabilities. The measure was incorporated into the AMA policy compendium, supporting broader advocacy to streamline prior authorization and reduce administrative burdens on physicians and patients.

*Proper Use of Virtual Overseas Assistants in Medical Practice*

The PPPS sponsored a resolution affirming that properly trained overseas virtual assistants are a legitimate administrative staffing option, while calling for AMA guidance to ensure patient, physician, and community protection. This led to the creation of a Board of Trustees report and a widely attended "Private Practice Simple Solutions" educational webinar. The virtual assistant tool is now used across multiple AMA sections.

The PPPS has provided expertise and undertaken efforts to address issues facing private practice physicians and those interested in independent practice. These included participating in an educational session at A-25 on the Centers for Medicare & Medicaid Services (CMS) Interoperability and Prior Authorization Final Rule and the role of HL7, a not-for-profit standards-developing organization for electronic health information. HL7 sought input from the PPPS members to provide real-life solutions on the final rule operationalization. Additionally, recognizing the challenges involved in starting an independent, physician-owned medical practice, PPPS has collaborated with AMA business units, particularly Professional Satisfaction and Practice Sustainability (PS2), on the design of a private practice incubator, a free-of-charge, 12-month program covering business planning, legal and regulatory considerations, contracting, human resources and patient acquisition. The program is designed to directly address the sustainability of independent practice models, and upon completion, participants will have developed a final business proposal for an independent practice.

The Section has placed a particular focus on improving the business climate for independent physicians who must, by necessity, possess expertise in the fundamentals of operating small businesses in addition to providing care and attention to patients. The PPPS has introduced resolutions that included efforts to roll back targeted components of Stark laws, which may interfere with an independent physician's business prospects, developing resources to optimize practice sustainability, and pioneering guidelines for ethical and appropriate use of offsite assistance. While the Section remains open to a variety of policy concerns as identified by independent physicians, its primary concern is ensuring the viability of private, independent physician practices.

Criterion 2: Consistency - Objectives and activities of the group are consistent with those of the AMA. Activities make good use of available resources and are not duplicative.

The PPPS has engaged in numerous efforts that support the AMA's strategic arcs. The Section has worked to address key issues impeding physicians' ability to deliver care including advocating for preserving private practice options in corporate health care environments, promoting continuity of care across diverse medical challenges, supporting physician reimbursement for interpreter

services, and addressing financial conflicts in corporate medicine. By leading educational programming, the Section has addressed emerging issues such as physician burnout, workplace violence, and cybersecurity. Other sessions have focused on empowering physicians through practice growth strategies, navigating employment contracts, and fostering success in private practice. These initiatives underscore the Section's commitment to reimagining medical education and lifelong learning to meet modern health care demands.

Each year, the PPPS Governing Council (GC) and staff collaborate to refine a comprehensive strategic plan for the Section. This plan outlines key initiatives with timelines that span monthly, biannual, and long-term actions. Strategic priorities include governance, such as internal operating procedures (IOPs) and the resolution development timeline, as well as efforts to expand membership and strengthen partnerships with other sections.

The Section works closely with the Marketing and Member Experience (MMX) business unit to identify shared goals and areas of mutual interest for private practice physicians. Notably, the PS2 business unit has been highly engaged, partnering with the Section to launch initiatives such as the Private Practice Boot Camp and the new Private Practice Physician Incubator, designed to support aspiring independent physicians.

Criterion 3: Appropriateness – The structure of the group will be consistent with its objectives and activities.

The PPPS is structured to allow for open participation by any member on nearly all functions of the Section, while the GC is tasked with managing the operational functions of the Section through monthly virtual meetings. Major directional planning for the Section is put toward the general membership for discussion, debate, and approval.

The PPPS relies heavily on its GroupMe and Google Group email list, both of which are open to PPPS members, to hear concerns from membership and to share new educational, policy, or experiential opportunities. Town halls are also structured for members to bring attention to issues related to their practices or to Section functioning.

Any PPPS member in good standing may submit a resolution for consideration at an annual or interim meeting of the HOD. All resolutions are accepted provided they pass a review from the AMA Office of the General Counsel. The PPPS Reference Committee reviews resolutions and makes recommendations, however that committee's review and conclusions are shared with the Section and the PPPS Assembly makes final determinations on amendments and whether resolutions are adopted by PPPS.

The only major change to the Section's operations since its inception five years ago is the adoption of the use of a PPPS online forum as a primary avenue for policy debate. The online forum was initially used as an emergency mechanism for policy discussion during the first years of the COVID-19 pandemic when face-to-face meetings were replaced by virtual meetings. Since the return of in-person meetings, the Section has found maintaining the online forum to be advantageous as it allows a greater number of members to review and comment on policy without requiring them to leave their practices to travel to an annual or interim meeting.

Since obtaining section status, much of the PPPS leadership has been comprised of legacy leadership from its time as a caucus, with the first two Chairs and the first and current Delegate comprised of longtime Private Practice Physician Caucus leadership. Members of the next generation of leaders have been identified through personal connections with existing GC members

or risen through involvement with Section committees or other organizing events. The Section has carefully employed mechanisms like voluntary committee service as a potential recruitment pipeline for developing future PPPS leadership and plans to continue to generate similar opportunities to open multiple pathways to future leadership.

Criterion 4: Representation Threshold – Members of the formal group would be based on identifiable segments of the physician population and AMA membership. The formal group would be a clearly identifiable segment of AMA membership and the general physician population. A substantial number of members would be represented by this formal group. At minimum, this group would be able to represent 1,000 AMA members.

The IOPs for PPPS state that Section members are AMA members in a physician-owned private practice. A physician-owned private practice shall be defined as a practice comprising 50 or fewer physicians in which those physicians, in the aggregate, own a controlling interest.

According to the 2024 AMA physician benchmark survey, 35.4 percent of physicians held an ownership stake in their practice, and 42.2 percent of physicians worked in practices that were wholly owned by physicians. In that study, the estimated eligible physician population was 737,195, meaning that 260,967 physicians in the United States held an ownership stake in their practice and 311,096 physicians worked in practices that were wholly owned by physicians. If the AMA's market share of active physicians is approximately 15 percent, approximately 39,145 AMA member physicians may hold an ownership stake in their practice, and approximately 46,664 AMA members may work in practices wholly owned by physicians. Additionally, per CLRPD Report 3-A-25, 15,703 AMA members practiced in self-employed solo practice and 3,780 physicians worked in two physician practices. While this total (19,483) does not represent all private practice physician members of the AMA, it is significantly higher than the 1,000 AMA member threshold required for delineated section status.

Criterion 5: Stability – The group has a demonstrated history of continuity. This segment can demonstrate an ongoing and viable group of physicians will be represented by this section and both the segment and the AMA will benefit from an increased voice within the policymaking body.

Membership in the PPPS has steadily increased since its founding in 2020. Starting with an initial membership of 191 members, in 2025 the membership totaled 387. Average growth over the past four years is approximately 20 percent, however growth slowed from year to year following an initial burst in new membership interest, likely due to the novel nature of the Section.

This membership represents physicians from solo practices and multi-physician practices. Among physicians in multi-physician practices, only the physician that applied to PPPS is credentialed by the Section and counts toward Section membership. An analysis of the PPPS membership roster revealed 40 members with double digit physician representation. Adding the number of private practice physicians in each of those 40 practices yielded a total of 1,062 physicians. In addition to those physicians in solo practice, a conservative estimate is that 1,409 private practice physicians are directly represented in the PPPS through their Section membership.

Criterion 6: Accessibility – Provides opportunity for members of the constituency who are otherwise underrepresented to introduce issues of concern and to be able to participate in the policymaking process within the AMA HOD.

The PPPS is one of three AMA sections that advocate through the lens of practice setting rather than demographics or career stage. While the OMSS and the IPPS represent employed physicians

or those whose income is largely tied to corporate or contractual arrangements, PPPS is unique in its representation of independent physicians who own or co-own small practices and retain operational and financial control. Without PPPS, there would be no formalized structure within the AMA to identify issues unique to private practice physicians, develop policy solutions tailored to small-scale, independent practice realities and ensure these issues reach the HOD for consideration. PPPS offers multiple avenues for members to introduce issues and engage in policymaking including the opportunity to develop resolutions for all members in good standing. Open forums and virtual town halls give members opportunities to discuss practice-specific challenges and shape resolutions collaboratively and allow members to work with elected Section leadership to refine policy language and prepare for HOD advocacy. All proposed resolutions are accepted as items of business following legal review from the AMA Office of the General Counsel. Resolutions are reviewed by a reference committee composed of PPPS members, or, in the event of late or emergency resolutions, by the PPPS Chair and Chair-Elect. The Section maintains a Resolution Writing Committee that serves as a peer resource for members who request assistance in drafting their resolutions. These processes ensure that solo and small-group physicians have a direct pipeline to influence AMA policy at the national level.

The Section develops consensus on policy and advocacy activities through its annual and interim business meetings and through virtual town halls held typically at least twice per year at times separate from the annual and interim meetings. The Section utilizes an online forum for all proposed resolutions that is open to any AMA member and serves as a mechanism for delivering testimony when a member may otherwise be unable to attend a face-to-face or virtual meeting. All policy is presented to the Section Assembly for amendment and approval before being forwarded to the HOD. Likewise, operational changes such as updating of IOPs can be devised by Section leadership or select committees, however approval of any recommended changes is presented to the Section Assembly for approval and ratification.

DISCUSSION

PPPS addresses issues uniquely impacting independent, physician-owned practices, concerns not fully addressed by other AMA groups. Their successes since obtaining section status include advancing policy on the site of service differential, PBM control of treating disease states, prior authorization reform, and guidance on overseas virtual assistants. Current initiatives, such as influencing the operationalization of CMS technology standards and launching a private practice incubator, show responsiveness to evolving member needs. This targeted focus ensures that AMA policymaking includes perspectives essential to sustaining small, independent practices.

The Section’s structure fosters open participation: any member in good standing can submit resolutions, engage in policy debate via online forums and meetings, and join committees. GC oversight is balanced by member-driven direction. The use of virtual communications and tools like the PPPS Newsletter, GroupMe, and a Google Group listserv expands access and feedback opportunities. While structural changes have been minimal, the adoption of online policy forums has enhanced inclusivity and efficiency.

Since its founding in 2020, PPPS has maintained a membership growth averaging approximately 20 percent annually; consistent meeting attendance, with at least 50 members participating at major meetings; and robust asynchronous communication strategies. These tools facilitate rapid mobilization, as seen in the Change Healthcare cyberattack response when the Department of Justice (DOJ) looked to connect with physicians who were directly affected by the attack. The PPPS was able to connect members to DOJ efforts to provide relief to practices as well as build a

case for legal action and protection. Regular programming including town halls, webinars, and educational sessions supports continuous engagement and policy advancement.

Private practice physicians are now a minority in U.S. medicine, and the PPPS ensures the perspectives of independent physicians are represented in organized medicine through open resolution submission, transparent debate, and multiple participation channels. This structure enables members, many of whom are unable to leave their practices for extended travel, to influence AMA and HOD agendas. The Section's culture values autonomy, reflecting its members' practice environments.

PPPS amplifies the critical, underrepresented perspective of physicians who both provide care and manage small businesses. Their dual clinical and operational expertise informs policy on payment equity, regulatory burden, and practice viability, issues that are central to preserving patient access outside large corporate systems. The Section's targeted advocacy complements the AMA's broader efforts, avoids redundancy through structured collaboration, and drives innovative solutions like the Private Practice Boot Camp and the Private Practice Physician Incubator. By sustaining and growing independent practice representation, PPPS strengthens the diversity, credibility, and reach of AMA policymaking.

The Council appreciates the thorough work of PPPS leadership and staff in completing this letter of application and follow-up communications, as well as the deliberation of the Section as it looks to build on its first five successful years of delineated section status.

CONCLUSION

The CLRPD has determined that the PPPS meets all criteria; therefore, it is appropriate to renew the delineated section status of the section, allowing the continued focused representation of PPPS members in the HOD.

RECOMMENDATION

The Council on Long Range Planning and Development recommends that our American Medical Association renew delineated section status for the Private Practice Physicians Section through 2030 with the next review no later than the 2030 Interim Meeting and that the remainder of this report be filed. (Directive to Take Action)

Fiscal Note: Minimal

REPORT OF THE COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT

CLRPD Report 2-I-25

Subject: Evaluation of the Structure of the AMA House of Delegates

Presented by: Jan Kief, MD, Chair

Referred to: Reference Committee F

---

As noted in Board of Trustees (BOT) Report 27-A-25, "AMA Reimbursement of Necessary HOD Business Expenses for Delegates and Alternates," the Council on Long Range Planning and Development (CLRPD) has been asked to comprehensively study and report back on potential changes to the length, format and structure of future AMA House of Delegates (HOD or House) meetings. The charge to CLRPD has been further defined to studying possible solutions to address the issue of the rapid growth of the HOD, while preserving its representative nature and improving efficiency and effectiveness.

This report highlights major events that have led to the current delegate apportionment procedure for the HOD and proposes placing a temporary pause on increases to delegate apportionment to allow your AMA HOD, the Council and the Board of Trustees time to thoughtfully consider the current structure of the House. The Council wishes to emphasize that this is just one step in what it hopes will be an open and collaborative process to determine the best course for the future of the HOD. To that end, the Council will be hosting a listening session at the 2025 Interim Meeting and hopes that all delegates and members present will attend and share their thoughts on the current function and structure of the HOD, and what changes they think would lead to the most optimal performance of the body moving forward.

## HOD APPORTIONMENT

The history of the AMA's HOD is important context for understanding current challenges and potential paths forward. The following highlights key events since the formation of the HOD in 1901 that led to the current apportionment model for the HOD. The initial model of the House was limited to delegates from constituent societies (U.S. states and territories), initially at a ratio of one delegate per every 500 members in the state, and since 1946 at a ratio of 1:1000.

With the adoption of Council on Long Range Planning and Development Report A-I-77, "Specialty Society Representation," pathways for direct specialty society representation were created. From 1978 to 1996, each specialty society, 50 at the outset, was apportioned one delegate regardless of the number of AMA members in that specialty. The recognition of the increasing number of smaller and more narrowly focused specialty organizations wishing to participate in the HOD led to the adoption of CLRPD Report D-I-90, "Representation of Specialty Organizations in the House of Delegates," which created alternative pathways with reduced membership thresholds for organizations wishing to join the HOD. In 1996, the House adopted recommendation 8 of BOT Report 2-A-96, "Transmission of the Report of the Study of the Federation," by which specialty societies would be apportioned one delegate for every 2,000 AMA members. Three years later, the representation ratio was reduced to one delegate for every 1,000 AMA members. At the 2016

© 2025 American Medical Association. All rights reserved.

Interim Meeting BOT Report 6-I-16, "Designation of Specialty Societies for Representation in the House of Delegates," modified the specialty society delegate allocation system so that the total number of national specialty society delegates would be equal to the total number of delegates apportioned to constituent societies, leading to an immediate and significant increase in the number of HOD delegates.

CLRPD Report 1-A-99, "Admission of Professional Interest Medical Associations," created a process through which Professional Interest Medical Associations (PIMAs) could be admitted to the HOD and be apportioned a single delegate each, as is the case with the federal services, AMA sections, American Medical Women's Association, American Osteopathic Association, and the National Medical Association. PIMAs represented in the HOD in 2025 were the American Association of Physicians of Indian Origin, American Medical Group Association, and GLMA: Health Professionals Advancing LGBTQ+ Equality.

To be represented in the HOD, specialty organizations and PIMAs must meet one of three criteria: have 1,000 AMA members; have 100 AMA members with 20 percent of eligible physicians in the AMA; or have had HOD representation at the 1990 Annual Meeting and have 20 percent AMA membership among its constituents. Groups must also be members of the Specialty and Service Society (SSS) for at least three years and are evaluated by the SSS Rules Committee using publicly available criteria. BOT Report 30-A-05, "Representation of Specialty Societies in the AMA House of Delegates" includes a history of HOD's delegate apportionment.

Student and resident/fellow representation were added in 1969 and 1971, respectively, to the HOD, with one delegate for each section. The adoption of BOT Report 19-I-00, "Medical Student Representation in the AMA House of Delegates," and BOT Report 20-A-06, "Resident and Fellow Representation in the AMA House of Delegates" led to the apportionment of one medical student delegate for every 2,000 medical student members in each of the seven regions defined in the Medical Student Section (MSS) Regional Section Structure, and one Resident and Fellow Section (RFS) delegate and for every 2,000 resident members, respectively.

Current allocation numbers as of January 1, 2025, consist of the following: constituent delegates 322; specialty delegates 322; section delegates 12; PIMA and other national society delegates 6; armed services 5; medical student delegates 25; and resident and fellow sectional delegates 41.

## CHALLENGES ASSOCIATED WITH HOD GROWTH

Continual increases in membership, driven in large part by the successful initiatives of the Marketing and Member Experience (MMX) unit, have resulted in recent increases in the delegate count of the HOD.

CLRPD's analysis finds the size of the HOD since 1990 has increased from 435 delegates to 733, a 68 percent increase (see graphic 1 in Appendix A). In recent years the growth in the number of delegates has accelerated even further, and in the last ten years alone, the HOD has increased in size by nearly 200 delegates, an increase of 35.7 percent. In its current structure, the HOD is projected in 2026 to add 55 additional delegates for an approximate total of 780. Membership growth has increased the number of constituent delegates, and due to parity between state and specialty apportionment established in 2016, has similarly increased the number of specialty delegates. The recent growth in the number of delegates has created pain points associated with logistics, cost and the deliberations of the HOD.

Duplicative apportionment tallies: Constituent associations use the total number of physicians, residents and medical students residing in the state or territory when reporting membership numbers, which then apply towards not only their allocation but also towards specialty allocations due to state/specialty parity. Additionally, specialty organizations and PIMAs include residents and fellows and sometimes medical students towards their total AMA membership. AMA members may be members of more than one of the 132 specialties represented in the HOD, and therefore, count towards each organization's membership. All of these factors can lead to members being counted multiple times to determine HOD apportionment.

Disproportional representation and membership: While the total number of AMA members is similar in 2024 compared to 1999, the HOD's size has significantly increased, due to specialty/state delegate parity, the addition of smaller specialty societies due to lowering of thresholds for representation, the addition of RFS and MSS delegations, and group memberships for physicians and residents. In 1999, the ratio of members to delegates was 591:1; in 2024, the ratio has been reduced to 441:1. (See graphic 2 in Appendix A).

Venues: Collaborating with AMA Meeting Services, CLRPD found only four venues nationwide that can accommodate the HOD's current size while meeting AMA's policy requirements. This was reported to the BOT in 2024. According to the Chicago Fire Marshall, A-25 exceeded the capacity of the ballroom at the Hyatt Regency Chicago (and would have also exceeded the capacities for all other scheduled venues). This situation created a safety issue and made it physically difficult for delegates and alternate delegates to carry out deliberations. This creates an obstacle to participation and limits the House's ability to debate and develop policy.

Cost: A larger HOD incurs greater costs for the AMA and federation societies, as well as for attendees. Convention centers are significantly more expensive than hotels and their usage may inadvertently create pressure to grow the HOD even more in order to reduce the per person cost. Additionally, few if any convention centers offer enough small meeting spaces needed for section, delegation, and caucus activities, while creating new accessibility challenges for attendees. The AMA's Emergency Assistance Pilot Program (EAP) was established in 2024 for two years (four meetings) as a temporary measure to help support federation members and ends in I-26. The EAP provided partial reimbursement to societies meeting its criteria for the attendance of 300 delegates and alternates at its first meeting, A-25. While the EAP helped with some attendance costs, physicians additionally face lost income from time away from their practice at a time when physician payments are already strained, and federation societies continue to face significant financial challenges. A cost savings plan to shorten each meeting by one day was ultimately paused for 2025 until further cost saving considerations could be evaluated. Efficiencies in this area that help decrease costs should still be considered as the cost savings would be significant for not only the AMA but also the federation and all attendees.

## AMA I-25 CLRPD EDUCATION AND LISTENING SESSION AND NEXT STEPS

CLRPD encourages all delegations to attend an important session on Sunday, November 16th from 11 a.m. – noon Eastern Time. During this 60-minute session, CLRPD will review key information presented in this report and facilitate a conversation for members to share ideas for setting the HOD on a course that is sustainable, equitable, and representative of AMA's diverse membership. The council is interested in learning all potential solutions to the problems with the size and function of our HOD. CLRPD will compile and analyze the data from this listening session, additional stakeholder surveys, and research into governance best practices. It will also convene several virtual meetings for the HOD. A comprehensive report on the Council's findings will be presented at the 2026 Interim Meeting.

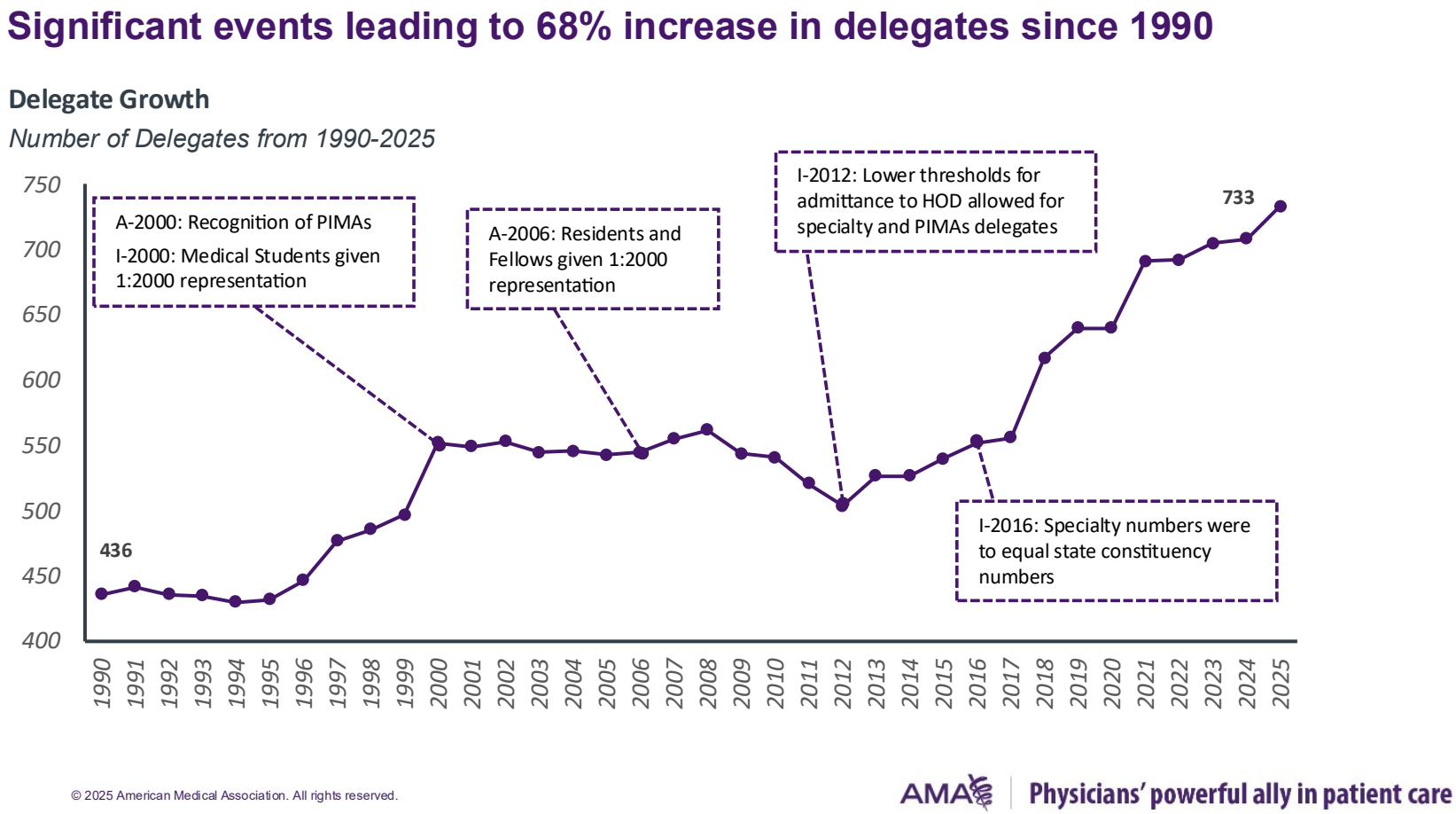
While this work takes place, the Council believes that instituting a temporary pause on increases to delegate allocation will allow the House to avoid further logistical disruption that would likely accompany the addition of 50-plus additional delegates to next year's apportionment.

RECOMMENDATION

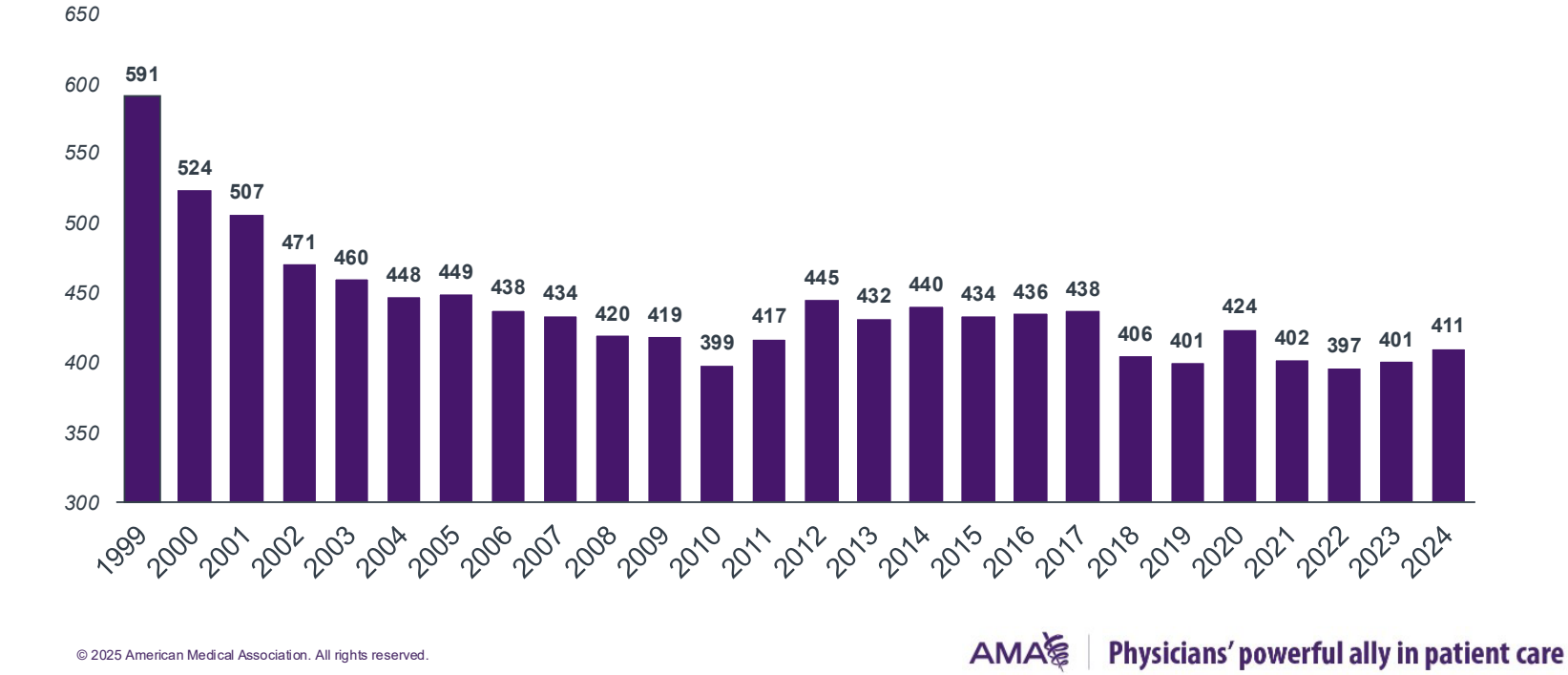
The Council on Long Range Planning and Development recommends that the delegate apportionment for the AMA House of Delegates be paused at 2025 levels through year-end 2026 and that this report be filed.

Fiscal Note: Minimal

Appendix A




Graphic 1. Significant events leading to 68% increase in HOD delegates, 1990-2025.




Graphic 2. Ratio of members represented by HOD Delegates 1999-2024.

APPENDIX B: RELATED AMA POLICIES

Statement of Collaborative Intent G-620.030

Designation of Specialty Societies for Representation in the House of Delegates G-600.027

Delegate Apportionment and Pending Members G-600.959

Specialty Organizations Seated in our AMA House of Delegates D-600.984

Admission of Professional Interest Medical Associations to our AMA House G-600.022

AMA Reimbursement of Necessary HOD Business Meeting Expenses for Delegates and Alternates D-600.951

Composition and Representation. B-2.0.1

Constituent Associations. B-2.1

Meetings of the House of Delegates. B-2.12

Committee on Rules and Credentials. B-2.13.2

National Medical Specialty Organizations. B-2.2

Medical Student Regional Delegates. B-2.3

Delegates from the Resident and Fellow Section. B-2.4

Speaker and Vice Speaker Additional Delegate. B-2.5

Other Delegates. B-2.6

Alternate Delegates. B-2.8

Delegate and Alternate Delegate. B-7.0.5

Representation in the House of Delegates. B-8.1

Responsibilities of National Medical Specialty Societies and Professional Interest Medical Associations. B-8.2

Specialty and Service Society. B-8.3

Application for Representation in the House of Delegates. B-8.4

Periodic Review Process. B-8.5

# REPORT OF THE HOUSE OF DELEGATES COMMITTEE ON THE COMPENSATION OF THE OFFICERS

Compensation Committee Report, I-2025

Subject: REPORT OF THE HOUSE OF DELEGATES COMMITTEE ON THE COMPENSATION OF THE OFFICERS

Presented by: Jessica Krant, MD, Chair

Referred to: Reference Committee F

---

This report by the committee at the November 2025 Interim Meeting documents the compensation paid to Officers for the period July 1, 2024, through June 30, 2025, including 2024 calendar year IRS reported taxable value of benefits, perquisites, and services for all Officers.

## BACKGROUND

At the 1998 Interim Meeting, the House of Delegates (HOD) established a House Committee on Trustee Compensation, currently named the Committee on Compensation of the Officers, (the "Committee"). The Officers are defined in the American Medical Association's (AMA) Constitution and Bylaws. (Note: under changes to the Constitution previously approved by the HOD, Article V refers simply to "Officer," which includes all 21 members of the Board among whom are President, President-Elect, Immediate Past President, Secretary, Speaker and Vice Speaker of the HOD, collectively referred to in this report as Officers.) The composition, appointment, tenure, vacancy process and reporting requirements for the Committee are covered under the AMA Bylaws. Bylaws 2.13.4.5 provides:

> The Committee shall present an annual report to the House of Delegates recommending the level of total compensation for the Officers for the following year. The recommendations of the report may be adopted, not adopted, or referred back to the Committee, and may be amended for clarification only with the concurrence of the Committee.

At A-00, the Committee and the Board jointly adopted the American Compensation Association's definition of total compensation which was added to the Glossary of the AMA Constitution and Bylaws. Total compensation is defined as the complete reward/recognition package awarded to an individual for work performance, including: (a) all forms of money or cash compensation; (b) benefits; (c) perquisites; (d) services; and (e) in-kind payments.

Since the inception of this Committee, its reports document the process the Committee follows to ensure that current or recommended Officer compensation is based on sound, fair, cost-effective compensation practices derived from research and use of independent external consultants, expert in Board compensation. Reports beginning in December 2002 documented the principles the Committee followed in creating its recommendations for Officer compensation.

© 2025 American Medical Association. All rights reserved.

CASH COMPENSATION SUMMARY

The cash compensation of the Officers shown in the following table will not be the same as compensation reported annually on the AMA's IRS Form 990s because Form 990s are based on a calendar year. The total cash compensation in the summary is compensation for the days these officers spent away from home on AMA business approved by the Board Chair. The total cash compensation in the summary includes work as defined by the Governance Honorarium, Per Diem for Representation and Telephonic Per Diem for External Representation.

The summary covers July 1, 2024, to June 30, 2025.

| AMA Officers | Position | Total Compensation | Total Days |
|---|---|---|---|
| David H Aizuss, MD | Chair-Elect | $211,630 | 73 |
| Toluwalase A. Ajayi, MD | Secretary | $92,200 | 72 |
| John H. Armstrong, MD | Vice Speaker, House of Delegates | $74,700 | 68 |
| Geralyn R. Breig | Officer | $67,000 | 34.5 |
| Madelyn E. Butler, MD | Officer | $76,800 | 53.5 |
| Alex Ding, MD, MS, MBA | Officer | $76,100 | 59.5 |
| Lisa Bohman Egbert, MD | Speaker, House of Delegates | $133,500 | 102.5 |
| Jesse M. Ehrenfeld, MD, MPH | Immediate Past President | $290,659 | 111.5 |
| Scott Ferguson, MD | Officer | $75,400 | 45.5 |
| Sandra Adamson Fryhofer, MD | Officer | $98,500 | 72.5 |
| Melissa J. Garretson, MD | Officer | $72,600 | 47.5 |
| Marilyn Heine, MD | Officer | $92,200 | 66.5 |
| Pauline P. Huynh, MD | Officer | - | 3 |
| Lynn Jeffers, MD, MBA | Officer | $71,900 | 55.5 |
| Pratistha Koirala, MD, PhD | Officer | $67,000 | 36.5 |
| Ilse R. Levin, DO, MPH & TM | Officer | $83,100 | 56 |
| Justin W. Magrath, PhD | Officer | - | 2 |
| Bobby Mukkamala, MD | President-Elect | $290,659 | 118 |
| Sheila Rege, MD | Officer | - | 3.5 |
| Bruce A. Scott, MD | President | $298,865 | 146 |
| Aliya Siddiqui, MS | Officer | $83,800 | 63.5 |
| Michael Suk, MD, JD, MPH, MBA | Chair | $285,886 | 122.5 |
| Willie Underwood, III, MD, MSc, MPH | Immediate Past Chair | $113,200 | 100.5 |
| Marta J. Van Beek, MD | Officer | - | 2 |
| David Welsh, MD, MBA | Officer | $82,400 | 52 |

President, President-Elect, Immediate Past President, and Chair
In 2024-2025, each of these positions received an annual Governance Honorarium which was paid in monthly increments. These four positions spent a total of 498 days on approved Assignment and Travel, or on average, 124.5 days each.

Chair-Elect
This position received a Governance Honorarium of approximately 74% of the Governance Honorarium provided to the Chair.

All Other Officers
All other Officers received cash compensation, which included a Governance Honorarium of $67,000 paid in monthly installments and per diems for approved assignment days.

Assignment and Travel Days
As defined, these are Assignment and Travel Days that are approved by the Board Chair to externally represent the AMA and for Internal Representation above 11 days. These days were compensated at a per diem rate of $1,400. The total Assignment and Travel Days for all Officers (excluding the President, President-Elect, Immediate Past President, and Chair) were 1,069.5.

EXPENSES

Total expenses paid for period, July 1, 2024 – June 30, 2025, was $1,061,975.

BENEFITS, PERQUISITES AND SERVICES

Officers are able to request benefits, perquisites and services, as defined in the "AMA Board of Trustees Standing Rules on Travel Expenses." These non-taxable business expenses are provided to assist the Officers in performing their duties.

- AMA Standard laptop computer or iPad
- American Express card (for AMA business use)
- Combination fax/printer/scanner (reimbursable up to $250)
- An annual membership to the airline club of choice offered each year during the Board member's tenure
- Personalized AMA stationery, business cards, and biographical data for official use
- Airline upgrade allowances of up to $5,000 per term for Presidents and $2,500 per term for all other Officers.

Additionally, all Officers are eligible for $305,000 term life insurance and are covered under the AMA's $500,000 travel accident policy and $10,000 individual policy for medical costs arising out of any accident while traveling on official business for the AMA. Life insurance premiums paid by the AMA are reported as taxable income. Also, travel assistance is available to all Officers when traveling more than 100 miles from home or internationally.

Secretarial support, other than that provided by the AMA's Board office, is available up to defined annual limits as follows: President, during the Presidential year, $15,000, and $5,000 each for the President-Elect, Chair, Chair-Elect, and Immediate Past President per year. Secretarial expenses incurred by other Officers in conjunction with their official duties are paid up to $750 per year per Officer. This is reported as taxable income to the recipient. Calendar year taxable life insurance and taxable secretarial fees included in the 2024 compensation reported to the IRS for the above individuals totaled $15,732 and $26,875 respectively. An additional $16,500 was paid to third parties for secretarial services during 2024.

Officers are also eligible to participate in a service provided to AMA employees by Care@Work through Care.com. This service offers referral services at no cost and back-up care for children and

adults up to 10 days a calendar year at a subsidized rate. If a Board member uses back-up care, it will be reported to the IRS as taxable income.

METHODOLOGY

In June 2024, the Committee commissioned Ms. Becky Glantz Huddleston, a consultant expert in board compensation with WTW, to update the 2019 research on compensation of non-leadership Officers. The purpose of the review was to ensure non-leadership roles are compensated appropriately for their work performed on behalf of the AMA. As a result of this analysis, the Committee recommended increases to the maximum secretarial support reimbursement for non-leadership Board Officers. The HOD approved an increase to the maximum secretarial support reimbursement from $750 to $1,125, effective January 1, 2025.

In November 2024, the Committee further recommended an increase to the honorariums and per diems for non-leadership Board Officers. The following recommendations were approved by the HOD effective July 1, 2025: the Governance Honorarium for non-leadership Board Officers increased by $1,500 to $68,500, the Per Diem for Representation increased by $150 to $1,550 and the Telephonic Per Diem increased by $75 to $775.

In June 2025, the Committee commissioned Ms. Becky Glantz Huddleston to review the compensation of the Speaker and Vice Speaker of the HOD. As a result of this analysis, the Committee recommended increases to the Governance Honorariums for the Speaker and Vice Speaker and the elimination of Per Diems for Internal Representation for all Officers. The following recommendations were approved by the HOD effective July 1, 2025: the Governance Honorariums for the Speaker and Vice Speaker increased to $125,000 and $115,000 respectively and Per Diems were eliminated in their entirety for those two positions. Additionally, Internal Per Diems were eliminated for non-leadership Officers.

FINDINGS

The Committee notes that Officers continue to make significant time commitments in supporting the AMA in governance and representation functions. Given the amount of time required by Board members, it is important that individuals seeking a position on the Board be aware of the scope of the commitment and the related compensation.

Based on the Committee's review of Officer compensation and recent changes to Officer compensation approved effective January 1, 2025, and July 1, 2025, the Committee recommends no additional changes to Officer compensation at this time.

The Committee thanks our Officers for their representation of the AMA.

RECOMMENDATION

1. That there be no additional changes to the Officers' compensation for the period beginning July 1, 2025, through June 30, 2026. (Directive to Take Action.)

2. That the remainder of the report be filed.

Fiscal Note: $0

APPENDIX

Board Leadership Honoraria during the Period of July 1, 2024, to June 30, 2025

| **POSITION** | **GOVERNANCE HONORARIUM** |
|---|---|
| President | $298,865 |
| Immediate Past President | $290,659 |
| President-Elect | $290,659 |
| Chair | $285,886 |
| Chair-Elect | $211,630 |

REPORT OF THE SPEAKERS

Speakers' Report 1-I-25

Subject: Online Reference Committee

Presented by: Lisa Bohman Egbert, MD, Speaker and John H. Armstrong, MD, Vice Speaker

Referred to: Reference Committee F

---

The American Medical Association Policy G-600.045, "Online Reference Committee Hearings in the House of Delegates," asks that our AMA:

> Convene Online Reference Committee Hearings prior to each House of Delegates meeting. These hearings shall open 10 days following the resolution submission deadline and remain open for 21 days.

DISCUSSION

The 21-day window for Online Reference Committees (ORCs) to be open for comment was established by Speakers' Report 1-A-24, "Report of the Resolution Modernization Task Force Update." Utilization data from the 2024 Interim Meeting and 2025 Annual Meeting show that the majority of comments are made during the first several days of the ORCs being open followed by a flurry of activity the last few days and hours prior to the close of the ORCs. After reviewing this data, your Speakers have determined that reducing the window that ORCs are open to 14 days, would allow more time for reference committees to develop and post Preliminary Reference Committee reports while providing delegations and caucuses with a similar timeframe to comment that has been previously utilized and more time to review the preliminary recommendations.

RECOMMENDATION

Your Speakers recommend that Policy G-600.045, "Online Reference Committee Hearings in the House of Delegates," be amended by addition and deletion and the remainder of the report be filed:

1. Our American Medical Association will convene Online Reference Committee Hearings prior to each House of Delegates meeting. These hearings shall open 10 days following the resolution submission deadline and remain open for ~~21~~ 14 days.

Fiscal note: Minimal

© 2025 American Medical Association. All rights reserved.

REPORT OF THE SPEAKERS

Speakers' Report 2-I-25

Subject: Election Committee Review of Election Rules for Clarification

Presented by: Lisa Bohman Egbert, MD, Speaker and John H. Armstrong, MD, Vice Speaker

Referred to: Reference Committee F

---

The American Medical Association's (AMA) policy G-610.090, "AMA Election Rules and Guiding Principles," has undergone significant changes over the last several years. Much of this work was done by Election Task Forces 1 and 2. The feedback on the elections rules changes has been positive. However, there are a few areas that have elicited questions over the last several election cycles. Therefore, your Speakers asked the Election Committee to identify areas within the rules in need of clarification. After careful consideration, the Election Committee recommended several clarifications.

DISCUSSION

*Election complaint process*

Although the necessary elements of an election complaint and to whom it must be reported are clearly delineated in policy, the formal complaint filing process is not stated in policy. Election monitoring uses a complaint-based process to identify allegations of election rule violations. Your Speakers and the Office of General Council are available for queries from candidates in interpreting the rules. Such queries are not formal complaints. The Election Committee recommends additional clarity regarding who has standing to file an election complaint for HOD elections and what the statute of limitations for filing should be. Further, clarification should include that a formal complaint must be made in writing, with receipt acknowledged within twenty-four hours.

The Elections Committee suggests that a formal complaint may only be made using the form on the AMA election website with the contents of the form submitted to the Speaker, Vice Speaker and/or the Office of General Counsel by a voting member of the HOD. Further, per House rules, action on a substantiated complaint that is announced to the HOD is ultimately adjudicated by the electorate. Therefore, the Election Committee recommends that all formal complaints must be submitted prior to the start of the election session at which the candidate is on the ballot.

*Campaign-related presentations*

Individuals running for an AMA office participate in a multitude of activities at AMA sponsored meetings and can be members of many different groups, formal and informal. Election rules do not preclude candidates from active involvement in these various activities and groups. However, questions have been raised regarding what is meant by a campaign-related presentation, as discussed under the interview rules, particularly regarding appearances before groups of which a candidate is a member. Candidates should not be impeded from actively participating in any group of which they are a member.

© 2025 American Medical Association. All rights reserved.

The Election Committee recommends clarification that a campaign-related presentation is a written or verbal presentation about a campaign or a solicitation of votes for an AMA election during a non-sponsoring group meeting. This allows candidates to make a general introduction and to further participate in non-sponsoring group meetings.

*Sponsoring group*

While a sponsoring group is clearly defined in our election policy, your Election Committee provides this clarification of sponsoring groups: a delegation, not a caucus, is the only group that may sponsor a candidate.

CONCLUSION

AMA election policy promotes fairness across campaigns. Your Election Committee has offered several clarifications.

RECOMMENDATION

Your Speakers recommend that the following clarifications be made to the AMA election policies and the remainder of the report be filed:

1. A formal election complaint must be filed in writing by a HOD delegate or alternate delegate via the election website before the commencement of the election session at which the candidate is currently seeking election.
2. A campaign presentation is a written or verbal presentation about a campaign or a solicitation of votes for an AMA election during a non-sponsoring group meeting.

Fiscal note: Minimal

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 601
(I-25)

Introduced by: New England Delegation

Subject: Reimagining and Modernizing the U.S. Healthcare Delivery System

Referred to: Reference Committee F

---

Whereas, the U.S. healthcare delivery system is increasingly failing patients, with persistent inequities in access, affordability, and outcomes, and insufficient investment in prevention and public health; and

Whereas, the Medicare Physician Fee Schedule (MPFS), established in the early 1990s, has become increasingly disconnected from the realities of modern medical practice, with annual updates constrained by legislative budget caps and default cuts and failing to keep pace with inflation and practice costs, and the volume-based system undervaluing essential physician work such as prevention, care coordination, and the management of patients with complex chronic or acute conditions; and

Whereas, as a result, physician reimbursement has declined significantly in real terms, undermining the long-term sustainability of medical practices, accelerating consolidation, reducing resources for patient care improvements, and contributing to physician burnout through administrative and financial pressures, with disproportionate impacts on independent practices, underserved communities, and specialties that rely heavily on cognitive services rather than procedures; and

Whereas, the MPFS was created following the 1989 enactment of Medicare payment reform legislation built on the Harvard resource-based relative value scale (RBRVS), a process in which the AMA played a central role through congressional testimony, policy advocacy, development of the CPT coding system, and the subsequent creation of the Relative Value Scale Update Committee (RUC) to inform CMS updates;[1] and

Whereas, given its historic role in shaping and maintaining public healthcare program reimbursement frameworks, the AMA has both a unique responsibility and opportunity to lead in reimagining a healthcare delivery system that now requires comprehensive reform; and

Whereas, rising patient cost-sharing through regressive copays and co-insurance create significant financial barriers to medically necessary services, even for insured individuals, and contribute to worsening disparities in care delivery; and

Whereas, even among insured patients, high deductibles and cost-sharing obligations contribute to widespread underinsurance, forcing patients to delay or forego needed care and exacerbating inequities in outcomes;[2] and

Whereas, the cumulative effect of administrative burdens—such as prior authorization, step therapy, arbitrary quality metrics, audits, and excessive documentation—erodes the physician-patient relationship, delays care, increases costs, and contributes significantly to physician burnout and patient harm; and

Whereas, the increasing prevalence of complex administrative requirements and burdensome prior authorization protocols imposed by commercial payers and Managed Care Organizations (MCOs), including entities that manage public program benefits, diverts physician time and resources from direct patient care and erects barriers to timely and appropriate access for patients; and

Whereas, the accelerating trend of vertical integration within the healthcare industry, including large insurers acquiring provider groups, pharmacy benefit managers, and other healthcare entities, creates conflicts of interest, stifles competition, drives up costs (including drug prices), and threatens patient choice and physician autonomy;[3] and

Whereas, current drug pricing mechanisms, particularly in Medicare Part B and Part D, have distorted incentives across the system and inadequately support the true costs of delivering complex therapies, with evaluation and management, pharmacy, and infusion services chronically underpaid and forcing many practices to rely on drug margins to cover these unmet costs, as Medicare Part B reimbursement based on Average Sales Price plus a percentage add-on provides only a 4.3 percent markup to physicians, which is insufficient to sustain the infrastructure necessary for safe delivery of high-cost drugs;[4,5] and

Whereas, pharmacy benefit managers (PBMs) have promoted higher drug costs and created intentionally obscure methods of pricing, purchasing, selling, and rebate arrangements in Medicare Part D and commercial markets, making the three largest PBMs among the most profitable corporations in America while driving many patients into financial distress or bankruptcy; and

Whereas, in some value-based care models, incentives tied to regimen cost or utilization benchmarks may pressure physicians to select lower-priced therapies even when newer, more expensive options may provide greater benefit, creating a conflict between patient outcomes and practice financial performance; and

Whereas, the Medicare Hospital Insurance (HI) Trust Fund, which finances inpatient hospital services, skilled nursing facilities, hospice, and some home health care for more than 65 million Americans, is projected to become insolvent within the next decade; and absent Congressional intervention, revenue from payroll taxes and other sources will be insufficient to cover scheduled benefits, threatening older Americans' access to care and destabilizing hospitals and physician practices that rely on Medicare, underscoring the urgent need to plan proactively for systemic reform rather than waiting for crisis-driven patches;[6] and

Whereas, recent federal legislation has imposed deep cuts to Medicaid—including work requirements, eligibility restrictions, and reduced provider funding—that threaten coverage for millions, destabilize safety-net providers, and reduce access to behavioral health and rural services; and

Whereas, Medicare Advantage plans, while expanding rapidly, have cost substantially more per beneficiary than traditional Medicare due to risk coding practices, impose high administrative burdens, restrict networks, and increasingly shift control of care away from physicians, further eroding access and practice sustainability;[7,8] and

Whereas, deeply entrenched structural flaws across both public programs (e.g., Medicare, Medicaid, ACA, VA, CHAMPVA) and private insurance render the healthcare delivery system increasingly unsustainable, and cannot be addressed through incremental adjustments alone, requiring an urgent and comprehensive reimagining of both care delivery and financing; and

Whereas, the AMA Council on Medical Service has previously produced health policy, approved by the House of Delegates, supporting a health system built on advanceable, refundable tax credits inversely related to income and administered by health plans that do not profit from the sale of insurance but from the efficient administration of care, which would maximize coverage, provide sufficient payment to sustain independent practices, avoid forcing patients to remain in jobs solely to maintain health insurance, minimize uncompensated care, and ensure access to the physician-led care team of the patient's choice; and

Whereas, politicization of evidence-based medical decision-making—such as restrictions on reproductive, gender-affirming, or end-of-life care—undermines the physician-patient relationship and threatens equitable access to medically necessary care;[9] and

Whereas, a redesigned healthcare delivery system must ensure equitable care for all patients, embed ethical standards in coverage and access decisions, protect the integrity of physician-patient decision-making free from political interference, and proactively prevent new inequities across socioeconomic, racial, ethnic, geographic, tribal, gender, and sexual identity groups; and

Whereas, past policymaking in healthcare delivery and financing has too often been reactive, negotiating patches only after crises, rather than guided by a clear vision for a sustainable, patient-centered, equitable system; and

Whereas, any financing mechanism within a reimagined system must facilitate access to care rather than maximize profit, with cost-sharing minimized or eliminated where it creates barriers to high-value care, particularly for low-income and underserved populations; and

Whereas, the absence of standardized, transparent reporting of the actual cost of care across payers and delivery settings impedes patients, physicians, and policymakers from identifying value and implementing reforms that reward high-quality, efficient care; and

Whereas, the AMA, as the nation's most representative physician organization, possesses unique expertise not only in physician payment systems but also in public health, prevention, and medical ethics, and has the convening power to unite diverse voices in developing viable, patient-centered solutions; and

Whereas, while the AMA has extensive existing policy on health system reform, proactively integrating and communicating that policy in a unified, evidence-based framework is essential to give physician members clarity of a shared vision for the future of healthcare and to effectively influence policy debates when political will emerges, ensuring that future systems benefit patients, support practice sustainability, and reflect the realities of clinical care; therefore be it

RESOLVED, that our American Medical Association will convene a multidisciplinary Task Force, under the direction of the Board of Trustees, that may include physicians and trainees, allied health professionals, leaders from hospitals and health systems, public and private payers, health economists, ethicists, patient advocates, and other relevant parties from across the health sector, to develop a legislative roadmap to reform the U.S. healthcare delivery system, drawing from and building upon existing AMA policy, and positioning our AMA as a convener of a broader national coalition to advance this vision; and that this roadmap will be structured around the following components:

1. Foundational Principles: The roadmap will specifically incorporate the following principles:
    a. Equitable access to affordable, high-quality healthcare for all as a basic human right;

b. Physician autonomy and the primacy of the patient-physician relationship;
c. Physician-led care as the foundation of clinical decision-making and healthcare delivery;
d. Freedom of patients and physicians to choose care settings and models of practice;
e. Physician practice sustainability through fair and predictable payment;
f. Science-based innovation that improves healthcare value and efficiency; and
g. Prevention, public health, and health equity as central pillars of a sustainable healthcare system;

2. Scope of Review: In developing the roadmap, the task force will consider issues related to healthcare delivery and financing, including, but is not limited to, the following systemic problems and potential solutions:
    a. Physician payment and workforce sustainability;
    b. Comprehensive valuation of physician work;
    c. Incentives that support timely, patient-centered care and uphold clinical judgment;
    d. Administrative, financial, and clinical interference by intermediaries;
    e. Uninsurance, underinsurance, and other cost-sharing issues;
    f. Universal coverage, including preventive services and public health;
    g. Equity in care delivery;
    h. Protection of physician-patient shared decision-making;
    i. Market consolidation, vertical integration, and profiteering;
    j. Drug pricing and access to evidence-based therapies; and
    k. Transparency and reporting of the true cost of care;
3. Environmental Scan: To inform the roadmap, the task force will conduct a comprehensive review of existing global and domestic healthcare programs and reform proposals to evaluate their strengths and weaknesses based on how each framework centers patients, upholds clinical judgment, and promotes healthcare system and physician practice sustainability; and
4. Reporting and Engagement: The task force will:
    a. Report at least annually to the AMA House of Delegates on its findings and progress;
    b. Provide recommendations to the AMA Board of Trustees on areas requiring further policy development to support this work;
    c. Regularly convene focus groups within and outside of the AMA House of Delegates to review draft elements of the roadmap as they are being developed; and
    d. Deliver a final comprehensive legislative roadmap to reform the U.S. healthcare delivery system for consideration by the AMA House of Delegates.

(Directive to Take Action)

Fiscal Note: $240,365 - Convene task force (similar expected for subsequent years).

Received: 9/18/25

**References:**

1. https://www.ama-assn.org/system/files/legislation-creating-the-medicare-rbrvs-payment-system.pdf
2. https://www.ajmc.com/view/despite-record-aca-enrollment-report-reveals-underinsured-americans-are-in-crisis
3. https://www.sciencedirect.com/science/article/pii/S104314892400037X
4. https://jamanetwork.com/journals/jama/fullarticle/2836859
5. https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun17_ch2.pdf
6. https://www.crfb.org/papers/analysis-2025-medicare-trustees-report
7. https://www.nejm.org/doi/full/10.1056/NEJMsb2313939
8. https://www.medpac.gov/wp-content/uploads/2023/10/MedPAC-MA-status-report-Jan-2024.pdf
9. https://www.sciencedirect.com/science/article/pii/S0277953624003563

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 602
(I-25)

Introduced by: American Academy of Family Physicians

Subject: Standardizing the Appointment Process for AMA Councils

Referred to: Reference Committee F

---

Whereas, the American Medical Association currently utilizes a hybrid structure for populating its councils, with some councils comprised of members elected by the House of Delegates and others appointed by the AMA Board of Trustees; and

Whereas, sound governance principles in nonprofit organizations emphasize that functional and advisory bodies, such as councils and committees, should be structured to ensure alignment with the organization's strategic goals and fiduciary obligations; and

Whereas, the work of the AMA Election Task Force was essential in structuring fair and streamlined election processes which should continue to be used for elected officer and board positions; and

Whereas, board-appointed council members are more likely to be selected based on expertise, experience, diversity, and alignment with institutional priorities rather than social recognition or political considerations, leading to more effective council performance; and

Whereas, allowing elections for only some councils introduces inconsistency and may lead to misalignment between councils and the Board of Trustees, complicating accountability and strategic execution; and

Whereas, nearly all major professional and nonprofit organizations vest appointment authority in their boards for internal working groups and advisory bodies, intended to streamline governance, ensure role clarity, and optimize representation of needed skillsets; and

Whereas, the current process for running a candidate for an elected council position often requires significant financial resources, which can create barriers for smaller organizations and societies; and

Whereas, the economic impact of this process can disproportionately affect these smaller entities, limiting their ability to participate fully in the democratic process; and

Whereas, creating a more equitable system would enable these organizations and societies to have a fair opportunity to nominate candidates, thereby enhancing the diversity and representation within the council; and

Whereas, such changes could lead to more inclusive decision-making that better reflects the needs and interests of all community members, particularly those from underrepresented groups; and

Whereas, large geographic and specialty-based caucuses are important in ensuring representation in political races, Councilors should be selected on the basis of qualification and diversity of thought regardless of state, specialty, or caucus alliance within the House of Delegates; and

Whereas, moving to a fully appointed council structure utilizing a blinded and objective process of selection would modernize AMA governance, reduce unnecessary politicization, and enable the Board of Trustees to better steward the mission and long-term vision of the AMA; and

Whereas, the utility of a Nominating Committee mitigates the risk for politicization and enables an objective process of evaluation and selection; and

Whereas, a diverse and rotating set of Nominating Committee members carrying vast institutional knowledge, may also have served previously on Councils or Board, and could be elected by the House of Delegates to serve in this term-limited capacity; and

Whereas, a process outlined by a task force would return to the House of Delegates a plan with necessary bylaws changes for implementation, allowing for delegates to review and amend the process prior to its finalization; therefore be it

RESOLVED, that our American Medical Association develop a phased implementation plan – including selection criteria, procedural steps, and necessary bylaw amendments – to establish a House of Delegates-elected Nominating Committee responsible for the appointment and reappointment of all Council members, subject to final approval by the Board of Trustees. (Directive to Take Action)

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

Received: 9/23/25

## Reference Committee J

**Report(s) of the Board of Trustees**

18 Published Metrics for Hospitals and Hospital Systems

**Report(s) of the Council on Medical Service**

01 Health Savings Account Reform
02 Telehealth Licensure
03 Payment Models to Sustain Rural Hospitals
04 Payment for Biosimilars

**Resolutions**

802 Patient Choice of Physician
804 Medicare Advantage Filing Limit
805 Shared Medical Appointments
806 Insurance Coverage for Colonoscopy Preparation Cost
807 Protecting Hospitals and Patients from Inappropriate Denials of Inpatient Admissions
808 No Prior Authorization for Inexpensive Medications
809 Ensuring Patient Safety and Physician Oversight in the Integration of Hospital Inpatient Virtual Nursing
811 Non-Medical Switching
812 Discontinue Review Choice Demonstration Project for Inpatient Rehabilitation Hospital Admissions
813 Increased Regulation of For-Profit Healthcare Insurance
814 Mandate for Insurance Companies to Assist in the Transition of Patients to Alternative Participating Physicians Upon Contract Termination
815 Mandating Health Insurers to Provide a Real-Time Online Tool for Coverage and Payment Policies, Integrated into Electronic Health Records (EHRs)
816 Prohibit Arbitrary Time Limits on Preauthorizations
817 Prohibiting Insurers from Denying Payment for Procedures Based on Site of Service
818 Universal Out-of-Network Benefits
819 Update the status of Virtual Credit card policy, EFT fees, and lack of Enforcement of Administrative Simplification Requirements by CMS
821 Improving Access to Emergency Ophthalmologic Surgical Care
822 Improving Home or Community-Based Services Waiver Waiting List Management
823 Accountability in the Use of Augmented Intelligence for Prior Authorization
824 Equitable Payment and Increased Access for In-Office Pediatric Lead Screening and Testing
825 Ensuring Coverage for In-Office Point-of-Care (POC) Testing in Outpatient Medical Practices
826 Increase National Immunization Rates by Advocating for Equitable Vaccine Payments
827 Opposition to Prior Authorization in Medicare Fee-for-Service, Burdensome Administrative Requirements
828 Creating a Public Scorecard on Insurer Delays in Care and Payment Caused by Prior Authorization
829 Publicize Insurer Financial Gains from Delayed Care and Payment Caused by Prior Authorization

REPORT 18 OF THE BOARD OF TRUSTEES (I-25)
Published Metrics for Hospitals and Hospital Systems
(Reference Committee J)

## EXECUTIVE SUMMARY

At the 2024 Interim Meeting of the House of Delegates (HOD), Policy D-215.979, "Published Metrics for Hospitals and Hospital Systems", was adopted. The policy directs our American Medical Association (AMA) to research and develop useful metrics that hospitals and hospital systems can use to improve physicians' experience, engagement, and work environment in a manner that is accessible to physicians. This report outlines the AMA's ongoing work to develop and implement metrics that enable health systems to effectively assess and enhance the physician experience, and ensure this information is accessible to physicians.

The Organizational Biopsy®, developed by the AMA in 2018, measures system-level drivers of physician burnout and organizational well-being among participating health care organizations. The tool assesses organizational culture, practice efficiency, work intentions, and support for individual resiliency. Surveying organizations receive a comprehensive summary report highlighting key performance indicators identified by the AMA, experts, and research including burnout, job satisfaction, job stress, and physicians' intent to leave or reduce clinical hours, feelings of being valued, and time spent on patient care versus administrative tasks. Additionally, AMA health system partners gain access to physician faculty support and tailored strategies to address identified issues.

Another of AMA's efforts to develop and implement metrics to improve the physician experience is the Joy in Medicine® Health System Recognition Program (The Recognition Program). The Recognition Program was developed in 2019 and provides public national recognition to health care organizations that have met a set of evidenced-based criteria for addressing physician burnout and organizational well-being. It provides a roadmap to help organizations navigate existing research and implement interventions aimed at improving organizational well-being and the physician experience. The measures included in the program's criteria include burnout, physicians' intent to leave or reduce work effort, teamwork assessments, leadership skills and its impact on direct team members, and electronic health record audit log data. The program requires that this data is shared with physicians that participate in the organizational well-being surveys.

In addition to the Organizational Biopsy and Recognition Program, the AMA also offers open access, physician-developed resources that guide physicians and practices in preventing physician burnout and improving practice efficiency through AMA STEPS Forward® toolkits, playbooks, webinars, and podcasts. The report also discusses several AMA policies and research regarding accessible hospital and hospital system metrics aimed at improving the physician experience.

Given the AMA's substantial progress in developing accessible, evidence-based metrics to assess and improve physician burnout and the overall physician experience—and its ongoing efforts to enhance and expand this work—the AMA recommends that Policy D-215.979, "Published Metrics for Hospitals and Hospital Systems", be rescinded (Rescind HOD Policy), the AMA continue to support metrics that improve the physician experience (New HOD Policy), and the remainder of the report be filed.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 18-I-25

Subject: Published Metrics for Hospitals and Hospital Systems

Presented by: David H. Aizuss, MD, Chair

Referred to: Reference Committee J

---

## INTRODUCTION

At the 2024 Interim Meeting of the House of Delegates (HOD), Policy D-215.979, "Published Metrics for Hospitals and Hospital Systems", was adopted. The policy states:

> Our American Medical Association (AMA) will research and develop useful metrics that hospitals and hospital systems can use to improve physicians' experience, engagement, and work environment in a manner accessible to physicians, with report back to the House of Delegates no later than Annual 2026.

The underlying report (BOT 15-I-24) includes detailed information about existing publicly available metrics for hospitals and hospital systems and their potential impact on physicians and patients. The report recommended that the AMA research useful metrics that hospitals and hospital systems can use to improve physicians' experience, engagement, and work environment and thus, this report serves to provide this information to the HOD.

## BACKGROUND

Recent research shows that over 45 percent of U.S. physicians experience at least one symptom of burnout.[1] Burnout and job dissatisfaction rose sharply during the first two years of the COVID-19 pandemic, prompting many physicians to consider reducing their work effort, leaving their organization, or exiting the profession entirely.[2] Nearly one-quarter of all physicians noted an intent to leave their job, and a recent study found that the annual rate of physician turnover in the United States increased between 2010 and 2018.[3,4] Time spent in the electronic health record (EHR) and managing the inbox has been associated with burnout.[5,6] Following the pandemic's onset, primary care physicians (PCPs) saw a notable rise in EHR-related workload, including time spent on orders, chart review, notes, inbox management, and after-hours work.[6] Also during this period, all physician specialties experienced an increase in time spent in the EHR, with PCPs most affected.[7] Additional challenges, such as lack of inbox coverage, have made it difficult for physicians to fully disconnect from work during vacation—or take time off at all—further contributing to burnout and increased likelihood of reducing clinical hours or leaving their current practice.[8,9]

Overall, these trends are alarming for the U.S. health care system. Nearly one billion dollars in excess patient costs are tied to physician turnover.[10] Physician burnout and turnover also risks exacerbating

existing health disparities, particularly for people living in rural areas and health systems caring for underserved communities. While many hospitals and hospital systems have begun to address the underlying system-level issues that cause burnout and turnover, much work remains to be done to address the work environment of physicians to reduce physician burnout and turnover.

Physician burnout and turnover have myriad causes and addressing these issues to reduce physician burnout (and lessen physician turnover) is a key pillar of the AMA's "You Are Why We Fight" campaign. Central to these efforts are AMA's collaborations over the past five years with more than 300 hospitals or hospital systems in measuring physician burnout and turnover, and incentivizing health systems to improve the physician experience through AMA's Organizational Biopsy and Joy in Medicine Health System Recognition Program (The Recognition Program). Currently, the AMA has developed a set of key metrics by which organizations can measure physicians' experience and work environment. These metrics are based on existing research, expert opinion, and data collected through the Organizational Biopsy. The AMA works directly with health systems to assess these metrics and make them accessible to physicians. The Recognition Program requires that organizations measure several of these key indictors and that these data are transparently shared back with physicians.

DISCUSSION

*The AMA Organizational Biopsy*

Overview

Since 2018, the AMA has completed research and development on metrics to support health systems in measuring the physician work environment and organizational well-being. Specifically, the AMA has worked to develop an assessment tool, the Organizational Biopsy, which provides health systems with a structured and validated survey tool to comprehensively measure organizational culture, practice efficiency, and other dimensions of the physician work environment. The Organizational Biopsy is available to all health systems, and the AMA offers a service delivery model that provides hands-on support to health systems for measurement and critical follow-up steps during the post-assessment period.

History and Background

Development of the Organizational Biopsy began in 2018 with a pilot of several health systems seeking a survey tool to measure system drivers of organizational well-being. The validated Mini-Z[11,12] is included in the Organizational Biopsy and has been a core component of the tool since its inception. Using data and feedback provided in the pilot, the AMA worked to continuously iterate on the tool to ensure actionable data that can guide health system strategies to improve the work environment of its physicians.

Importantly, the Organizational Biopsy measures system-level drivers of organizational well-being and physician burnout. While solutions that support individual resilience are an important contributor to physicians thriving, the AMA focuses primarily on the work environment, as burnout originates in systems. Organizations that survey with the AMA are provided with a comprehensive summary report and AMA health system partners gain access to AMA physician faculty to support them in follow-up steps and development strategies to address issues identified in the survey. More information about the AMA's approach to offering these metrics, data, and follow-up steps are included below.

Psychometric Evaluation

The Mini-Z is a 10-question tool adapted from the Minimizing Error Maximizing Outcome clinician survey. It was designed to assess workplace satisfaction, stress, and burnout by capturing factors including work control, value alignment with organizational leadership, teamwork, documentation time pressure, and EHR use.[13,14] In 2022, the tool was re-evaluated using new data, and the AMA conducted psychometric evaluation to re-validate it.[12]

Metrics

The Organizational Biopsy consists of over 75 questions that measure four overarching domains related to the physician experience. They include:

- Organizational culture (leadership, teamwork, trust, etc.)
- Practice efficiency (team structure, team stability, workflow design, workload control, etc.)
- Work intentions (intention to leave and/or reduce hours)
- Organizational support for individual resiliency (protected time off, work-life balance, etc.)

A complete list of the question set within the tool is available to participating organizations that contact the AMA to schedule a demonstration, access the question bank, and sign up to participate.

Key Performance Indicators

The AMA has identified six key performance indicators (KPIs) that should be used by organizations to regularly assess the state of organizational well-being. These KPIs were developed based on expert opinion, existing research, and correlations in the Organizational Biopsy data that indicated certain metrics are highly valuable in assessing the state of organizational well-being. These six indicators include:

- Burnout (as defined by the single-item Mini-Z assessment)
- Job satisfaction
- Job stress
- Work intentions (physician intent to leave the organization or reduce their clinical hours)
- Feeling valued (how valued do physicians feel by their organization?)
- Time spend (how much time are physicians spending on patient care, administrative work, etc.?)

These KPIs are published annually in the AMA national comparison report, which is provided to all health systems that have measured using the Organizational Biopsy. The national comparison report is also shared with AMA health system partners, and the AMA participates in a variety of national conferences and forums each year to share these data widely with the field and to urge organizations to adopt these key indicators.

Organizations that survey using the Organizational Biopsy receive their KPI results in their executive summary report. These KPIs are also presented to them by various data stratifications, including specialty, gender, and the number of years post-training so that organizations can more readily identify areas that may need additional support, resources, or interventions. More information about these reports can be found below.

The AMA continues to conduct research on emerging metrics to identify new metrics as they arise. This is an ongoing priority for the AMA and efforts to identify new areas for measurement and improvement based on emerging evidence will continue.

Service Delivery

When an organization collaborates with the AMA to distribute the Organizational Biopsy to their physicians, they are supported directly by a team of AMA staff to develop, draft, and distribute their survey. The AMA educates each organization on the KPIs and guides them in selecting questions from the Organizational Biopsy question bank that are actionable and based on organizational need. The service delivery team works closely with each organization to build and test their survey and provide support during the distribution of the survey, usually lasting around six weeks.

Reporting

All data collected through the Organizational Biopsy are stored in the AMA Data Lab, a dynamic and secure reporting platform that is proprietary to the AMA. The AMA offers a survey for practicing physicians and non-physician providers in addition to a resident/fellow survey. Each organization that surveys with the AMA is provided with a unique login to view a reporting dashboard that includes all their survey results, including their KPIs. Survey results are only shared in aggregate with participating organizations. AMA does not report aggregate data unless there are at least six total respondents in any aggregation. Response-level data is confidential and never shared with organizations to maintain the confidentiality of survey respondents. Names and emails are not collected in the survey. Organizations actively use this dashboard to report data back to their executive leadership teams and physicians. The dashboard is user-friendly and allows organizations to seamlessly analyze their survey results, pinpoint areas for improvement, and develop reports for internal reporting.

Organizations also receive customized executive summary reports of their data, which include aggregated findings of the KPIs and other measures included in their survey. The executive summary is paired with a virtual report-out in which AMA staff and physician faculty walk through salient findings and provide organizations with additional context for their results. The executive summary report also includes stratification of the KPIs by several demographics including specialty, gender, and number of years post-training. These initial stratifications allow the AMA to highlight specific areas and/or populations that are in greatest need of support or intervention. Organizations can further analyze their data using the Data Lab. AMA health system partners receive greater attention and support in follow-up from their Organizational Biopsy. The AMA often provides more detailed executive reports for health system partners, including specialty-specific reports and detailed statistical analysis to further inform their approaches to improving the physician work environment.

The AMA also develops an annual national comparison report for its Organizational Biopsy data. This report is developed using the previous year's data (i.e., the 2025 national comparison report includes 2024 data). This comprehensive report provides aggregate insights on the four domains of the Organizational Biopsy and the KPIs. This report also includes data stratifications to highlight specific physician segments that may have different results (e.g., specialties with the highest burnout).

Support Post-Survey

After an executive summary report and virtual report-out are completed, organizations can continue to utilize the Data Lab for any additional reporting needs. Additionally, health systems have access to AMA STEPS Forward, a resource that offers physician-developed toolkits, playbooks, podcasts, and webinars to guide physicians and practices in mitigating burnout and improving practice efficiency.

AMA health system partners are provided with in-depth support from physician faculty to support the development of well-being strategic plans, conduct workshops, and advise on the implementation of interventions. The AMA also provides additional report-outs to health system partners, including reports to executive leaders when requested.

Sharing Results with Physicians Post-Survey

The AMA encourages all organizations that use the Organizational Biopsy to share survey results with their physicians as a critical next step in their work, recognizing that making these results accessible to their physicians is critical for several reasons:

1. Builds Trust and Organizational Credibility

   Transparency signals that leadership values honesty and openness. When health systems share well-being data with physicians, it demonstrates that the organization is committed to addressing the realities of physician experience. This transparency builds credibility and helps foster a culture of trust which is essential for engagement and retention.

2. Promotes Shared Accountability

   Sharing well-being data empowers physicians to be part of the solution. When physicians are aware of trends, challenges, and progress, they can participate meaningfully in developing interventions. This can lead to more collaborative, relevant, and accepted well-being initiatives.

3. Supports Data-Driven Improvements

   Physicians, as scientifically trained professionals, respect and respond to data. Transparency allows physicians to understand the scope of issues like burnout, dissatisfaction, or workload strain. Data shared openly can guide quality improvement efforts in a targeted, measurable way.

4. Normalizes Conversations About Burnout and Well-Being

   Many physicians hesitate to speak up about well-being issues due to stigma or fear of professional consequences. Sharing aggregate data encourages open dialogue, which is crucial for reducing stigma and fostering psychological safety.

5. Enables Benchmarking and Progress Tracking

   When well-being data is shared over time, physicians can see whether interventions are making a difference. This creates a sense of momentum and accountability for ongoing improvements.

6. Enhances Engagement and Morale

   When physicians feel heard and see their feedback reflected in data and subsequent changes, morale and engagement can improve.

Information about the importance of sharing data back with physicians and making it accessible to them is included in Organizational Biopsy materials and is identified as a core part of the survey process.

The AMA typically works with health systems on an annual basis to re-measure to determine whether improvements have led to better outcomes.

*The Joy in Medicine Health System Recognition Program*

Launched in 2019, the Joy in Medicine Health System Recognition Program (the Recognition Program) incentivizes health systems to improve the physician experience by providing public national recognition for organizations that have met a set of evidence-informed criteria centered on addressing the primary system drivers of physician burnout and organizational well-being. Organizations self-attest through an annual application process to criteria involving bronze, silver, and gold levels of recognition. Organization must submit supporting documentation as evidence of their work. A review committee reviews each application to determine if an organization adequately meets recognition criteria requirements.

The Recognition Program provides a comprehensive roadmap to guide organizations through the existing research and interventions to improve organizational well-being—and thus, the physician experience. Measurement of various outcomes and processes are foundational to the program, as AMA asserts that this data can and should be used to understand unique organizational drivers of physician burnout within an organization and to help focus system-specific solutions.

Measures included in the Recognition Program criteria include:

- Burnout (using a validated tool)
- Intentions to leave or reduce work effort (via survey)
- Teamwork assessments (via surveys)
- Leadership skills assessments and their impact on direct team members (via surveys) and
- EHR audit log data to help illuminate the day-to-day experience of physicians and identify workload/workflow improvements.

The Recognition Program includes required criteria for health systems to share these data internally with their physicians as well as their executive leadership teams for shared decision making and increased accountability.

Specifically, the Recognition Program criteria states that to receive recognition at any level, organizations must "share survey results with the physicians that participated in the survey".[15] Organizations must attest in their application that they have done so, providing information on how, when, and where those results were made accessible to their physicians. This further incentivizes organizations, as organizations cannot receive recognition without doing so.

Organizational recognition is valid for two years. Since 2019, AMA has recognized more than 150 organizations for their efforts, and this body of work continues to gain a national spotlight in the efforts to improve physician well-being. Health system leaders have publicly noted the impact the Recognition Program has had on their efforts to improve conditions for their workforce and in providing them with a critical framework for addressing a complex issue. AMA continues to review emerging evidence and expert opinions to identify the most pressing issues related to organizational well-being and a thriving physician workforce. It is an ongoing priority to regularly evaluate our framework, seeking input from our health system partners and other stakeholders to ensure that the AMA remains the national leader in physician well-being.

*AMA Research*

Beginning in 2011, researchers from the AMA, Mayo Clinic, University of Colorado School of Medicine, and Stanford Medicine produced the only study to regularly measure physician burnout rates.[16] Since

then, this study series has measured the prevalence of occupational burnout, professional fulfillment, and satisfaction with work-life integration among physicians and the general U.S. working population every three years. The most recent study found that in 2023, 45.2 percent of physicians reported at least one symptom of burnout compared to 62.8 percent in 2021, 38.2 percent in 2020, 43.9 percent in 2017, 54.4 percent in 2014, and 45.5 percent in 2011. Burnout among U.S. physicians peaked in 2021 during the earlier part of the COVID-19 pandemic and improved in 2023, returning to pre-pandemic levels seen in 2017. Despite this improvement, physicians remain at increased risk for burnout compared to the general U.S. working population.[1]

The AMA also continues to advance the science on the use of EHR user audit log data to better understand EHR use and its impact on the physician experience. This research helps stakeholders identify factors that support or hinder patient care; contribute to burnout and physicians' intent to reduce clinical hours, leave their practice, or exit medicine altogether; and inform improvements in workflow efficiency and resource allocation. Using audit log data, the AMA has defined and standardized key EHR use metrics[17,18], and examined factors such as cognitive load[19], documentation[20–22], inbox management[6,7,23], after-hours work[24], and work during vacation.[8] Studies also used these metrics to analyze variations by specialty.[25,26]

Additionally, the AMA has been a leading contributor to the literature on physicians' work intentions. Its published studies have examined the relationship between physicians' work intentions and stress[27] and work overload[3] during the COVID-19 pandemic, as well as factors such as work environment[28] , work control[29], and perceived pay fairness.[30]

AMA POLICY

The AMA has several policies related to accessible hospital and hospital system metrics aimed at improving the physician experience.

The AMA will study current tools and develop metrics to measure physician professional satisfaction (Policy D-405.985, "Physician Satisfaction").

The AMA will also foster the creation of quality measures and rating systems that incorporates the satisfaction and perspective of the medical staff regarding individual hospitals (Policy D-215.988, "Capturing Physician Sentiments of Hospital Quality").

Further, the AMA promotes physician-developed guidelines for evaluating patient and physician satisfaction with plans, accreditation standards, utilization, quality and cost policies (Policy H-450.962, "National Committee for Quality Assurance").

Additionally, the AMA supports that the "Triple Aim" be expanded to the Quadruple Aim, adding the goal of improving the work-life balance of physicians and other health care providers.
The AMA will also advocate that addressing physician satisfaction count as a Clinical Practice Improvement Activity under the Merit-Based Incentive Payment System (MIPS) (Policy H-405.955, "Support for the Quadruple Aim").

The AMA also recognizes that medical students, resident physicians, and fellows face unique challenges that contribute to burnout during medical school and residency training, such as debt burden, inequitable compensation, discrimination, limited organizational or institutional support, stress, depression, suicide, childcare needs, mistreatment, long work and study hours, among others, and that such factors be included as metrics when measuring physician well-being, particularly for this population of physicians (Policy H-405.948, "Factors Causing Burnout").

## CONCLUSION

The AMA has made substantial efforts to address and improve physician burnout, professional satisfaction, and workforce turnover. Such efforts have included the adoption of a variety of policies, advocacy, partnerships with professional organizations, development and dissemination of tools, research, educational resources, and hands-on support for health systems to regularly assess the state of their physician workforce.

The AMA has been tracking burnout and other key metrics nationally since 2011. At the organizational level, the AMA has worked over the past several years to develop a set of KPIs related to physician experience, burnout, and the work environment. These include: burnout, job satisfaction, job stress, feeling valued, work intentions, and overall time spent on various clinical and administrative tasks. These KPIs are published in the AMA's annual national comparison report and the AMA currently works with over 150 health systems in measuring these KPIs on an annual basis and reporting them back to their physicians. The Joy in Medicine Health System Recognition Program further incentivizes health systems to measure these KPIs and make them accessible to physicians by requiring that organizations do so to receive national recognition from the AMA.

## RECOMMENDATIONS

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

1. Our American Medical Association supports the use of metrics that hospitals and hospital systems can use to improve physicians' experience, engagement, and work environment in a manner accessible to physicians (New HOD Policy)

2. That Policy D-215.979, "Published Metrics for Hospitals and Hospital Systems," be rescinded as being accomplished by this report. (Rescind HOD Policy)

Fiscal Note: Minimal

REFERENCES

1. Shanafelt TD, West CP, Sinsky C, et al. Changes in Burnout and Satisfaction With Work–Life Integration in Physicians and the General US Working Population Between 2011 and 2023. *Mayo Clin Proc*. 2025;100(7):1142-1158. doi:10.1016/j.mayocp.2024.11.031

2. Shanafelt TD, West CP, Dyrbye LN, et al. Changes in Burnout and Satisfaction With Work-Life Integration in Physicians During the First 2 Years of the COVID-19 Pandemic. *Mayo Clin Proc*. 2022;97(12):2248-2258. doi:10.1016/j.mayocp.2022.09.002

3. Rotenstein LS, Brown R, Sinsky C, Linzer M. The Association of Work Overload with Burnout and Intent to Leave the Job Across the Healthcare Workforce During COVID-19. *J Gen Intern Med*. Published online March 23, 2023:1-8.

4. Bond AM, Casalino LP, Tai-Seale M, et al. Physician Turnover in the United States. *Ann Intern Med*. 2023;176(7):896-903. doi:10.7326/m22-2504

5. Adler-Milstein J, Zhao W, Willard-Grace R, Knox M, Grumbach K. Electronic Health Records and Burnout: Time Spent on the Electronic Health Record After Hours and Message Volume Associated with Exhaustion but not with Cynicism Among Primary Care Clinicians. *J Am Med Inform Assoc*. 2020;27(4):531-538. doi:10.1093/jamia/ocz220

6. Arndt BG, Micek MA, Rule A, Shafer CM, Baltus JJ, Sinsky CA. More Tethered to the EHR: EHR Workload Trends Among Academic Primary Care Physicians, 2019-2023. *Ann Fam Med*. 2024;22(1):12-18. doi:10.1370/afm.3047

7. Holmgren AJ, Apathy NC, Sinsky CA, Adler-Milstein J, Bates DW, Rotenstein L. Trends in Physician Electronic Health Record Time and Message Volume. *JAMA Intern Med*. 2025;185(4):461. doi:10.1001/jamainternmed.2024.8138

8. Obermiller C, Bundy R, Witek L, et al. Electronic Health Record Use During Paid Time Off Among Primary Care Physicians. *JAMA Netw Open*. 2025;8(3):e250465. doi:10.1001/jamanetworkopen.2025.0465

9. Sinsky CA, Shah P, Carlasare LE, Shanafelt TD. Association Between Vacation Characteristics and Career Intentions of US Physicians—A Cross-Sectional Analysis. *Mayo Clin Proc*. 2025;100(5):814-827. doi:10.1016/j.mayocp.2024.09.020

10. Sinsky CA, Shanafelt TD, Dyrbye LN, Sabety AH, Carlasare LE, West CP. Health Care Expenditures Attributable to Primary Care Physician Overall and Burnout-Related Turnover: A Cross-sectional Analysis. *Mayo Clin Proc*. 2022;97(4):693-702. doi:10.1016/j.mayocp.2021.09.013

11. David Shaholli, Chiara Bellenzier, Corrado Colaprico, et al. Mini-Z Validation for Burnout and Stress Evaluation: An Observational Study. *Riv Psichiatr*. 2024;(March-April 2024). doi:10.1708/4259.42359

12. Linzer M, McLoughlin C, Poplau S, Goelz E, Brown R, Sinsky C. The Mini Z Worklife and Burnout Reduction Instrument: Psychometrics and Clinical Implications. *J Gen Intern Med*. 2022;37(11):2876-2878. doi:10.1007/s11606-021-07278-3

13. Linzer M, Poplau S, Babbott S, et al. Worklife and Wellness in Academic General Internal Medicine: Results from a National Survey. *J Gen Intern Med*. 2016;31(9):1004-1010. doi:10.1007/s11606-016-3720-4

14. Institute for Professional Worklife (IPW). Mini Z Survey. Professional Worklife. Accessed March 5, 2025. https://www.professionalworklife.com/mini-z-survey

15. American Medical Association (AMA). Joy in Medicine Health System Recognition Program: 2025 Guidelines. Published online September 2024. Accessed July 16, 2025. https://www.ama-assn.org/system/files/joy-in-medicine-guidelines.pdf

16. American Medical Association (AMA). National physician burnout survey. AMA. May 15, 2025. Accessed July 22, 2025. https://www.ama-assn.org/practice-management/physician-health/national-physician-burnout-survey

17. Melnick ER, Ong SY, Fong A, et al. Characterizing physician EHR use with vendor derived data: a feasibility study and cross-sectional analysis. *J Am Med Inform Assoc*. 2021;28(7):1383-1392. doi:10.1093/jamia/ocab011

18. Sinsky CA, Rule A, Cohen G, et al. Metrics for assessing physician activity using electronic health record log data. *J Am Med Inform Assoc*. 2020;27(4):639-643. doi:10.1093/jamia/ocz223

19. Lew D, Baratta LR, Xia L, et al. Association of EHR-Integrated Secure Messaging Use with Clinician Workload and Attention Switching. *J Gen Intern Med*. Published online March 14, 2025:1-8. doi:10.1007/s11606-025-09466-x

20. Rotenstein LS, Fong AS, Jeffery MM, et al. Gender Differences in Time Spent on Documentation and the Electronic Health Record in a Large Ambulatory Network. *JAMA Netw Open*. 2022;5(3):e223935. doi:10.1001/jamanetworkopen.2022.3935

21. Micek MA, Arndt B, Baltus JJ, et al. The effect of remote scribes on primary care physicians' wellness, EHR satisfaction, and EHR use. *Healthcare*. 2022;10(4):100663. doi:10.1016/j.hjdsi.2022.100663

22. Rotenstein L, Melnick ER, Iannaccone C, et al. Virtual Scribes and Physician Time Spent on Electronic Health Records. *JAMA Netw Open*. 2024;7(5):e2413140. doi:10.1001/jamanetworkopen.2024.13140

23. Bundy R, Moses A, Stambaugh E, et al. Assessment of EHR Efficiency Tools and Resources Associated with Physician Time Spent on the Inbox. *J Gen Intern Med*. 2024;39(13):2432-2437. doi:10.1007/s11606-024-08761-3

24. Arndt BG, Micek MA, Rule A, Shafer CM, Baltus JJ, Sinsky CA. Refining Vendor-Defined Measures to Accurately Quantify EHR Workload Outside Time Scheduled With Patients. *Ann Fam Med*. 2023;21(3):264-268. doi:10.1370/afm.2960

25. Sinsky CA, Rotenstein L, Holmgren AJ, Apathy NC. The number of patient scheduled hours resulting in a 40-hour work week by physician specialty and setting: a cross-sectional study using electronic health record event log data. *J Am Med Inform Assoc*. 2025;32(1):235-240. doi:10.1093/jamia/ocae266

26. Holmgren AJ, Sinsky CA, Rotenstein L, Apathy NC. National Comparison of Ambulatory Physician Electronic Health Record Use Across Specialties. *J Gen Intern Med*. 2024;39(14):2868-2870. doi:10.1007/s11606-024-08930-4

27. Sinsky CA, Brown RL, Stillman MJ, Linzer M. COVID-Related Stress and Work Intentions in a Sample of US Health Care Workers. *Mayo Clin Proc Innov Qual Outcomes*. 2021;5(6):1165-1173.

28. Mallick S, Douglas PS, Shroff GR, et al. Work Environment, Burnout, and Intent to Leave Current Job Among Cardiologists and Cardiology Health Care Workers: Results From the National Coping With COVID Survey. *J Am Heart Assoc*. 2024;13(18):e034527. doi:10.1161/JAHA.123.034527

29. Sinsky CA, Brown RL, Rotenstein L, Carlasare LE. Association of Work Control With Burnout and Career Intentions Among U.S. Physicians: A Multi-institution Study. *Ann Intern Med*. 2024;178(1). doi:https://doi.org/10.7326/ANNALS-24-00884

30. Kao AC, Jager AJ, Koenig BA, et al. Physician Perception of Pay Fairness and its Association with Work Satisfaction, Intent to Leave Practice, and Personal Health. *J Gen Intern Med*. 2018;33(6):812-817.

REPORT 1 OF THE COUNCIL ON MEDICAL SERVICE (I-25)
Health Savings Account Reform
(Reference Committee J)

## EXECUTIVE SUMMARY


At the 2024 Interim Meeting, the House of Delegates referred Resolution 803-I-24, "Health Care Savings Account Reform," which 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 which 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.

An HSA pairs with an HSA-eligible 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. In 2023, there were 36 million active HSA accounts that reported holding over $116 billion in assets. 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. As long as HSA funds are used for qualified medical 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.

Council on Medical Service Report 1-I-25 examines each of the proposed clauses and makes several policy recommendations to improve usability and flexibility for those who have HSAs but does not encourage or incentivize replacing other forms of health coverage with these accounts. The report recommends supporting HSA contributions from family members, employers, or other designated individuals; supporting continued contributions to HSAs by Medicare enrollees, with further study on appropriate guardrails for using those funds; amending AMA policy to include dental, vision, and hearing insurance premiums as qualified medical expenses; supporting external research and/or demonstration projects on the feasibility and tax integrity of transferring HSA funds between spouses and family members; supporting ACA premium tax credit design that allows unused or residual tax credits be placed in an HSA; amending AMA policy to support individual market bronze and silver plans being treated as HSA-qualified HDHPs; and supporting education on the use of HSAs, specifically to Medicare enrollees and those interested in bronze or silver plans on the ACA marketplace.


© 2025 American Medical Association. All rights reserved.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 1-I-25

Subject: Health Savings Account Reform

Presented by: Betty Chu, MD, MBA, Chair

Referred to: Reference Committee J

---

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

© 2025 American Medical Association. All rights reserved.

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. (New HOD Policy)

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. (New HOD Policy)

3) That our AMA amend Policy H-165.852 by addition to read as follows:

HEALTH SAVINGS ACCOUNTS, H-165.852
It is the policy of the AMA that:

(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. (Modify Current HOD Policy)

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. (New HOD Policy)

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. (New HOD Policy)

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 being treated as HSA-qualified high-deductible health plans.
(Modify Current HOD Policy)

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. (New HOD Policy)

8) 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. (Reaffirm HOD Policy)

9) 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. (Reaffirm HOD Policy)

10) 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. (Reaffirm HOD Policy)

Fiscal Note: Minimal

REFERENCES

[1] Fidelty Investments. What is a Health Savings Account and How Does it Work? https://www.fidelity.com/learning-center/smart-money/what-is-an-hsa#:~:text=An%20HSA%20is%20a%20tax,rays%2C%20and%20a%20lot%20more.
[2] CMS.gov. What is a Health Savings Account? https://www.cms.gov/marketplace/outreach-and-education/health-savings-account.pdf
[3] Consumer Financial Protection Bureau. Issue Spotlight: Health Savings Accounts. May 1, 2024. https://www.consumerfinance.gov/data-research/research-reports/issue-spotlight-health-savings-accounts/
[4] *Supra.* Item 1
[5] IRS. Health Savings Accounts. Publication 969. https://www.irs.gov/publications/p969
[6] Goodman, John C. What Should be Done About Health Savings Accounts? Health Affairs Forefront. October 29, 2024. https://www.healthaffairs.org/content/forefront/should-done-health-savings-accounts
[7] Levitis, J., C. O'Brien, R. Totz. The Pointless Proliferation of Tax-Preferred Health Spending Arrangements, Part 2: Ideas for Reform. *Health Affairs Forefront.* May 2, 2025. https://www.healthaffairs.org/content/forefront/pointless-proliferation-tax-preferred-health-spending-arrangements-part-2-ideas-reform
[8] Lukens, Gideon. Expanding Health Savings Accounts Would Boost Tax Shelters, Not Access to Care. Center on Budget and Policy Priorities. June 22, 2023. https://www.cbpp.org/research/health/expanding-health-savings-accounts-would-boost-tax-shelters-not-access-to-care
[9] Bureau of Labor Statistics, U.S. Department of Labor. Health care plan provisions for private industry workers in the United States, 2023. Available at: https://www.bls.gov/ebs/publications/health-care-plan-provisions-for-private-industry-workers-2023.htm#/ebs/publications/health-care-plan-provisions-for-private-industry-workers-2023.htm#tabs-4
[10] Agarwal, R., O. Mazurenko, N. Menachemi. High-Deductible Health Plans Reduce Health Care Cost and Utilization, Including Use of Needed Preventive Services. October 2017. https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.0610
[11] *Supra.* Item 8
[12] Zewde, N., S. Rivera Rodriguez, Sherry A. Glied. High-Deductible Health Insurance May Exacerbate Racial and Ethnic Wealth Disparities. *Health Affairs.* October 2024. https://www.healthaffairs.org/doi/10.1377/hlthaff.2023.01199
[13] *Supra.* Item 8
[14] *Supra.* Item 10
[15] IRS.gov. IRS Publication 2004-50. Revised August 9, 2004. https://www.irs.gov/pub/irs-drop/n-04-50.pdf
[16] *Supra.* Item 6
[17] Congressional Budget Office Cost Estimate. H.R. 5687, HSA Modernization Act of 2023. December 19, 2023. https://www.cbo.gov/system/files/2023-12/hr5687.pdf
[18] KFF. Health Provisions in the 2025 Federal Budget Reconciliation Bill. Updated July 8, 2025. https://www.kff.org/tracking-the-health-savings-accounts-provisions-in-the-2025-budget-bill/
[19] *Supra*. Item 5
[20] Ascensus. How HSA Contributions can be Split Between Family Members. May 15, 2025. https://thelink.ascensus.com/articles/2025/5/12/how-can-hsa-contributions-be-split-between-family-members#:~:text=If%20one%20or%20both%20spouses,contribution%20to%20their%20own%20HSA.
[21] *Supra.* Item 18

**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 even 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)

REPORT 2 OF THE COUNCIL ON MEDICAL SERVICE (I-25)
Telehealth Licensure
(Reference Committee J)

## EXECUTIVE SUMMARY

Telehealth falls within the Council on Medical Service's purview and has been the subject of several reports, including Council on Medical Service Report 8-Jun-21, Licensure and Telehealth, which established American Medical Association (AMA) policy supporting an exception for out-of-state physicians providing continuity of care to existing patients (Policy D-480.960), and Council on Medical Service Report 1-I-19, Established Patient Relationships and Telemedicine, which established 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).

The Council monitors telehealth policy issues and self-initiated this updated report to assess the need for new AMA policy supporting licensure exceptions that permit physicians to provide medical care to out-of-state patients using telehealth. Existing AMA policy supports exceptions allowing interstate telehealth for continuity of care purposes, physician-to-physician consultations, and in the event of urgent or emergent circumstances. Additional AMA policy supports streamlining licensure processes and reducing licensure costs, as well as state efforts to expand licensure recognition across state lines.

Consistent with previous work on this topic, 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 policies to protect patients, and that licensure of physicians and other health professionals should remain within the purview of each state, which is the prevailing standard. At the same time, AMA policy needs to keep pace with telehealth innovations, including those that lessen geographic barriers to care by enabling patients to access medical services not available close to home. After reviewing the literature and updated telehealth policies from the Federation of State Medical Boards, the Uniform Law Commission, and across states, the Council found that additional licensure exceptions are warranted for 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, the Council recommends amending Policy H-480.969[1] to support exemptions 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; physicians screening out-of-state patients for acceptance into a clinical trial; and physicians conducting assessments of out-of-state patients that are required as part of a clinical trial, as long as certain conditions are met.

© 2025 American Medical Association. All rights reserved.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 2-I-25

Subject: Telehealth Licensure

Presented by: Betty Chu, MD, MBA, Chair

Referred to: Reference Committee J

---

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

© 2025 American Medical Association. All rights reserved.

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.

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.

~~d~~g. 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. (Modify Current HOD Policy)

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. (Reaffirm HOD Policy)

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. (Reaffirm HOD Policy)

Fiscal Note: Minimal

REFERENCES

[1] Federation of State Medical Boards. The Appropriate Use of Telemedicine Technologies in the Practice of Medicine. Report of the FSMB Workgroup on Telemedicine Adopted by the FSMB House of Delegates, April 2022 Available at: https://www.fsmb.org/siteassets/advocacy/policies/fsmb-workgroup-on-telemedicineapril-2022-final.pdf
[2] Carol Kane. Preliminary analysis of 2018 - 2024 AMA Physician Practice Benchmark Survey data. Unpublished as of September 1, 2025.
[3] Jolin JR, Richman B, Mehrotra A, and Shachar C. Reforming Physician Licensure in the United States to Improve Access to Telehealth: State, Regional, and Federal Initiatives. *The Milbank Quarterly*, Vol. 102, No. 4, 2024. Available at: https://pubmed.ncbi.nlm.nih.gov/39158210/
[4] Jolin JR, Richman B, Mehrotra A, and Shachar C. Reforming Physician Licensure in the United States to Improve Access to Telehealth: State, Regional, and Federal Initiatives. *The Milbank Quarterly*, Vol. 102, No. 4, 2024. Available at: https://pubmed.ncbi.nlm.nih.gov/39158210/
[5] Interstate Medical Licensure Compact. Webpage accessed May 2025. Available at: https://imlcc.com/a-faster-pathway-to-physician-licensure/#WhoDevelopedTheCompact
[6] Interstate Medical Licensure Compact. Information Release: IMLCC Data Study Year 8. July 3, 2025. Available at: https://imlcc.com/wp-content/uploads/2025/07/IMLCC__Year8_DataStudy-7-3-2025-FINAL.pdf
[7] *Ibid*.
[8] Federation of State Medical Boards. Comparison of States with Permanent Interstate Telemedicine. Accessed May 2025 from the FSMB Web site. Available at: https://www.fsmb.org/siteassets/advocacy/key-issues/comparison-of-states-with-permanent-interstate-telemedicine.pdf
[9] *Ibid*.
[10] Federation of State Medical Boards. States with Episodic and/or Follow-Up Care Licensure Exceptions. Webpage accessed July 17, 2025. Available at: https://www.fsmb.org/siteassets/advocacy/policies/states-with-episodic-follow-up-care.pdf
[11] Laws of Alaska: Enrolled House Bill 265 (2022). Available at: https://www.akleg.gov/PDF/32/Bills/HB0265Z.PDF
[12] Federation of State Medical Boards. Comparison of States with Permanent Interstate Telemedicine. Accessed May 2025 from the FSMB Web site. Available at: https://www.fsmb.org/siteassets/advocacy/key-issues/comparison-of-states-with-permanent-interstate-telemedicine.pdf
[13] 2024 Alabama Code, Section 34-24-702 Licensure Requirements Available at: https://law.justia.com/codes/alabama/title-34/chapter-24/article-12/section-34-24-702/

[14] 2024 Minnesota Statutes. 147.032 Interstate Practice of Telehealth. Available at: https://www.revisor.mn.gov/statutes/cite/147.032
[15] Federation of State Medical Boards. Comparison of States with Permanent Interstate Telemedicine. Accessed May 2025 from the FSMB Web site. Available at: https://www.fsmb.org/siteassets/advocacy/key-issues/comparison-of-states-with-permanent-interstate-telemedicine.pdf
[16] *Ibid*.
[17] *Ibid*.
[18] *Ibid*.
[19] Interstate Medical Licensure Compact. What does it cost? Webpage accessed July 17, 2025. Available at: https://imlcc.com/what-does-it-cost/
[20] Federation of State Medical Boards. The Appropriate Use of Telemedicine Technologies in the Practice of Medicine. Report of the FSMB Workgroup on Telemedicine Adopted by the FSMB House of Delegates, April 2022 Available at: https://www.fsmb.org/siteassets/advocacy/policies/fsmb-workgroup-on-telemedicineapril-2022-final.pdf
[21] National Organization of Rare Disorders. Letter to Chair and Vice Chair of Colorado Senate Subcommittee on Health and Human Services. February 21, 2024. Available at: https://rarediseases.org/wp-content/uploads/2024/02/CO-SB24-141-Support.pdf
[22] National Organization of Rare Disorders. Letter to Chair and Vice Chair of Hawaii House Committee on Finance. March 30, 2023. Available at: https://rarediseases.org/wp-content/uploads/2023/03/Hawai%CA%BBi-SB-674-NORD-Testimony-033023.pdf
[23] Jolin JR, Richman B, Mehrotra A, and Shachar C. Reforming Physician Licensure in the United States to Improve Access to Telehealth: State, Regional, and Federal Initiatives. *The Milbank Quarterly*, Vol. 102, No. 4, 2024. Available at: https://pubmed.ncbi.nlm.nih.gov/39158210/

## 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 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." | **Policy H-480.969** supports exemption of 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. 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 …" | **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:<br>a. The physician has an active license to practice medicine in a state or US territory and has not been subjected to disciplinary action.<br>b. There is a pre-existing and ongoing physician-patient relationship.<br>c. The physician has had an in-person visit(s) with the patient.<br>d. The telehealth services are incident to an existing care plan or one that is being modified.<br>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.<br>f. Telehealth use complies with Health Insurance Portability and Accountability Act privacy and security rules.<br><br>**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. |

| | |
|---|---|
| **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 but do not specifically address follow-up care after patients have traveled to another state for surgical or medical treatment. |
| **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." | Not addressed in AMA policy. |

REPORT 3 OF THE COUNCIL ON MEDICAL SERVICE (I-25)
Payment Models to Sustain Rural Hospitals
(Reference Committee J)

## EXECUTIVE SUMMARY


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, adopted as a part of Council on Medical Service Report 6-I-23, Rural Hospital Payment Models, called for report back on recommendations for improved rural hospital payment models.

The Council reviewed information on the present state of rural hospitals and their payment systems. Currently, many rural hospitals are struggling to stay open, and the problem only seems to be increasing in magnitude. In efforts to stay open, some rural hospitals are forced to stop providing services such as obstetric/gynecologic care or chemotherapy services. Other rural hospitals are turning to private equity investment to keep their doors open. While neither of these strategies have yielded successful results, in the short term these strategies may give hospitals a few additional months or years to serve their communities. Additionally, it is projected that the newly passed legislation, One Big Beautiful Bill Act (OBBBA), will exacerbate existing challenges for rural hospitals. Specifically, the OBBBA is expected to result in rural hospitals losing approximately $137 billion dollars over 10 years. Although the bill includes a $50 billion rural health transformation fund, it is not expected to be enough to cover the overall losses. Additionally, its implementation timeline is unclear. In order to look for potential solutions for rural hospitals, the Council reviewed three existing payment models as well as one model in development. While none of these payment models provide a perfect solution or a singular answer to fixing rural hospital payment, each provides insight into what could make an alternative payment model successful. Finally, the Council intends to initiate a future report fully discussing issues impacting rural hospitals beyond payment models, such as workforce, infrastructure, federal designation(s), and supply chain.

Based on its review of alternative payment models, the Council recommends the adoption of new policy outlining minimum standards for alternative payment models for rural hospitals. Specifically, this new policy outlines that alternative payment models should include fixed cost payments, include adequate payment rates for variable services, ensure affordable patient cost-sharing, include high-quality care, and minimize administrative burdens. The Council recommends the adoption of a new policy to emphasize the importance of rural hospitals and encourage monitoring and education regarding alternative payment models. New policy is also recommended to ensure that funds allocated for rural hospitals are used for their express intent. Additionally, the Council recommends the amendment of Policy D-465.999 to update language, Policy D-465.998 to include education and advocacy around the impact of Medicare Advantage in rural hospitals, and Policy D-190.969 to remove the clause accomplished by this report. Finally, the Council recommends the reaffirmation of Policies H-465.994, H-465.982, and H-465.997, which all work to support rural hospitals beyond payment models.


© 2025 American Medical Association. All rights reserved.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 3-I-25

Subject: Payment Models to Sustain Rural Hospitals

Presented by: Betty Chu, MD, MBA, Chair

Referred to: Reference Committee J

---

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 Heath 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

© 2025 American Medical Association. All rights reserved.

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. (New HOD Policy)

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, providers, and patients on alternative payment models for rural hospitals. (New HOD Policy)

3. That our AMA supports that funds allocated for rural hospitals be used to enhance or maintain rural health care. (New HOD Policy)

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. (Modify Current HOD Policy)

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 and physicians 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. (Modify Current HOD Policy)

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. (Reaffirm HOD Policy)

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. (Reaffirm HOD Policy)

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. (Reaffirm HOD Policy)

9. That the second clause of Policy D-190.969 be rescinded as it is accomplished by this report. (Rescind AMA Policy)

Fiscal Note: Minimal

REFERENCES


[1] U.S. Census Bureau. One in Five Americans Live in Rural Areas. 2017. https://www.census.gov/library/stories/2017/08/rural-america.html#:~:text=About%2060%20million%20people%2C%20or,the%20official%20Census%20Bureau%20classification.

[2] Centers for Disease Control. About Rural Health. 2024. https://www.cdc.gov/rural-health/php/about/index.html#:~:text=People%20who%20live%20in%20rural%20areas%20in%20the%20United%20States,likely%20to%20have%20health%20insurance.

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

[4] Hearn M, Pinto C, Moss JL. Evaluating the Connection Between Rural Travel Time and Health: A Cross-Sectional Analysis of Older Adults Living in the Northeast United States. *J Prim Care Community Health*. 2024;15:21501319241266114. https://doi.org/10.1177/21501319241266114

[5] Topchik M, Brown T, Pinnette M, Balfour B, Wiesse A. Unrelenting Pressure Pushes Rural Safety Net Crisis into Uncharted Territory. CHARTIS. 2024. https://www.chartis.com/insights/unrelenting-pressure-pushes-rural-safety-net-uncharted-territory

[6] Sheffert E, Sandalow M. Sustaining Rural Hospital Access: Adjustments to Medicare Rural Hospital Designations. Bipartisan Policy Center. 2025. https://bipartisanpolicy.org/report/sustaining-rural-hospital-access-adjustments-to-medicare-rural-hospital-designations/

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

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

[9] Symington BE. Uncovering the Hidden Drivers of Rural Health Care Disparities. Cancer Journal for Clinicians. 2025;75(4):280-281. https://doi.org/10.3322/caac.70009

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

[11] Rural Healthcare Payment and Reimbursement. 2025. Rural Health Information Hub. https://www.ruralhealthinfo.org/topics/healthcare-payment

[12] Ochieng N, Cottrill A, Cubanski J, Neuman T. Key Facts About Medicare Beneficiaries in Rural Areas. KFF. 2025. https://www.kff.org/medicare/issue-brief/key-facts-about-medicare-beneficiaries-in-rural-areas/

[13] Critical Access Hospitals. 2024. Centers for Medicare and Medicaid Services. https://www.cms.gov/medicare/health-safety-standards/certification-compliance/critical-access-hospitals

[14] Turrini G, Volkov E, Peters C, De Lew N, Buchmueller T. Access to Health Care in Rural America: Current Trends and Key Challenges. 2024. ASPE: Office of Health Policy. https://aspe.hhs.gov/reports/health-care-rural-america

[15] Status of State Medicaid Expansion Decisions. 2025. KFF. https://www.kff.org/status-of-state-medicaid-expansion-decisions/

[16] Fugkesten Biniek J, Clerveau G, Damico A, Neuman T. Medicare Advantage Enrollment, Plan Availability and Premiums in Rural Areas. KFF. 2023. https://www.kff.org/medicare/issue-brief/medicare-advantage-enrollment-plan-availability-and-premiums-in-rural-areas/

[17] The Growing Impact of Medicare Advantage on Rural Hospitals Across America. 2025. American Hospital Association. https://www.aha.org/guidesreports/growing-impact-medicare-advantage-rural-hospitals-across-america

[18] Zionts A. Rural Hospitals Question Whether They Can Afford Medicare Advantage Contracts. 2025. KFF Health News. https://kffhealthnews.org/news/article/rural-hospitals-private-medicare-advantage-contracts-reimbursements/

[19] Tribble, SJ. Tiny, Rural Hospitals Feel the Pinch as Medicare Advantage Plans Grow. 2023. KFF Health News. https://kffhealthnews.org/news/article/medicare-advantage-rural-hospitals-financial-pinch/

[20] Lambrew J, Ford E. Rural Americans Face Unprecedented Price Hikes for Health Care. 2025. The Century Foundation. https://tcf.org/content/commentary/rural-americans-face-unprecedented-price-hikes-for-health-care/

[21] National Rural Health Association. One Big Beautiful Bill and Rural Health. 2025. https://www.ruralhealth.us/getmedia/daabe69b-4fdd-4b5a-8e24-b6c22b0ebed4/OBBBA-Talking-Points-7-22-25_1.pdf

[22] Euhus R, Williams E, Burns A, Rudowitz R. Allocating CBO's Estimates of Federal Medicaid Spending Reductions Across the States: Enacted Reconciliation Package. 2025. KFF. https://www.kff.org/medicaid/issue-brief/allocating-cbos-estimates-of-federal-medicaid-spending-reductions-across-the-states-enacted-reconciliation-package/
[23] Levinson Z, Neuman T. A Closer Look at the $50 Billion Rural Health Fund in the New Reconciliation Law. 2025. KFF. https://www.kff.org/medicaid/issue-brief/a-closer-look-at-the-50-billion-rural-health-fund-in-the-new-reconciliation-law/
[24] Tribble, SJ. $50B Rural Health 'Slush Fund' Faces Questions, Skepticism. 2025. KFF Health News. https://kffhealthnews.org/news/article/rural-health-transformation-program-hospitals-medicaid-implementation-kansas/
[25] NRHA Statement on President's FY 2026 Budget Request. 2025. National Rural Health Association. https://www.ruralhealth.us/blogs/2025/05/nrha-statement-on-president%E2%80%99s-fy-2026-budget-request#:~:text=The%20National%20Rural%20Health%20Association,the%20SORH%20and%20Flex%20programs.
[26] CMS Innovation Center. Pennsylvania Rural Health Model (PARHM). Center for Medicare and Medicaid Services. 2024. https://www.cms.gov/priorities/innovation/innovation-models/pa-rural-health-model
[27] NORC at the University of Chicago. The Pennsylvania Rural Health Model (PARHM): Fourth Annual Evaluation Report. 2024. https://www.cms.gov/priorities/innovation/data-and-reports/2024/parhm-ar4
[28] CMS Innovation Center. Maryland Total Cost of Care Model (MD TOC). Center for Medicare and Medicaid Services. 2025. https://www.cms.gov/priorities/innovation/innovation-models/md-tccm
[29] CMS Innovation Center. Maryland Total Cost of Care Model (MD TOC) Evaluation of the First Four Years (2019-2022). Center for Medicare and Medicaid Services. 2024. https://www.cms.gov/priorities/innovation/data-and-reports/2024/md-tcoc-1st-progress-rpt-aag
[30] CMS Innovation Center. Vermont All-Payer ACO Model (VTAPM). Center for Medicare and Medicaid Services. 2025. https://www.cms.gov/priorities/innovation/innovation-models/vermont-all-payer-aco-model
[31] CMS Innovation Center. Vermont All-Payer ACO Model (VTAPM) Evaluation of the First Five Years (2018-2022). Center for Medicare and Medicaid Services. 2023. https://www.cms.gov/priorities/innovation/data-and-reports/2024/vtapm-4th-eval-report-aag
[32] CMS Innovation Center. States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model. Center for Medicare and Medicaid Services. 2025. https://www.cms.gov/priorities/innovation/innovation-models/ahead

**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-68Reaffirmed: 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 polices, 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)

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 4-I-25

Subject: Payment for Biosimilars

Presented by: Betty Chu, MD, MBA, Chair

Referred to: Reference Committee J

---

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]

© 2025 American Medical Association. All rights reserved.

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. (New HOD Policy)

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;
    b. Account for physician/practice administrative and acquisition costs, including but not limited to, obtaining, storing, and administering the drug;
    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. (New HOD Policy)

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. (New HOD Policy)

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. (Reaffirm HOD Policy)

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. (Reaffirm HOD Policy)

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. (Reaffirm HOD Policy)

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. (Reaffirm HOD Policy)

Fiscal Note: Minimal

## REFERENCES


[1] Lucio SD, Stevenson JG, Hoffman JM. Biosimilars: Implications for health-system pharmacists. Am J Health Syst Pharm. 2013;70(22):2004-2017. doi:10.2146/ajhp130119

[2] U.S. Food and Drug Administration (FDA). Biosimilar and Interchangeable Biologics: More Treatment Choices. 2023. https://www.fda.gov/consumers/consumer-updates/biosimilar-and-interchangeable-biologics-more-treatment-choices

[3] Raedler LA. Zarixo (Pilgrastim-sndz): First Biosimilar Approved in the United States. Am Health Drug Ben 2016;9. PMCID: PMC5013845

[4] U.S. Food and Drug Administration (FDA). Biosimilar Product Information. 2025. https://www.fda.gov/drugs/biosimilars/biosimilar-product-information

[5] IQVIA Institute for Human Data Science. Biosimilars in the United States 2023–2027. 2023. Available from www.iqviainstitute.org

[6] IQVIA Institute for Human Data Science. Long-term Market Sustainability for Infused Biosimilars in the U.S. 2024. Available from www.iqviainstitute.org

[7] Biosimilars Council. The U.S. Generic & Biosimilar Medicines Savings Report. 2024. Association for Accessible Medicines. https://accessiblemeds.org/resources/reports/2024-savings-report/

[8] Chambers J D, et al. Coverage for Biosimilars vs Reference Products Among US Commercial Health Plans. JAMA. 2020;323(19):1972–1973. https://doi.org/doi:10.1001/jama.2020.2229

[9] Hong D, Kesselheim AS, Sarpatwari A, Rome BN. Biosimilar Uptake in the US: Patient and Prescriber Factors. Health Affairs. 2024; 43(8):1159-1164. https://doi.org/10.1377/hlthaff.2023.012515

[10] Humphreys S. Understanding Interchangeable Biosimilars at the Federal and State Levels. Ev-Based Onc. 2023; 29(7): 545-548. https://doi.org/10.37765/ajmc.2023.89419

[11] Cubanski J, Neuman T, Freed M. Explaining the Prescription Drug Provisions in the Inflation Reduction Act. Kaiser Family Foundation;2023. https://www.kff.org/medicare/issue-brief/explaining-the-prescription-drug-provisions-in-the-inflation-reduction-act/

[12] Boutross L, Poblete G, Sangwan S. Pharmacy Benefit is a Whole New Ball game for Biosimilars. ZS Pharmacy and Biotech. 2022. https://www.zs.com/insights/pharmacy-benefit-is-a-whole-new-ball-game-for-biosimilars#:~:text=The%20U.S.%20biosimilar%20landscape%20has,the%20products%20need%20to%20meet.

[13] USC Schaeffer Center. Biosimilar Drugs Underutilized Due to Commercial Insurance Restrictions. 2023. https://healthpolicy.usc.edu/article/biosimilar-drugs-underutilized-due-to-commercial-insurance-restrictions/

[14] Caremark. CVS Caremark accelerates biosimilars adoption through formulary changes. 2024. CVS. https://www.cvshealth.com/news/pbm/cvs-caremark-accelerates-biosimilars-adoption-through-formulary-changes.html

[15] Formulary Watch. Express Scripts to Remove Humira from Commercial Formularies. 2024. https://www.managedhealthcareexecutive.com/view/express-scripts-to-remove-humira-from-commercial-formularies

[16] Formulary Watch. Optum Rx Switches Up Humira Biosimilar Coverage for 2025. 2024. https://www.managedhealthcareexecutive.com/view/optum-rx-switches-up-humira-biosimilar-coverage-for-2025

[17] Bertuzzi L and Maini L. Benefit Design and Biosimilar Coverage in Medicare Part D: Evidence and Implications from Recent Reforms. Health Affairs. 2024; 43(5).

[18] https://doi.org/10.1377/hlthaff.2023.01297

[19] Kozlowski S, Kwist A, McEvoy R, et al. Biosimilar Uptake in Medicare Advantage vs Traditional Medicare. JAMA Health Forum. 2023;4(12):e234335. doi:10.1001/jamahealthforum.2023.4335

[20] Office of Inspector General. Most Medicare Part D Plans' Formilaries Included Humira Biosimilars for 2025. 2025. U.S. Department of Health and Human Services. https://oig.hhs.gov/reports/all/2025/most-medicare-part-d-plans-formularies-included-humira-biosimilars-for-2025/

[21] Cubanski, J. Summary of Recent and Proposed Changes to Medicare Prescription Drug Coverage and Reimbursement. 2018. KFF. https://www.kff.org/medicare/issue-brief/summary-of-recent-and-proposed-changes-to-medicare-prescription-drug-coverage-and-reimbursement/

[22] Cubanski J, Neuman T, Freed M. Explaining the Prescription Drug Provisions in the Inflation Reduction Act. KFF https://www.kff.org/medicare/issue-brief/explaining-the-prescription-drug-provisions-in-the-inflation-reduction-act/

[23] Certara. How has the Inflation Reduction Act Impacted the Biosimilars Market? 2024. https://www.certara.com/blog/how-has-the-inflation-reduction-act-impacted-the-biosimilars-market/

[24] The One Big Beautiful Bill Act (OBBBA): A Trillion-Dollar Turn in US Health Policy. PricewaterhouseCoopers (PwC). 2025. https://www.pwc.com/us/en/industries/health-industries/library/impact-of-obbba-on-us-health-system.html

[25] President Trump D. Lowering Drug Prices by Once Again Putting Americans First. Executive Order No. 14273, 90 Fed. Reg. 16441 (April 15, 2025)

[26] President Trump D. Delivering Most-Favored-Nation Prescription Drug Pricing to American Patients. Executive Order No. 14297, 90 Fed. Reg. 20749 (May 12, 2025)

[27] Weidner S, Diaz M, Schaedig C, Gordan L. Observations Regarding the Average Sales Price Reimbursement Methodology. AJMC, 2021; 27(4); SP165-160. https://www.ajmc.com/view/observations-regarding-the-average-sales-price-reimbursement-methodology

[28] Arad N, et al. Realizing the Benefits of Biosimilars: Overcoming Rebate Walls. 2022. Margolis Center for Health Policy. Duke University. https://healthpolicy.duke.edu/publications/realizing-benefits-biosimilars-overcoming-rebate-walls

[29] Arad N, Rapista D, Hamilton Lopez M, McClellan M. Originator Biologics and Biosimilars: Payment Policy Solutions to Increase Price Competition While Maintaining Market Sustainability in Medicare Part B. 2021. Margolis Center for Health Policy. Duke University. https://healthpolicy.duke.edu/publications/originator-biologics-and-biosimilars-payment-policy-solutions-increase-price

[30] Office of Inspector General. Least Costly Alternative Policies: Impact on Prostate Cancer Drugs Covered Under Medicare Part B. 2012. U.S. Department of Health and Human Services. https://oig.hhs.gov/reports/all/2012/least-costly-alternative-policies-impact-on-prostate-cancer-drugs-covered-under-medicare-part-b/

[31] Prohibition on Billing Qualified Medicare Beneficiaries. Center for Medicare and Medicaid Services. MLN7936176. 2024. https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/se1128.pdf

[32] Report to Congress: Medicare and the Health Care Delivery System. Medicare Payment Advisory Commission (MedPAC). 2017. https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun17_reporttocongress_sec.pdf

**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)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 802
(I-25)

Introduced by: Michigan

Subject: Patient Choice of Physician

Referred to: Reference Committee J

---

Whereas, policies imposed by insurance companies and hospital insurance plans can disrupt patient-physician relationships; and

Whereas, out-of-network services policies and penalties imposed by insurance companies and hospital insurance plans often restrict or prohibit patients from continuing long standing patient-physician relationships; and

Whereas, insurance companies and hospital insurance plans can refuse to reimburse patient-physician relationships that are out of their network even though it's the patients' preference; and

Whereas, hospital insurance managed care plans are negligent in paying out-of-network physicians any compensation; therefore be it

RESOLVED, that our American Medical Association continue its support of the patient-physician relationship and the patient's choice of physician by reaffirming existing AMA policies, "Preservation of Physician-Patient Relationships and Promotion of Continuity of Patient Care H-160.901" and "Physician Penalties for Out-of-Network Services H-180.952." (Reaffirm HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 9/3/25

**RELEVANT AMA POLICY**

**Preservation of Physician-Patient Relationships and Promotion of Continuity of Patient Care H-160.901**
Our AMA supports: (1) policies that encourage the freedom of patients to choose the health care delivery system that best suits their needs and provides them with a choice of physicians; (2) the freedom of choice of physicians to refer their patients to the physician practice or hospital that they think is most able to provide the best medical care when appropriate care is not available within a limited network of providers; and (3) policies that encourage patients to return to their established primary care provider after emergency department visits, hospitalization or specialty consultation.

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 804
(I-25)

Introduced by: New England Delegation

Subject: Medicare Advantage Filing Limit

Referred to: Reference Committee J

---

Whereas, the AMA currently has no policy regarding limits on filing claims for services provided to Medicare Advantage patients; and

Whereas, in the sponsors' observations, many medical practices are burdened with increased costs that threaten the financial viability of the practice; and

Whereas, the sponsors have observed that Medicare reimbursement continues to decline as practice costs increase; and

Whereas, the sponsors believe that many Medicare patients chose Medicare Advantage plans as a more affordable option; and

Whereas, the sponsors have observed that many Medicare patients are not able to provide initial or updated information about their specific type of Medicare insurance or changes made in their insurance or their primary care physician since the last time they were treated; and

Whereas, some Medicare Advantage plans require filing of claims within a relatively short, 60-day period from the time of service and deny payment for claims filed after that, but traditional Medicare allows claims to be made up to one year after date of service[1]; and

Whereas, in the sponsors' experiences, many Medicare Advantage plans require referrals, which in some cases can be challenging to obtain in a prompt manner and prior to the required filing limit deadline, especially for services already provided; therefore be it

RESOLVED, that our American Medical Association and other stakeholders advocate for and support federal efforts to ensure policy uniformity regarding claim filing time limits between Medicare Advantage plans and traditional Medicare, with a uniform time of one calendar year. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/18/25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 805
(I-25)

Introduced by: New England Delegation, American College of Lifestyle Medicine

Subject: Shared Medical Appointments

Referred to: Reference Committee J

---

Whereas, our American Medical Association's policy H-160-911 promotes physician education about the potential value of Shared/Group Medical Appointments (SMAs) for diagnoses that might benefit from such venues such as chronic diseases, pain, pregnancy, etc.; and

Whereas, physician shortages have led to decreased access to care for patients and less time for individual patient appointments[1]; and

Whereas, the treatment of chronic medical conditions requires significant patient education and counseling for behavior change to promote health[2]; and

Whereas, SMAs involve a cohort of patients meeting with a physician or members of a physician-led, interdisciplinary team in a group setting, allowing for extended consultation and treatment times, peer support, and comprehensive education[3]; and

Whereas, the option of individual patient appointments in a private room or shared medical appointments (SMAs) for appropriate patient cohort(s) should be made available to patients depending upon the choice of the individual patient, the cohort's comparable diagnoses and the relevant services to be provided; and

Whereas, in addition to education and counseling, participants in a SMA receive the full range of services ordinarily provided in an individual visit, including: (i) guided, experiential learning such as training on insulin pumps, injectable, asthma inhalers or in teaching kitchens; (ii) necessary physical exams; and, (iii) delivery of treatment protocols , including ordering and interpreting laboratory tests, initiating referrals, prescribing medications and related clinical; management; and

Whereas, the SMA model of care is particularly effective for managing chronic conditions such as diabetes, hypertension, and obesity, where lifestyle modifications, behavioral support, and patient education play crucial roles[4]; and

Whereas, SMAs have been shown to increase access, increase doctor-patient contact time, and increase time for consultation, treatment and patient education[5,6]; and

Whereas, the SMA model of care is the most efficient and effective means to realistically achieve (e.g.,) the USPSTF's recommended intensive counseling of at least 26 contact hours for patients with a high BMI in a 6-to-12-month period or an estimated 6 hours of contact time over 6-18 months for adults with cardiovascular risk [7]; and

Whereas, a number of State and Specialty Societies have begun to support and utilize SMAs for themselves; therefore be it

RESOLVED, that our American Medical Association recognizes Shared Medical Appointments, also known as Group Medical Visits, as an effective model of care delivery (New HOD Policy); and be it further

RESOLVED, that our AMA advocate to hospitals and health systems that they support physicians and other clinicians who desire to host Shared Medical Appointments, also known as Group Medical Visits (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate to Medicare, Medicaid, private insurers, and other appropriate indemnity organizations, for payment of in-person or telehealth Shared Medical Appointments, also known as Group Medical Visits, commensurate with standard Evaluation and Management billing codes (i.e., 99212-99215) based on Medical Decision Making criteria or the time spent in the delivery of individualized care, with individual assessments occurring either within the group setting or in private. (Directive to Take Action)

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

Received: 9/18/25

**REFERENCES**

1. GlobalData Plc. The Complexities of Physician Supply and Demand: Projections From 2021 to 2036. Washington, DC: AAMC; 2024. https://www.aamc.org/media/75236/download?attachment
2. Hampl SE, Hassink SG, Skinner AC, Armstrong SC, Barlow SE, Bolling CF, Avila Edwards KC, Eneli I, Hamre R, Joseph MM, Lunsford D, Mendonca E, Michalsky MP, Mirza N, Ochoa ER, Sharifi M, Staiano AE, Weedn AE, Flinn SK, Lindros J, Okechukwu K. Clinical Practice Guideline for the Evaluation and Treatment of Children and Adolescents with Obesity. Pediatrics. 2023 Feb 1;151(2):e2022060640. doi:10.1542/peds.2022-060640. Erratum in: Pediatrics. 2024 Jan 1;153(1):e2023064612. doi:10.1542/peds.2023-064612. PMID: 36622115. https://www.aap.org/obesitycpg
3. Lacagnina S, Tips J, Pauly K, Cara K, Karlsen M. Lifestyle Medicine Shared Medical Appointments. Am J Lifestyle Med. 2020 Jul 30;15(1):23-27. doi: 10.1177/1559827620943819. PMID: 33456418; PMCID: PMC7781059. https://pubmed.ncbi.nlm.nih.gov/33456418/
4. Edelman D, McDuffie JR, Oddone E, Gierisch JM, Nagi A, Williams JW Jr. Shared Medical Appointments for Chronic Medical Conditions: A Systematic Review [Internet]. Washington (DC): Department of Veterans Affairs (US); 2012 Jul. PMID: 22916369. https://www.hsrd.research.va.gov/publications/esp/shared-medappt.pdf
5. Wadsworth KH, Archibald TG, Payne AE, Cleary AK, Haney BL, Hoverman AS. Shared medical appointments and patient-centered experience: a mixed-methods systematic review. BMC Fam Pract. 2019 Jul 8;20(1):97. doi: 10.1186/s12875-019-0972-1. PMID: 31286876; PMCID: PMC6615093. https://pubmed.ncbi.nlm.nih.gov/31286876/
6. Vigue D, Mirsky J, Brodney S, Thorndike AN. Patient Perspectives on Lifestyle Medicine Virtual Group Visits. Am J Lifestyle Med. 2024 Sep 2:15598276241274233. Doi: 10.1177/15598276241274233. Epub ahead of print. PMID: 39554912; PMCID: PMC11562221. https://pubmed.ncbi.nlm.nih.gov/39554912/
7. 7. USPSTF. 2018. Weight Loss to Prevent Obesity-Related Morbidity and Mortality in Adults: Behavioral Interventions. JAMA. 2018;320(11):1163-1171. doi:10.1001/jama.2018.13022.
retrieved online <adult-obesity-intervention-final-rec-statement.pdf>

**RELEVANT AMA POLICY**

**Value of Group Medical Appointments H-160.911**
Our American Medical Association promotes education about the potential value of group medical appointments for diagnoses that might benefit from such appointments including chronic diseases, pain, and pregnancy.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 806
(I-25)

Introduced by: Mississippi

Subject: Insurance Coverage for Colonoscopy Preparation Cost

Referred to: Reference Committee J

---

Whereas, colorectal cancer is the second leading cause of cancer-related deaths in the United States, and regular colonoscopy screenings are proven to reduce mortality by early detection of pre-cancerous growths; and

Whereas, the Affordable Care Act (ACA) mandates coverage for preventative screenings, including colonoscopies, without patient cost-sharing to promote public health and reduce the financial burden of preventative care; and

Whereas, despite this coverage requirement, many insurance providers do not fully cover the costs of colonoscopy preparation materials (colon preps), which are essential to the efficacy of the screening; and

Whereas, the cost of colon prep kits can be a significant barrier for patients, potentially discouraging them from undergoing this lifesaving procedure and thereby undermining the ACA's goal of expanding access to preventative care; and

Whereas, financial barriers to colon prep coverage disproportionately impact low-income and underserved populations, exacerbating health inequities and contributing to lower screening rates and worse health outcomes in these communities; and

Whereas, closing this coverage gap aligns with public health goals and supports a more equitable healthcare system by ensuring that all patients have access to comprehensive, cost-free preventative care; therefore be it

RESOLVED, that our American Medical Association advocates for a federal mandate to include full coverage of colonoscopy preparation costs as part of the Affordable Care Act's preventative care requirements, ensuring that all Americans have access to necessary, cost-free preventative measures for colorectal cancer. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/22/25

**RELEVANT AMA POLICY**

**H-185.960 Support for the Inclusion of the Benefit for Screening for Colorectal Cancer in All Health Plans**

1. Our American Medical Association supports health plan coverage for the full range of colorectal cancer screening tests.
2. Our AMA will advocate through legislation and/or regulation, as appropriate for adequate payment and the elimination of cost-sharing in all health plans for the full range of colorectal cancer screening and all associated costs, including colonoscopy that includes a “diagnostic” intervention (i.e. the removal of a polyp or biopsy of a mass), as defined by Medicare. To further this goal, the AMA will develop a coding guide to promote common understanding among health care providers, payers, health care information technology vendors, and patients.
3. Our AMA will seek to eliminate cost-sharing in all health plans for “follow-on” colonoscopies performed for colorectal cancer screening and all associated costs, defined as when other alternative screening tests (i.e., stool- or blood-based tests) are found to be positive.
4. Our AMA will seek to classify follow-up, follow-on, or surveillance colonoscopy after an original screening colonoscopy that required polyp removal as a screening service under the Affordable Care Act preventive services benefit and will seek to eliminate patient cost sharing in all health plans under such circumstances. [Res. 726, I-04 Reaffirmation I-07 Reaffirmed: CMS Rep. 01, A-17 Reaffirmed: Res. 123, A-17 Appended: CMS/CSAPH Joint Rep. 01, A-18 Modified: Res. 106, A-24]

**H-330.877 Improving the Prevention of Colon Cancer by Insuring the Waiver of the Co-Payment in all Cases**

1. Our AMA supports requiring Medicare to waive the coinsurance for colorectal screening tests, including therapeutic intervention(s) required during the procedure.
2. Our AMA will continue to support Medicare coverage for colorectal cancer screenings consistent with ACA-compliant plan coverage requirements. [Res. 123, A-17 Appended: CMS/CSAPH Joint Rep. 01, A-18]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 807
(I-25)

Introduced by: Mississippi

Subject: Protecting Hospitals and Patients from Inappropriate Denials of Inpatient Admissions

Referred to: Reference Committee J

---

Whereas, oftentimes insurance companies require a peer to peer or review process for hospital admissions; and

Whereas, if a physician assesses a patient as an appropriate full admission, the peer to peer physician often denies “full admission” status; and

Whereas, if full admission status is denied, the insurance companies do not allow the patient to be reverted to “observation status,” which results in no payment to the hospital and a significant debt for the patient; therefore be it

RESOLVED, that our American Medical Association assert that if an insurance company denies “full admission” status for a patient being hospitalized, that the insurance company must provide the ability to revert the status to observation so the hospital and patient are protected from total denial. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 9/22/25

**RELEVANT AMA POLICY**

**H-160.944 Defining “Observation Care”**

1. The AMA will work with third party payers to establish a uniform definition of "observation care," including the following: (a) The patient should be designated as under "observation care" if the physician's intent for hospital stay is less than 24 hours. If the physician's intent and expectation is for a hospital stay of greater than 24 hours, then the stay should be considered inpatient. The use of 24 hours as a threshold for observation is a guideline. It is not unusual for observation to extend to a few hours beyond 24 hours or for patients to be admitted to inpatient status before 24 hours. (b) Patients classified as under "observation care" require hospital level-of-care. (c) The patient should be registered as under "observation care" after initial physician evaluation of the patient's signs and symptoms and appropriate testing. Post day surgical patients should be registered as under "observation care" if, after a normal recovery period, they continue to require hospital level-of-care as determined by a physician.

2. The AMA will establish policy on "observation care" and develop model legislation to ensure that: (a) After initial approval of inpatient admission by insurers, there should be no retrospective reassignment to "observation care" status by insurers unless the original information given to insurers is incorrect. (b) Insurers should provide 60 days prior notice to providers of changes to "observation care" criteria or the application of those criteria with opportunity for comment. There should be no implementation of criteria or changes without first following these protocols. (c) Insurers' "observation care" policies should include

an administrative appeal process to deal with all utilization and technical denials within a 60 day time frame for final resolution. An expedited appeal process should be available for patients in the admission process, allowing for a decision within 24 hours. (d) Insurers and HMOs should provide clearly written educational materials on "observation care" to subscribers highlighting differences between inpatient and "observation care" benefits and patient appeal procedures.

3. Our AMA will work with all appropriate governmental and non-governmental organizations to assure that both patients and physicians are treated fairly in the process of delineating the hospital admission status of patients, and to ensure that the process is transparent and administratively simple. [Res. 808, I-95 Reaffirmed: CMS Rep. 7, A-05 Reaffirmed: BOT Action in response to referred for decision Res. 715, I-07 Reaffirmed: BOT Rep. 32, A-09 Appended: Res. 808, I-11 Reaffirmed: CMS Rep. 4, A-14 Reaffirmed: CMS Rep. 01, A-24]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 808
(I-25)

Introduced by: Organized Medical Staff Section

Subject: No Prior Authorization for Inexpensive Medications

Referred to: Reference Committee J

---

Whereas, a key element of American Medical Association principles is to enhance access to medical care; and

Whereas, the process known as prior authorization or preauthorization (PA) was devised for the stated purpose of restraining excessive medical care costs; and

Whereas, over time, prior authorization has increasingly been imposed on a wide spectrum of pharmaceutical and procedural medical care, including those of lower nominal cost; and

Whereas, prior authorization applied without the justification of real cost-containment can result in adverse health consequences via delay or denial of service; and

Whereas, efforts to restrain excessively intrusive prior authorization have failed to curtail such abuses by attempting to eliminate prior authorization entirely; and

Whereas, a strategy of eliminating truly nuisance application of prior authorization may be more successful; and

Whereas, a formula for determining what constitutes low cost should be devised, such as a ceiling equal to the quarterly cost of health insurance; and

Whereas, existing AMA policy already states that, “our American Medical Association advocates that low-cost noninvasive procedures that meet existing standard Medicare guidelines should not require prior authorization,” thus establishing that there should be a cost floor on the application of that process; therefore be it

RESOLVED, that our American Medical Association identify through the Council on Medical Services or other professional content experts a cost threshold below which medical services and medications should not require prior authorization (Directive to Take Action); and be it further

RESOLVED, that our American Medical Association advocate that low-cost medications and procedures should not require prior authorization. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/22/25

**RELEVANT AMA POLICY**

**Insurer Accountability When Prior Authorization Harms Patients D-320.974**

1. Our American Medical Association advocates for increased legal accountability of insurers and other payers when delay or denial of prior authorization leads to patient harm, including but not limited to the prohibition of mandatory pre-dispute arbitration regarding prior authorization determinations and limitation on class action clauses in beneficiary contracts.
2. Our American Medical Association advocates that low-cost noninvasive procedures that meet existing standard Medicare guidelines should not require prior authorization.
3. Our AMA supports that physicians be allowed to bill insurance companies for all full time employee hours required to obtain prior authorization.
4. Our AMA supports that patients be allowed to sue insurance carriers which preclude any and all clauses in signed contracts should there be an adverse outcome as a result of an inordinate delay in care.

Citation: Res. 711, A-24

**Approaches to Increase Payer Accountability H-320.968**

Our AMA supports the development of legislative initiatives to assure that payers provide their insureds with information enabling them to make informed decisions about choice of plan, and to assure that payers take responsibility when patients are harmed due to the administrative requirements of the plan. Such initiatives should provide for disclosure requirements, the conduct of review, and payer accountability.

1. Disclosure Requirements. Our American Medical Association supports the development of model draft state and federal legislation to require disclosure in a clear and concise standard format by health benefit plans to prospective enrollees of information on:
    a. Coverage provisions, benefits, and exclusions.
    b. Prior authorization or other review requirements, including claims review, which may affect the provision or coverage of services.
    c. Plan financial arrangements or contractual provisions that would limit the services offered, restrict referral or treatment options, or negatively affect the physician's fiduciary responsibility to their patient.
    d. Medical expense ratios.
    e. Cost of health insurance policy premiums. (Ref. Cmt. G, Rec. 2, A-96; Reaffirmation A-97)
2. Conduct of Review. Our AMA supports the development of additional draft state and federal legislation to:
    a. Require private review entities and payers to disclose to physicians on request the screening criteria, weighting elements and computer algorithms utilized in the review process, and how they were developed.
    b. Require that any physician who recommends a denial as to the medical necessity of services on behalf of a review entity be of the same specialty as the practitioner who provided the services under review.
    c. Require every organization that reviews or contracts for review of the medical necessity of services to establish a procedure whereby a physician claimant has an opportunity to appeal a claim denied for lack of medical necessity to a medical consultant or peer review group which is independent of the organization conducting or contracting for the initial review.
    d. Require that any physician who makes judgments or recommendations regarding the necessity or appropriateness of services or site of service be licensed to practice medicine in the same jurisdiction as the practitioner who is proposing the service or whose services are being reviewed.
    e. Require that review entities respond within 48 hours to patient or physician requests for prior authorization, and that they have personnel available by telephone the same business day who are qualified to respond to other concerns or questions regarding

medical necessity of services, including determinations about the certification of continued length of stay.

f. Require that any payer instituting prior authorization requirements as a condition for plan coverage provide enrollees subject to such requirements with consent forms for release of medical information for utilization review purposes, to be executed by the enrollee at the time services requiring such prior authorization are recommended or proposed by the physician.

g. Require that payers compensate physicians for those efforts involved in complying with utilization review requirements that are more costly, complex and time consuming than the completion of standard health insurance claim forms. Compensation should be provided in situations such as obtaining preadmission certification, second opinions on elective surgery, and certification for extended length of stay.

3. Accountability. Our AMA believes that draft federal and state legislation should also be developed to impose similar liability on health benefit plans for any harm to enrollees resulting from failure to disclose prior to enrollment the information on plan provisions and operation specified under Section 1 (a)-(d) above.

Citation: Issued: BOT Rep. M, I-90; Reaffirmed: Res. 716, A-95; Reaffirmed: CMS Rep. 4, A-95; Reaffirmed: I-96; Reaffirmed: Rules and Cred. Cmt, I-97; Reaffirmed: CMS Rep. 13; I-98; Reaffirmed: I-98; Reaffirmed:A-99; Reaffirmation: I-99; Reaffirmed: A-00; Reaffirmed in lieu of: Res. 839, I-08; Reaffirmed: A-09; Reaffirmed: Sub. Res. 728, A-10; Modified: CMS Rep. 4, I-10; Reaffirmed: A-11; Reaffirmed in lieu of Res. 108, A-12; Reaffirmed: Res. 709, A-12; Reaffirmed; CMS Rep. 07, A-16; Reaffirmed in lieu of: Res. 242, A-17; Reaffirmed in lieu of: Res. 106, A-17; Reaffirmed: A-17; Reaffirmed: A-18; Reaffirmed: A-19; Reaffirmed: Res. 206, I-20; Reaffirmed: A-22; Modified: Speakers Rep. 02, I-24

**Promoting Accountability in Prior Authorization D-285.960**

1. Our American Medical Association will advocate that peer-to-peer (P2P) prior authorization (PA) determinations must be made and actionable at the end of the P2P discussion notwithstanding mitigating circumstances, which would allow for a determination within 24 hours of the P2P discussion.
2. Our AMA will advocate that the reviewing P2P physician must have the clinical expertise to treat the medical condition or disease under review and have knowledge of the current, evidence-based clinical guidelines and novel treatments.
3. Our AMA will advocate that P2P PA reviewers follow evidence-based guidelines consistent with national medical specialty society guidelines where available and applicable.
4. Our AMA will continue to advocate for a reduction in the overall volume of health plans' PA requirements and urge temporary suspension of all PA requirements and the extension of existing approvals during a declared public health emergency.
5. Our AMA will advocate that health plans must undertake every effort to accommodate the physician's schedule when requiring peer-to-peer prior authorization conversations.
6. Our AMA will advocate that health plans must not require prior authorization on any medically necessary surgical or other invasive procedure related or incidental to the original procedure if it is furnished during the course of an operation or procedure that was already approved or did not require prior authorization.

Citation: CMS Rep. 4, A-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 809
(I-25)

Introduced by: Organized Medical Staff Section

Subject: Ensuring Patient Safety and Physician Oversight in the Integration of Hospital Inpatient Virtual Nursing

Referred to: Reference Committee J

---

Whereas, inpatient hospital virtual nursing is a healthcare model that uses technology to provide nursing care remotely to patients admitted to a hospital; and

Whereas, virtual nursing in the inpatient setting involves experienced registered nurses working remotely—often from a centralized command center—to support bedside nurses and patients via video, audio, and digital tools; and

Whereas, virtual nursing can transform healthcare delivery by addressing long-standing challenges such as nursing shortages, burnout, and capacity issues in hospitals; virtual nursing has potential to alleviate the stress on direct-care staff but also can provide significant operational and financial benefits to healthcare organizations; and

Whereas, virtual nurses handle paperwork, patient education, and discharge planning to reduce the workload on bedside nurses as admission and discharge support; and

Whereas, virtual nursing can assist in ongoing patient monitoring, such as vital sign reviews and safety checks and provide information, answer questions, and check on patient well-being; and

Whereas, virtual nurses can be useful in patient and family education and communication; and

Whereas, there is currently no national policy or governance structure in place to guide the development and adoption of inpatient virtual nursing besides state nursing boards; and

Whereas, the Centers for Medicare & Medicaid Services does not yet have comprehensive guidelines just for inpatient virtual nursing, preferring to defer to state regulations and accrediting bodies; and

Whereas, current AMA policy H-225.957, “Positions for Strengthening the Physician-Hospital Relationship states, “the organized medical staff and the hospital governing body are responsible for the provision of quality care, providing a safe environment for patients, staff, and visitors, and working continuously to improve patient care rendered and for patient safety vested with the organized medical staff; and responsibility of the organized medical staff and the hospital governing body for the proper performance of their respective obligations;” and

Whereas, the deployment of virtual nursing models without adequate input from medical staff may lead to fragmentation of care, unclear clinical responsibilities, and diminished physician oversight; and

Whereas, the thoughtful integration of virtual nursing requires collaboration among physicians, nurses, hospital leadership, and technology developers to ensure that innovations support—not replace—physician-led high-quality, patient-centered care; therefore be it

RESOLVED, that our American Medical Association undertake a comprehensive study of hospital inpatient virtual nursing, including an assessment of its benefits and risks for patient safety and an analysis of guidelines for credentialing, privileging, and documentation standards and any policy gaps related to oversight by the Centers for Medicare & Medicaid Services and The Joint Commission (Directive to Take Action); and be it further

RESOLVED, that our AMA recognizes that organized medical staffs, as leaders in hospital medicine who have a duty to protect patient safety within their institutions, should work collaboratively to ensure physician-led, high-quality, patient-centered care in the integration of inpatient virtual nursing, (New HOD Policy)

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

Received: 9/22/25

**REFERENCES**

1. 'More than just technology': How virtual nursing models are shaping care delivery innovation. Beckers Hospital Review. Accessed: May 13, 2025. 'More than just technology': How virtual nursing models are shaping care delivery innovation - Becker's Hospital Review | Healthcare News & Analysis
2. TeledocHealth. Inpatient virtual nursing fundamentals, uses, and benefits: Mitigate the nursing shortage and enhance patient care with inpatient virtual nursing. Accessed: May 13, 2025. https://www.teladochealth.com/content/dam/tdh-www/us/en/documents/white-paper/Virtual_Nursing_White_Paper_Teladoc_Health.pdf
3. Sellinger T. Breaking down indemnification clauses. Physician's Weekly. January 23, 2025. Accessed March 9, 2025. https://www.physiciansweekly.com/qa-breaking-down-indemnification-clauses/.

**RELEVANT AMA POLICY**

**Principles for Strengthening the Physician-Hospital Relationship H-225.957**

The following twelve principles are our American Medical Association policy:
PRINCIPLES FOR STRENGTHENING THE PHYSICIAN-HOSPITAL RELATIONSHIP

1. The organized medical staff and the hospital governing body are responsible for the provision of quality care, providing a safe environment for patients, staff and visitors, protection from interruption of delivery of care, and working continuously to improve patient care and health outcomes—including but not limited to the development, selection, and implementation of augmented intelligence—with the primary responsibility for the quality of care rendered and for patient safety vested with the organized medical staff. These activities depend on mutual accountability, interdependence, and responsibility of the organized medical staff and the hospital governing body for the proper performance of their respective obligations.
2. The organized medical staff, a self-governing organization of professionals, possessing special expertise, knowledge and training, discharges certain inherent professional responsibilities by virtue of its authority to regulate the professional practice and standards of its members, and assumes primary responsibility for many functions, including but not limited to: the determination of organized medical staff membership; performance of credentialing, privileging and other peer review; and timely oversight of clinical quality and patient safety.
3. The leaders of the organized medical staff, with input from the hospital governing body and senior hospital managers, develop goals to address the healthcare needs of the community and are involved in hospital strategic planning as described in the medical staff bylaws.
4. Ongoing, timely and effective communication, by and between the hospital governing body and the organized medical staff, is critical to a constructive working relationship between the organized medical staff and the hospital governing body.

5. The organized medical staff bylaws are a binding, mutually enforceable agreement between the organized medical staff and the hospital governing body. The organized medical staff and hospital bylaws, rules and regulations should be aligned, current with all applicable law and accreditation body requirements and not conflict with one another. The hospital bylaws, policies and other governing documents do not conflict with the organized medical staff bylaws, rules, regulations and policies, nor with the organized medical staff's autonomy and authority to self govern, as that authority is set forth in the governing documents of the organized medical staff. The organized medical staff, and the hospital governing body/administration, shall, respectively, comply with the bylaws, rules, regulations, policies and procedures of one another. Neither party is authorized to, nor shall unilaterally amend the bylaws, rules, regulations, policies or procedures of the other.
6. The organized medical staff has inherent rights of self governance, which include but are not limited to:
    a. Initiating, developing and adopting organized medical staff bylaws, rules and regulations, and amendments thereto, subject to the approval of the hospital governing body, which approval shall not be unreasonably withheld. The organized medical staff bylaws shall be adopted or amended only by a vote of the voting membership of the medical staff.
    b. Identifying in the medical staff bylaws those categories of medical staff members that have voting rights.
    c. Identifying the indications for automatic or summary suspension, or termination or reduction of privileges or membership in the organized medical staff bylaws, restricting the use of summary suspension strictly for patient safety and never for purposes of punishment, retaliation or strategic advantage in a peer review matter. No summary suspension, termination or reduction of privileges can be imposed without organized medical staff action as authorized in the medical staff bylaws and under the law.
    d. Identifying a fair hearing and appeals process, including that hearing committees shall be composed of peers, and identifying the composition of an impartial appeals committee. These processes, contained within the organized medical staff bylaws, are adopted by the organized medical staff and approved by the hospital governing board, which approval cannot be unreasonably withheld nor unilaterally amended or altered by the hospital governing board or administration. The voting members of the organized medical staff decide any proposed changes.
    e. Establishing within the medical staff bylaws:
        1. The qualifications for holding office.
        2. The procedures for electing and removing its organized medical staff officers and all organized medical staff members elected to serve as voting members of the Medical Executive Committee.
        3. The qualifications for election and/or appointment to committees, department and other leadership positions.
    f. Assessing and maintaining sole control over the access and use of organized medical staff dues and assessments, and utilizing organized medical staff funds as appropriate for the purposes of the organized medical staff.
    g. Retaining and being represented by legal counsel at the option and expense of the organized medical staff.
    h. Establishing in the organized medical staff bylaws, the structure of the organized medical staff, the duties and prerogatives of organized medical staff categories, and criteria and standards for organized medical staff membership application, reapplication credentialing and criteria and processing for privileging. The standards and criteria for membership, credentialing and privileging shall be based only on quality of care criteria related to clinical qualifications and professional responsibilities, and not on economic credentialing, conflicts of interest or other non-clinical credentialing factors.
    i. Establishing in the organized medical staff bylaws, rules and regulations, clinical criteria and standards to oversee and manage quality assurance, utilization review and other organized medical staff activities, and engaging in all activities necessary and proper to implement those bylaw provisions including, but not limited to, periodic meetings of the organized medical staff and its committees and departments and review and analysis of patient medical records.

   j. The right to define and delegate clearly specific authority to an elected Medical Executive Committee to act on behalf of the organized medical staff. In addition, the organized medical staff defines indications and mechanisms for delegation of authority to the Medical Executive Committee and the removal of this authority. These matters are specified in the organized medical staff bylaws.
   k. Identifying within the organized medical staff bylaws a process for election and removal of elected Medical Executive Committee members.
   l. Defining within the organized medical staff bylaws the election process and the qualifications, roles and responsibilities of clinical department chairs. The Medical Executive Committee must appoint any clinical chair that is not otherwise elected by the vote of the general medical staff.
   m. Enforcing the organized medical staff bylaws, regulations and policies and procedures.
   n. Establishing in medical staff bylaws, medical staff involvement in contracting relationships, including exclusive contracting, medical directorships and all hospital-based physician contracts, that affect the functioning of the medical staff.
7. Organized medical staff bylaws are a binding, mutually enforceable agreement between the organized medical staff and the hospital governing body, as well as between those two entities and the individual members of the organized medical staff.
8. The self-governing organized medical staff determines the resources and financial support it requires to effectively discharge its responsibilities. The organized medical staff works with the hospital governing board to develop a budget to satisfy those requirements and related administrative activities, which the hospital shall fund, based upon the financial resources available to the hospital.
9. The organized medical staff has elected appropriate medical staff member representation to attend hospital governing board meetings, with rights of voice and vote, to ensure appropriate organized medical staff input into hospital governance. These members should be elected only after full disclosure to the medical staff of any personal and financial interests that may have a bearing on their representation of the medical staff at such meetings. The members of the organized medical staff define the process of election and removal of these representatives.
10. Individual members of the organized medical staff, if they meet the established criteria that are applicable to hospital governing body members, are eligible for full membership on the hospital governing body. Conflict of interest policies developed for members of the organized medical staff who serve on the hospital's governing body are to apply equally to all individuals serving on the hospital governing body.
11. Well-defined disclosure and conflict of interest policies are developed by the organized medical staff which relate exclusively to their functions as officers of the organized medical staff, as members and chairs of any medical staff committee, as chairs of departments and services, and as members who participate in conducting peer review or who serve in any other positions of leadership of the medical staff.
12. Areas of dispute and concern, arising between the organized medical staff and the hospital governing body, are addressed by well-defined processes in which the organized medical staff and hospital governing body are equally represented. These processes are determined by agreement between the organized medical staff and the hospital governing body.

Citation: Res. 828, I-07; Reaffiremd in lieu of Res. 730, A-09; Modified: Res. 820, I-09; Reaffirmed: Res. 725, A-10; Reaffirmed: A-12; Reaffirmed: CMS Rep. 6, I-13; Reaffirmed: CMS Rep. 5, A-21; Modified: Res. 024, A-24

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 811
(I-25)

Introduced by: Florida, South Carolina, Tennessee, Oklahoma

Subject: Non-Medical Switching

Referred to: Reference Committee J

---

Whereas, non-medical switching is defined as the practice of changing a patient's medication for reasons other than clinical efficacy or safety, typically due to formulary or cost considerations imposed by pharmacy benefit managers (PBMs) or health insurers; and

Whereas, non-medical switching often disrupts stable treatment regimens and can lead to adverse clinical outcomes, including increased side effects, reduced therapeutic effectiveness, and diminished medication adherence; and

Whereas, studies have shown that patients subject to non-medical switching may experience increased healthcare utilization, including more physician visits, emergency department use, and hospitalizations; and

Whereas, physicians, as licensed medical professionals, are in the best position to determine the appropriate medication regimen based on a patient's individual medical history and clinical condition; and

Whereas, PBM-driven formulary changes often occur with minimal notice and no requirement for physician consent or medical justification; and

Whereas, the AMA has longstanding policies opposing undue interference in the physician-patient relationship and supporting transparency in PBM practices; and

Whereas, a number of states have introduced or passed legislation to limit or ban non-medical switching, affirming a growing national concern about this practice; therefore be it

RESOLVED, that our American Medical Association opposes the practice of non-medical switching by pharmacy benefit managers and health insurers, except when clinically justified and approved by the prescribing physician (New HOD Policy); and be it further

RESOLVED, that our American Medical Association study and report back at I-26 on the clinical and economic impact of non-medical switching on patient outcomes, medication adherence, and overall healthcare utilization, and disseminate these findings to policymakers and the public. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/24/25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 812
(I-25)

Introduced by: American Academy of Physical Medicine and Rehabilitation

Subject: Discontinue Review Choice Demonstration Project for Inpatient Rehabilitation Hospital Admissions

Referred to: Reference Committee J

---

Whereas, Inpatient Rehabilitation Facility (IRF) care is an important part of all health care systems, providing intensive inpatient rehabilitation to patients who sustain major injuries or illnesses, such as stroke, traumatic brain injuries, limb amputation, hip fractures, major neurological impairments, or spinal cord injuries; and

Whereas, a CMS demonstration project called the Inpatient Rehabilitation Facility Review Choice Demonstration (IRF RCD) is currently burdening inpatient rehabilitation physicians and hospitals while failing to meet its goal of identifying any fraud, waste, or abuse; and

Whereas, under the IRF RCD, 100% pre-claim or post-payment review of all IRF patient admissions was implemented by CMS through contractors as a pilot project in Alabama in 2023 and Pennsylvania in 2024 with the stated objective of eliminating fraud, waste, and abuse[1]; and

Whereas, CMS plans to expand the IRF RCD to Texas and California[1]; and

Whereas, this project will continue to expand to nearly half of the IRFs in the country if fully implemented[1]; and

Whereas, there have been high affirmation rates to date in the first two states subject to the IRF RCD with no evidence of fraud, waste, and abuse; and

Whereas, this 100% review is an additional burden on physicians, IRFs, and staff without findings of major problems; and

Whereas, this demonstration project may institute additional barriers to access for some patients, even though their treating physicians believe IRF care is reasonable and necessary; and

Whereas, this demonstration project is expensive for CMS to implement and this money could better be used to improve other areas of the Medicare program, including physician payment; and

Whereas, this project institutes significant expenses on IRFs in the program, who must dedicate staff time and resources to the administrative needs of the demonstration; and

Whereas, a stated focus of this Administration and CMS is to remove unnecessary provider burden, and avoid duplicative regulations; and

Whereas, the IRF stakeholder community is aligned on the position that the IRF RCD should not be expanded to Texas or California and should be discontinued as soon as possible[2,3,4,5,6] therefore be it

RESOLVED, that our American Medical Association oppose CMS's expansion of the Inpatient Rehabilitation Facility Review Choice Demonstration Project and advocate that the project be immediately discontinued. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/26/25

**REFERENCES**

1. 9/3/2021 Federal Register Notice on Proposal to Implement IRF RCD: Federal Register: Agency Information Collection Activities: Submission for OMB Review; Comment Request
2. 7/28/25 AAPM&R Comments to CMS in response to IRF RCD Request for Information: aapmr-comments_irf-rcd-july-28-2025.pdf
3. 7/28/25 American Medical Rehabilitation Providers Association (AMRPA) Comments to CMS in response to IRF RCD Request for Information: RCD Comment Letter Procedural Argument (D1189450).DOCX
4. 6/10/25 Coalition to Preserve Rehabilitation Comments in response to FY 2026 IRF PPS Proposed Rule: CPR Comments re: FY 2026 IRF PPS Proposed Rule (Final Draft) (D1181187).DOCX
5. 8/11/23 Joint Stakeholder Letter to CMS Requesting an Immediate Delay to Implementation of the IRF RCD: irf-stakeholder-letter-re-rcd-delay-8.11.2023-final.pdf
6. 10/8/21 AAPM&R Comments on Proposed IRF RCD: aapm-r-comments-on-proposed-review-choice-demonstration-for-inpatient-rehabilitation-facility-services.pdf

## RELEVANT AMA POLICY

**H-330.921 Medicare Prepayment and Postpayment Audits**

1. AMA policy is that with respect to prepayment and postpayment audits by the Medicare program, the following principles guide AMA advocacy efforts:
(a) The confidential medical record should be preserved as an instrument of clinical care, with strong confidentiality protections and, we oppose its use as an accounting document;
(b) CMS should discontinue random prepayment audits of E&M services;
(c) In lieu of prepayment audits, CMS should use focused medical review of outliers based on reviews of patterns of services, using an independent medical peer review process, where physicians practicing in the same specialty, review their peers;
(d) No financial or legal penalties should be assessed based on one level of disagreement in E&M code assignment; and
(e) CMS must stop the practice of requiring physicians to repay alleged Medicare overpayments before an actual appeal is rejected or a final administrative decision or a court order is rendered. Legislative relief will be sought if advocacy with CMS is not successful in this regard.
2. Our AMA advocates that all government recovery programs contain complete physician access to any data mining criteria and programs, that there is same-specialty/same-subspecialty physician review prior to denial of claims, and that any denial of claims be based on medical necessity review as determined by that same-specialty/same-subspecialty physician reviewer, and will explore options for increased reimbursement of physician costs related to government audits, including remedies available through the Equal Access to Justice Act.
3. Our AMA supports the enactment of federal legislation or regulation that requires fairness in the practice of conducting physicians' post-payment audits as contained in paragraph 1 above, and which would include the following:
(a) The requirement for such audits to be reviewed by a physician board certified within the same specialty prior to any requirement for repayment by the audited physician
(b) The requirement for the repayment to be placed in escrow until the appeals process is complete
(c) The removal of any incentives that are based upon a percentage of recovery for contracted government auditors
(d) The establishment of a mechanism for recovery of a practice's legal fees incurred for unsuccessful audits

(e) The full disclosure of contract terms with audit contractors
(f) The elimination or improvement of the extrapolation formula
(g) The payment for costly documentation requests
(h) Imposition of penalties on auditors for inaccurate findings, and
(i) Incentivizing the auditors to perform more physician education.
4. Our AMA will formally request that Medicare employ rules for prepayment and postpayment audits that are at least as protective as the Recovery Audit Contractor (RAC) rules for physicians, and that our AMA continue to advocate for reforms to the audit process, including giving great weight to the treating physician's determination of medical necessity.
5. Our AMA will propose to Medicare that there be a mechanism by which prepayment and postpayment audit denials can be resolved via the telephone or other electronic communications.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 813
(I-25)

Introduced by: New York

Subject: Increased Regulation of For-Profit Healthcare Insurance

Referred to: Reference Committee J

---

Whereas, health insurance companies operating as for-profit entities prioritize shareholder profits over patient care, leading to higher administrative costs, increased premiums, and reduced funding for direct patient services; and

Whereas, for-profit health insurers often deny coverage for necessary medical treatments to minimize costs, creating barriers to timely and equitable healthcare access; and

Whereas, for-profit health insurers have created vertically-integrated systems that bypass regulations to increase profits with an overall increase in healthcare costs; and

Whereas, MSSNY has previously passed many resolutions directed at reining in health insurance company abuses without effective change; therefore be it

RESOLVED, that our American Medical Association promote public awareness of the harms of for-profit vertical integration of health insurance systems (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for a comprehensive review by the legislature of current regulations and increased regulatory oversight and increased resources for the monitoring of State Medicaid and Managed Medicare for-profit health plans, including vertical integration. (Directive to Take Action)

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

Received: 9/26/25

**REFERENCES**

**EXISTING MSSNY POLICY:**

- 120.897 Reducing Prior Authorization Burden and Separate Payment When Not Part of a Patient Encounter
- 120.898 Prior Authorization Reform
- 120.903 Bypassing Surprise Bill Good Faith Negotiation
- 120.913 Qualified Physicians on Preauthorization Phone Lines
- 120.914 Difficulty Obtaining Pre-Op Information for Insurers
- 120.915 Insurers' Procedures Regarding Termination and Resignations
- 120.916 Contract Non Renewals by Third Party Insurers: Problems With the Insurers' Notification Process
- 120.922 Insurers Withhold Key Financial Information from Out-ofNetwork Physicians
- 120.925 Peer-to-Peer Reviews by Insurers
- 120.926 Private Insurers and Managed Care Organizations Pre–Authorization/Pre–Certification Protocols
- 120.931 NYS Private Payer Medical Necessity Guidelines
- 120.935 Non-Experimental Status Determined by Centers for Medicare and Medicaid Services

• 120.939 Physician-Directed Medication Access
• 120.949 Health Insurance Policies for Small Groups
• 120.986 Non-Assignability Clauses in Health Insurance Contracts
• 120.999 Health Insurer Abuses
• 165.834 Payment for Pre-Authorized/Pre-Certified Procedures
• 165.835 Regulation Against Insurance Company Denials Following Insurer Peer-toPeer Prior Authorization
• 165.840 Insurers and Vertical Integration
• 165.842 Request for Action on MSSNY Policy
• 165.933 Managed Care Organization Downcoding,
• 165.847 Pharmacy Benefit Managers Interfering with the Progress and Continuity of Treatment
• 165.848 Medicare Advantage Insurer Abuses
• 165.850: Insurers' Use of Offsets with Refund Demands
• 165.855 Identification of Insurance Plans by Payer ID
• 165.869 Participating Provider Lists
• 165.876 Ownership of Managed Care Organizations
• 165.897 MCOs Use of Pre-Payment Claim Reviews to Circumvent the New York State Prompt Payment Law
• 165.918 Time Limit for Retrospective Denials
• 165.937 Full Adoption of the National Specialty Societies' Practice Parameter Guidelines by Third-Party Insurer

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 814
(I-25)

Introduced by: New York

Subject: Mandate for Insurance Companies to Assist in the Transition of Patients to Alternative Participating Physicians Upon Contract Termination

Referred to: Reference Committee J

---

Whereas, patients rely on their physicians to manage and coordinate their medical care, and changes in the physician network can significantly disrupt their continuity of care; and

Whereas, physicians may elect to terminate participation in a particular insurance plan or network due to changes in payment policy or irreconcilable differences in contract terms; and

Whereas, when a physician notifies an insurer of their intent to terminate participation in a specific insurance plan, it can create confusion and hardship for patients who may be forced to find a new physician on short notice, often with limited options; and

Whereas, the transition to a new physician can result in gaps in care, delays in treatment, and increased patient distress, particularly for individuals with complex or ongoing medical needs; and

Whereas, many patients, especially those with chronic conditions, may require ongoing management from specialists and may need assistance navigating the process of finding an in-network physician that can effectively take over their care; and

Whereas, it frequently becomes the responsibility and burden of the physician to assist the patient in locating and securing a new in-network physician; and

Whereas, it is in the best interest of both patients and insurers to ensure that patients can continue to receive timely, high-quality care without unnecessary disruption, and that insurers play an active role in facilitating this transition; and

Whereas, current regulations do not require insurers to directly assist in the transition of care when a physician exits the network, leaving patients to navigate these challenges on their own or the physician burdened to provide these services; therefore be it

RESOLVED, that our American Medical Association advocate through legislation or regulations that private and public health insurers be mandated on the event of a treating physician terminating participation with that insurer to provide assistance to affected patients in transitioning to other in-network physicians, including providing a list of alternative participating physicians who can continue to provide care to the patient (Directive to Take Action); and be it further

RESOLVED, that our American Medical Association advocate through legislation or regulations that private and public health insurers be mandated to provide resources to ensure continuity of care for patients who are mid-treatment or require ongoing care with the exiting physician

without penalties to the physician, including offering extended benefits or out-of-network coverage when necessary (Directive to Take Action); and be it further

RESOLVED, that our American Medical Association advocate through legislation or regulations that private and public health insurers be mandated to provide an online payment policy tool that has a uniform interface that works across all insurers and physicians, ensuring consistent and streamlined access to coverage information for physicians and patients. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/26/25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 815
(I-25)

Introduced by: New York

Subject: Mandating Health Insurers to Provide a Real-Time Online Tool for Coverage and Payment Policies, Integrated into Electronic Health Records (EHRs)

Referred to: Reference Committee J

---

Whereas, Physicians and patients frequently experience delays and difficulties in determining the coverage and payment policies for medical procedures under various health insurance plans, leading to inefficiencies and potential financial burdens for patients; and

Whereas, the ability to accurately and quickly ascertain coverage information is essential for informed decision-making by both healthcare providers and patients, ensuring timely access to necessary medical services; and

Whereas, current systems for determining insurance coverage and payment policies are often opaque, inconsistent, and cumbersome, causing unnecessary administrative burdens on healthcare providers, including staff time and resources; and

Whereas, a real-time, online tool that provides immediate, clear, and comprehensive coverage and payment policy information for medical procedures would streamline the process, reduce administrative inefficiencies, and enhance transparency in insurance practices; and

Whereas, this tool should be available to physicians at the time a procedure is suggested, allowing providers to receive real-time, accurate coverage and payment policy information for the proposed procedure, enabling them to make informed decisions and discuss coverage options with patients before proceeding; and

Whereas, for maximum efficiency, the real-time online tool should be a uniform interface that works across all insurers and healthcare providers, ensuring consistency, ease of use, and integration into existing workflows; and

Whereas, the integration of this tool directly into Electronic Health Records (EHRs) would enable seamless, real-time access to coverage and payment policy information within the physician's existing clinical workflow, enhancing usability and reducing administrative burden; therefore be it

RESOLVED, that our American Medical Association shall advocate for legislation or regulations requiring all health insurers in every State to provide a real-time online tool for physicians and patients to determine coverage and payment policies for medical procedures, treatments, and services at the time of suggested procedures (Directive to Take Action); and be it further

RESOLVED, that our AMA advocates that the online payment policy tool must include detailed, accurate, and up-to-date information regarding covered services, co-pays, deductibles, and payment policies for specific procedures, and that this tool be binding on the insurers for the purposes of determining payment for claims (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate that the online payment policy tool must be a uniform interface that works across all insurers and physicians, ensuring consistent and streamlined access to coverage information for physicians and patients. (Directive to Take Action)

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

Received: 9/26/25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 816
(I-25)

Introduced by: New York

Subject: Prohibit Arbitrary Time Limits on Preauthorizations

Referred to: Reference Committee J

---

Whereas, patients are increasingly having access to care delayed or denied by insurance companies as health insurers report yearly increases in revenue, suggesting that the majority of denials are financially motivated; and

Whereas, reducing added insurer administrative hurdles such as having to repeat the preauthorization process due to an expired preauthorization is paramount to preventing further moral injury to already overburdened, increasingly underpaid physicians; and

Whereas, arbitrary time limits on preauthorizations for diagnostic and therapeutic interventions are one of the many tools used to delay and deny access to care, harming patients; and

Whereas, there is no accepted scientific medical rationale for placing time limits on access to care published in peer-reviewed medical literature; and

Whereas, when, for a variety of reasons medical and nonmedical, completing preauthorized care within the arbitrary insurance time frame isn't possible; therefore be it

RESOLVED, that our American Medical Association advocate for changes in State legislation and Division of Financial Services policy to prohibit health insurers in any State, including Medicaid plans, from establishing time limits on duration of preauthorization for care of less than one year (Directive to Take Action); and be it further

RESOLVED, that our AMA seek similar changes in Federal legislation and policies to prohibit Medicare Advantage, Medicaid, and Employee Retirement Income Securement Act of 1974 (ERISA) plans from establishing time limits on preauthorizations for care of less than one year. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/26/25

**REFERENCES**

**EXSISTING MSSNY POLICY**

1. 120.893 Fifteen Month Lab Orders
   MSSNY will advocate for legislation and/or regulation for all insurances to allow any standing laboratory order to be valid for up to 15 months before a new order is required. MSSNY will submit a resolution to the AMA seeking action by the Centers for Medicare/Medicaid Services (CMS) to allow standing laboratory orders to be active for 15 months. (HOD 2021-101)
2. 120.906 Grandfathering of Medications that have been Prescribed for Over 1 Year MSSNY will advocate that a physician be able to ensure continued insurer authorization for a particular medication that a patient has been using for over one year by noting on the e-prescription that the patient is stabilized on that medication. (HOD 2019-68)
3. 120.907 Nuisance Prior Authorizations Prior authorizations for medication must have a sound clinical justification which would be available upon request from the Pharmacy Benefit Manager and which would include, but not be limited to, promotion of adherence to guidelines, promotion of generic alternatives, and prevention of adverse reactions. MSSNY will advocate with the NYS Department of Health and NYS Department of Financial Services to prevent health insurers from imposing prior authorizations without appropriate clinical justification and to instruct Medicaid managed care contractors to approve prior authorizations for a minimum of one year. (HOD 2019-61)
4. 120.912 Reducing the Rate of Precertification Requirements In an effort to improve patient care and reduce the unnecessary burden regarding precertification requirements for physicians, MSSNY will continue and expand its efforts to force health insurers to reduce the level of required pre-certifications and preauthorizations physicians must obtain prior to rendering care. (HOD 2018-264)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 817
(I-25)

Introduced by: New York

Subject: Prohibiting Insurers from Denying Payment for Procedures Based on Site of Service

Referred to: Reference Committee J

---

Whereas, physicians, healthcare providers, and patients rely on insurance reimbursement to ensure that medically necessary procedures and treatments are covered, regardless of where the procedure is performed; and

Whereas, insurers may deny payment for procedures based solely on the site of service, despite the medical necessity of the service; and

Whereas, these site-of-service denials create significant barriers to timely care, cause unnecessary delays, and place a financial burden on both patients and providers, ultimately compromising patient outcomes and the quality of care; and

Whereas, there has been an expansion of the ability to perform more extensive procedures in the physician's office, frequently motivated by the self-same health insurers that are denying care; and

Whereas, the cost of performing the same procedure may vary significantly depending on the site of service, with higher costs often associated with hospital-based procedures, which can result in increased healthcare expenditures without improving the quality of care; and

Whereas, treating physicians should have the autonomy to determine the most appropriate site of service for their patients based on clinical considerations, not based on the cost-benefit analysis imposed by insurers; and

Whereas, such practices may disproportionately affect certain patient populations, including those in rural or underserved areas, where alternative sites of care may not be easily accessible; therefore be it

RESOLVED, that our American Medical Association advocates for legislation or regulation that prohibit insurers in all States from denying payment for a procedure based on the site of service in which it was performed, provided that the procedure is medically necessary. (Directive to Take Action)

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

Received: 9/26/25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 818
(I-25)

Introduced by: New York

Subject: Universal Out-of-Network Benefits

Referred to: Reference Committee J

---

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

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

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

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

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

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

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

RESOLVED, that our American Medical Association will advocate for federal and state laws that requires all private insurers to offer health insurance plans with out-of-network benefits. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/26/25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 819
(I-25)

Introduced by: New York

Subject: Update the status of Virtual Credit card policy, EFT fees, and lack of Enforcement of Administrative Simplification Requirements by CMS

Referred to: Reference Committee J

---

Whereas, our American Medical Association adopted policies CMS Administrative Requirements D-190.970, Virtual Credit Card Payments H-190.955, Amend Virtual Credit Card and Electronic Funds Transfer Fee Policy D-190.968; and

Whereas, despite the efforts of the American Medical Association and other groups, the sneaky practices and associated costs of virtual credit cards and EFT fees have not abated; and

Whereas, these possible violations of the HIPAA administrative simplification requirements have not been remedied; and

Whereas, enforcement of these laws preventing imposition of costs for EFT requires continued vigilance by the AMA, medical societies and physicians across the country; therefore be it

RESOLVED, that our American Medical Association report at the Annual 2027 Meeting on the progress of implementation of AMA Policies D-190.970, H-190.955, and D-190.968. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/26/25

**RELEVANT AMA POLICY**

**CMS Administrative Requirements D-190.970**
Our AMA will: (1) forcefully advocate that the Centers for Medicare and Medicaid Services (CMS) investigate all valid allegations of HIPPPA Administrative simplification requirements thoroughly and offers transparency in its processes and decisions as required by the Administrative Procedure Act (APA);

(2) forcefully advocate that the CMS resolve all complaints related to the non-compliant payment methods including opt-out virtual credit cards, charging processing fees for electronic claims and other illegal electronic funds transfer (EFT) fees; (3) communicate its strong disapproval of the failure by the CMS Office of Burden Reduction to effectively enforce the HIPAA administrative simplification requirements as required by the law and its failure to impose financial penalties for non-compliance by health plans; and (4) through legislation, regulation or other appropriate means, advocate for the prohibition of health insurers charging physicians and other providers to process claims and make payment.

**Amend Virtual Credit Card and Electronic Funds Transfer Fee Policy D-190.968**

1. Our American Medical Association will advocate for legislation or regulation that would prohibit the use of virtual credit cards (VCCs) for electronic health care payments.

2. Our AMA will advocate on behalf of physicians and plainly state that it is not advisable or beneficial for medical practices to get paid by VCCs.

3. Our AMA will engage in legislative and regulatory advocacy efforts to address the growing and excessive electronic funds transfer (EFT) add-on service fees charged by payers when paying physicians, including advocacy efforts directed at: (a) the issuance of Centers for Medicare & Medicaid Services (CMS) regulatory guidance affirming physicians' right to choose and receive timely basic EFT payments without paying for additional services, (b) CMS enforcement activities related to this issue, and (c) physician access to a timely no fee EFT option as an alternative to VCCs.

**Virtual Credit Card Payments H-190.955**

Our American Medical Association will educate its members about the use of virtual credit cards by third party payers, including the costs of accepting virtual credit card payments from third party payers, the beneficiaries of the administrative fees paid by the physician practice inherent in accepting such payments and the lower cost alternative of electronic funds transfer via the Automated Clearing House.

2. Our AMA will advocate for advance disclosure by third-party payers of transaction fees associated with virtual credit cards and any rebates or other incentives awarded to payers for utilizing virtual credit cards.

3. Our AMA supports transparency, fairness, and provider choice in payers' use of virtual credit card payments, including: advanced physician consent to acceptance of this form of payment; disclosure of transaction fees; clear information about how the provider can opt out of this payment method at any time; and prohibition of payer contracts requiring acceptance of virtual credit card payments for network inclusion.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 821
(I-25)

Introduced by: Oklahoma, American Society of Retina Specialists, American Society of Cataract and Refractive Surgery

Subject: Improving Access to Emergency Ophthalmologic Surgical Care

Referred to: Reference Committee J

---

Whereas, AMA Code of Medical Ethics, 11.1.4 Financial Barriers to Health Care Access, states "Health care is a fundamental human good because it affects our opportunity to pursue life goals, reduces our pain and suffering, helps prevent premature loss of life, and provides information needed to plan for our lives;" and

Whereas, AMA Code of Medical Ethics 11.1.4 also states "as professionals, physicians individually and collectively have an ethical responsibility to ensure that all persons have access to needed care;" and

Whereas, enhancing access to ophthalmologic surgical services is expected to reduce the incidence of permanent vision loss by enabling timely surgical management for urgent conditions such as acute retinal detachment, traumatic open globe injuries, endophthalmitis, and intraocular foreign bodies; and

Whereas, acute retinal detachment is the leading vision-threatening condition that requires prompt surgical treatment to prevent permanent loss of vision; [1] and

Whereas, delayed treatment of retinal detachment, particularly involving the macula, significantly worsens visual prognosis and increases the risk of irreversible blindness; [2–5] and

Whereas, access to emergency vitreoretinal surgical services faces significant restrictions across the United States due to insufficient facility reimbursement, resulting in hospital retina service closures and ambulatory surgery centers reducing retina block time or eliminating services entirely, while also constraining surgical room availability during nights and weekends; [6-11] and

Whereas, hospital privileging for vitreoretinal surgical services including retinal detachment (RD) surgery is hindered by institutional barriers—low reimbursement, resource and staffing limitations, and infrastructure demands—such that the decision to grant and sustain privileges often reflects hospital capacity and financial feasibility as much as surgeon expertise, ultimately restricting timely access to this procedure; and

Whereas, according to American Society of Retina Specialists' 2025 Preferences and Trends (PAT) survey, more than 70% of 889 respondents reported experiencing challenges with adequate operating room (OR) availability or access, particularly for emergent cases such as retinal detachment repair; [7] and

Whereas, some patients are forced to travel significant distances experiencing delays in care; [8] and

Whereas, inequities in access to timely retinal detachment surgery disproportionately affect underserved populations, including Medicaid beneficiaries, the uninsured, and residents of rural communities; [6-9] and

Whereas, payer-imposed barriers such as prior authorization and inadequate Medicaid and Medicare coverage further delay time-sensitive surgical care; and

Whereas, untreated or delayed treatment of retinal detachment not only results in blindness but also increases long-term societal costs through disability claims, Medicare and Medicaid expenditures, and loss of patient independence and productivity; and

Whereas, improving systems of care, reimbursement incentives, privileging standards, and payer rules, could enhance timely access to surgical management and prevent avoidable vision loss; [6-9] therefore be it

RESOLVED, that our American Medical Association supports policies aimed at enhancing access to emergency ophthalmic care—including vitreoretinal surgical services and traumatic open globe injuries— through initiatives such as improved operating room availability, facility reimbursement reforms, and changes to hospital privileging that exclude economic criteria to facilitate timely surgical care (New HOD Policy); and be it further

RESOLVED, that our AMA advocates to reduce payer barriers, including prior authorization and inadequate Medicaid and Medicare reimbursement, that hinder access to surgical ophthalmologic emergency care including vitreoretinal surgery and traumatic open globe injuries (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for reducing geographic and socioeconomic barriers to timely ophthalmologic emergency care—including both surgical vitreoretinal services and traumatic open globe injuries—in alignment with AMA health equity policies, with emphasis on rural and underserved communities. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/26/25

**REFERENCES**

1. Mitry D, Chalmers J, Anderson K, et al. Temporal trends in retinal detachment incidence in Scotland between 1987 and 2006. Br J Ophthalmol. 2011;95(3):365-369.https://doi.org/10.1136/bjo.2009.172296%C2%A0
2. Van Bussel EM, van der Valk R, Bijlsma WR, La Heij EC. Impact of duration of macula-off retinal detachment on visual outcome: a systematic review and meta-analysis of literature. Retina. 2014 Oct;34(10):1917-25. doi: 10.1097/IAE.0000000000000296. PMID: 25121930.
3. Babu N, Kohli P, Shetty R, et al. Duration of macular detachment and visual outcome in rhegmatogenous retinal detachment surgery. Indian J Ophthalmol. 2022;70(3):955-961. doi:10.4103/ijo.IJO_1029_21
4. Kobayashi M, Kishi S, Shimizu K, et al. Shorter duration of macular detachment correlates with better postoperative vision: results from the Japan Retinal Detachment Registry. Am J Ophthalmol. 2023;248:78-86. doi:10.1016 j.ajo.2023.03.003 36707048
5. Qureshi DM, Steel DH. Factors affecting visual outcome in patients undergoing surgery for macula-off rhegmatogenous retinal detachment: a review of the literature. Graefes Arch Clin Exp Ophthalmol. 2020;258(12):2473-2483. doi:10.1007/s00417-020-04850-5

6. Rosenberg JB, Flynn HW. Emerging challenges in access to emergency retina care in the United States. Retina Today. March 2020. Accessed August 30, 2025. https://retinatoday.com/articles/2020-mar/emerging-challenges-in-access-to-emergency-retina-care
7. Hahn P, ed. ASRS 2025 Preferences and Trends Membership Survey. Chicago, IL. American Society of Retina Specialists; 2025
8. National Rural Health Association. Rural health disparities. Published 2020. Accessed August 30, 2025.https://www.ruralhealthweb.org/about-nrha/about-rural-health-care
9. Lichter PR. The looming ophthalmologist shortage: how to avoid a crisis. Ophthalmology. 2008;115(7):1220-1225. doi:10.1016/j.ophtha.2007.11.034 Impact of duration of macula-off retinal detachment on visual outcome: a systematic review and meta-analysis of literature - PubMed
10. U.S. Department of Health and Human Services. Designated Health Professional Shortage Areas Statistics. Health Resources & Services Administration. Accessed August 30, 2025. https://data.hrsa.gov
11. Thompson JT. The Economics of Emergency Retinal Surgery and Declining Access to Care. *Journal of VitreoRetinal Diseases*. 2025;9(1):9-10. The Economics of Emergency Retinal Surgery and Declining Access to Care - John T. Thompson, 2025

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 822
(I-25)

Introduced by: Medical Student Section

Subject: Improving Home or Community-Based Services Waiver Waiting List Management

Referred to: HOD Reference Committee J

---

Whereas, individuals with permanent disabilities are often unable to meet their Activities of Daily Living without long-term caregivers that deliver home or community-based services (HCBS); and

Whereas, in 2024, individuals waited an average of 40 months to receive HCBS, and as of 2024, over 700,000 individuals, primarily with intellectual and developmental disabilities (I/DD), remain on HCBS waiting lists across the United States[1,2]; and

Whereas, waiting list management for HCBS waivers differs between states, with some states maintaining waiting lists for enrolled individuals for whom services are not currently available (due to workforce shortages or waiver caps) while other states maintain waiting lists of individuals who have yet to be screened for eligibility[1]; and

Whereas, automatic eligibility screening ensures that only qualified applicants are placed on a waiting list, increasing efficiency and ensuring that individuals who need services the most receive them in a timely manner[3]; and

Whereas, people with I/DD residing in states that do not automatically screen for eligibility wait longer for services than people with I/DD residing in states that do automatically screen (70 months versus 43 months, on average)[1]; and

Whereas, over half of people (428,000) on HCBS waiting lists live in the eight states that do not screen people for eligibility prior to adding them to the list[2]; and

Whereas, Texas reports some individuals have been on their HCBS waiting lists for over 15 years, with 1,469 (3.5%) of those screened for eligibility in 2024 found to be deceased[4]; and

Whereas, Ohio developed a new waiting list assessment in 2019, which removed ineligible people from the list who did not meet waiver criteria, providing them with other Medicaid state resources where applicable, and cutting the waiting list from 69,000 to 2,000 people[1,3]; and
Whereas, states' implementation of eligibility screening for HCBS waivers was associated with increased HCBS enrollment, and promoted need-based access to HCBS; and

Whereas, increasing access to HCBS waivers has been shown to improve cost efficiency for states in delivering long-term services and supports, particularly for individuals with I/DD, with

states that enroll more people into HCBS programs achieving lower per-person Medicaid spending compared to those who rely on institutional care[5]; therefore be it

RESOLVED, that our American Medical Association support automatic eligibility screening for home or community-based services (HCBS) waivers. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Date Received: 09/30/2025

**REFERENCES**

1. Burns A, Wolk A, Watts MO, Mohamed M, Published MTP. A look at waiting lists for medicaid home- and community-based services from 2016 to 2024. KFF. October 31, 2024. Accessed March 9, 2025. https://www.kff.org/medicaid/issue-brief/a-look-at-waiting-lists-for-medicaid-home-and-community-based-services-from-2016-to-2024/
2. Medicaid HCBS waiver waiting list enrollment, by target population and whether states screen for eligibility. KFF. April, 2 2025. Accessed April 7, 2025. https://www.kff.org/medicaid/state-indicator/medicaid-hcbs-waiver-waiting-list-enrollment-by-target-population-and-whether-states-screen-for-eligibility/
3. Gallegos A, Gordon C, Benally H, et al. Toward economic security: the impact of income and asset limits on people with disabilities. National Council on Disability. October, 31 2023. Accessed March 9, 2025. https://www.ncd.gov/assets/uploads/reports/2023/ncd_2023-progress-report.docx
4. Texas Health and Human Services. Interest List Data. January 2025. Accessed April 7, 2025. https://www.hhs.texas.gov/sites/default/files/documents/interest-list-data-jan-2025.xlsx
5. Cost-efficiency in Medicaid long-term support services: the role of home and community based services. SpringerPlus. July 6, 2013. Accessed April 7, 2025. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3710567/

**RELEVANT AMA POLICY**

**H-280.945 Financing of Long-Term Services and Supports**
Our American Medical Association supports policies and incentives that standardize and simplify private Long Term Care Insurance (LTCI) to achieve increased coverage and improved affordability for all Americans.
Our AMA supports adding transferable and portable LTCI coverage as part of workplace automatic enrollment with an opt-out provision potentially available to both current employees and retirees.
Our AMA supports allowing employer-based retirement savings to be used for LTCI premiums and LTSS expenses, including supporting penalty-free withdrawals from retirement savings accounts for purchase of private LTCI.
Our AMA supports innovations in LTCI product design, including the insurance of home and community-based services, and the marketing of long-term care products with health insurance, life insurance, and annuities.
Our AMA supports permitting Medigap plans to offer a limited LTSS benefit as an optional supplemental benefit or as separate insurance policy.
Our AMA supports Medicare Advantage plans offering LTSS in their benefit packages.
Our AMA supports permitting Medigap and Medicare Advantage plans to offer a respite care benefit as an optional benefit.
Our AMA supports a back-end public catastrophic long-term care insurance program.
Our AMA supports incentivizing states to expand the availability of and access to home and community-based services; and
Our AMA supports better integration of health and social services and supports, including the Program of All-Inclusive Care for the Elderly. [CMS Rep. 05, A-18 Reaffirmation: I-18 Reaffirmed: CMS Rep. 10, A-19 Reaffirmed: CMS Rep. 4, I-21 Reaffirmed: A-23 Modified: Res. 815, I-23]

**H-280.944 Financing of Home and Community-Based Services**
Our American Medical Association supports federal funding for payment rates that promote access and greater utilization of home and community-based services (HCBS).
Our AMA supports policies that help train, retain, and develop an adequate HCBS workforce.

Our AMA supports efforts to simplify state plan amendments and Medicaid waivers to allow additional state flexibility to offer HCBS.
Our AMA supports that Medicaid's Money Follows the Person demonstration program be extended or made permanent.
Our AMA supports cross-agency and federal-state strategies that can help improve coordination among HCBS programs and streamline funding and the provision of services.
Our AMA supports HCBS programs tracking protocols and outcomes to make meaningful comparisons across states and identify best practices.
Our AMA supports that the Centers for Medicare and Medicaid Services and private insurers extend flexibility to implement innovative programs including but not limited to hospital at home programs. [CMS Rep. 4, I-21 Reaffirmed: A-23 Copyright]

**H-290.982 Transforming Medicaid and Long-Term Care and Improving Access to Care for the Uninsured**
Our American Medical Association urges that Medicaid reform not be undertaken in isolation, but rather in conjunction with broader health insurance reform, in order to ensure that the delivery and financing of care results in appropriate access and level of services for low-income patients.
Our AMA encourages physicians to participate in efforts to enroll children in adequately funded Medicaid and State Children's Health Insurance Programs using the mechanism of "presumptive eligibility," whereby a child presumed to be eligible may be enrolled for coverage of the initial physician visit, whether or not the child is subsequently found to be, in fact, eligible.
Our AMA encourages states to ensure that within their Medicaid programs there is a pluralistic approach to health care financing delivery including a choice of primary care case management, partial capitation models, fee-for-service, medical savings accounts, benefit payment schedules and other approaches.
Our AMA calls for states to create mechanisms for traditional Medicaid providers to continue to participate in Medicaid managed care and in State Children's Health Insurance Programs.
Our AMA calls for states to streamline the enrollment process within their Medicaid programs and State Children's Health Insurance Programs by, for example, allowing mail-in applications, developing shorter application forms, coordinating their Medicaid and welfare (TANF) application processes, and placing eligibility workers in locations where potential beneficiaries work, go to school, attend day care, play, pray, and receive medical care.
Our AMA urges states to administer their Medicaid and SCHIP programs through a single state agency.
Our AMA strongly urges states to undertake, and encourages state medical associations, county medical societies, specialty societies, and individual physicians to take part in, educational and outreach activities aimed at Medicaid-eligible and SCHIP-eligible children. Such efforts should be designed to ensure that children do not go without needed and available services for which they are eligible due to administrative barriers or lack of understanding of the programs.
Our AMA supports requiring states to reinvest savings achieved in Medicaid programs into expanding coverage for uninsured individuals, particularly children. Mechanisms for expanding coverage may include additional funding for the SCHIP earmarked to enroll children to higher percentages of the poverty level; Medicaid expansions; providing premium subsidies or a buy-in option for individuals in families with income between their state's Medicaid income eligibility level and a specified percentage of the poverty level; providing some form of refundable, advanceable tax credits inversely related to income; providing vouchers for recipients to use to choose their own health plans; using Medicaid funds to purchase private health insurance coverage; or expansion of Maternal and Child Health Programs. Such expansions must be implemented to coordinate with the Medicaid and SCHIP programs in order to achieve a seamless health care delivery system, and be sufficiently funded to provide incentive for families to obtain adequate insurance coverage for their children.
Our AMA advocates consideration of various funding options for expanding coverage including, but not limited to: increases in sales tax on tobacco products; funds made available through for-profit conversions of health plans and/or facilities; and the application of prospective payment or other cost or utilization management techniques to hospital outpatient services, nursing home services, and home health care services.
Our AMA calls for CMS to develop better measurement, monitoring, and accountability systems and indices within the Medicaid program in order to assess the effectiveness of the program, particularly

under managed care, in meeting the needs of patients. Such standards and measures should be linked to health outcomes and access to care.
Our AMA supports innovative methods of increasing physician participation in the Medicaid program and thereby increasing access, such as plans of deferred compensation for Medicaid providers. Such plans allow individual physicians (with an individual Medicaid number) to tax defer a specified percentage of their Medicaid income.
Our AMA supports increasing public and private investments in home and community-based care, such as adult day care, assisted living facilities, congregate living facilities, social health maintenance organizations, and respite care.
Our AMA supports allowing states to use long-term care eligibility criteria which distinguish between persons who can be served in a home or community-based setting and those who can only be served safely and cost-effectively in a nursing facility. Such criteria should include measures of functional impairment which take into account impairments caused by cognitive and mental disorders and measures of medically related long-term care needs.
Our AMA supports buy-ins for home and community-based care for persons with incomes and assets above Medicaid eligibility limits; and providing grants to states to develop new long-term care infrastructures and to encourage expansion of long-term care financing to middle-income families who need assistance.
Our AMA supports efforts to assess the needs of individuals with intellectual disabilities and, as appropriate, shift them from institutional care in the direction of community living.
Our AMA supports case management and disease management approaches to the coordination of care, in the managed care and the fee-for-service environments.
Our AMA urges CMS to require states to use its simplified four-page combination Medicaid / Children's Health Insurance Program (CHIP) application form for enrollment in these programs, unless states can indicate they have a comparable or simpler form.
Our AMA urges CMS to ensure that Medicaid and CHIP outreach efforts are appropriately sensitive to cultural and language diversities in state or localities with large uninsured ethnic populations.
To prevent a delay in care, our AMA supports favoring the treating physician’s judgment if the reviewing physician is not available. [BOT Rep. 31, I-97 Reaffirmed by CMS Rep. 2, A-98 Reaffirmation A-99 and Reaffirmed: Res. 104, A-99Appended: CMS Rep 2, A-99 Reaffirmation A-00 Appended: CMS Rep. 6, A-01 Reaffirmation A-02 Modified: CMS Rep. 8, A-03 Reaffirmed: CMS Rep. 1, A-05Reaffirmation A-05 Reaffirmation A-07Modified: CMS Rep. 8, A-08 Reaffirmation A-11 Modified: CMS Rep. 3, I-11 Reaffirmed: CMS Rep. 02, A-19 Reaffirmed: CMS Rep. 3, I-21 Reaffirmation: A-22 Reaffirmed: CMS Rep. 3, A-22 Modified: Res. 803, I-23 Appended: Res. 804, I-23]

**H-210.994 Home Health Care**
Our AMA (1) reaffirms its support of home health care as an alternative to hospital, nursing home, or institutional care;
(2) encourages physicians to take a more active role in the provision of home health care;
(3) supports modifications in Medicare regulations for home health care, so that those regulations include appropriate standardized definitions and instructions to fiscal intermediaries;
(4) supports improving patient accessibility to home health services by seeking modifications in the Medicare regulations to provide coverage for the care of homebound patients by qualified individuals working under the supervision of the patient's attending physician; and
(5) supports continued monitoring of the adequacy of the home health care system to meet the accessibility needs of homebound patients. [BOT Rep. EE, A-87 Reaffirmed by Res. 122, A-97 Reaffirmed: Sunset Report, I-97 Reaffirmed by Res. 129, A-98 Reaffirmed: CMS Rep. 4, A-08 Reaffirmed: CMS Rep. 01, A-18]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 823
(I-25)

Introduced by: American College of Rheumatology, Association for Clinical Oncology, American Academy of Dermatology, American Society of Anesthesiologists, American Gastroenterological Association, American College of Physicians, American Association for Geriatric Psychiatry, American Society for Gastrointestinal Endoscopy, American Society of Nuclear Cardiology, Society for Cardiovascular Magnetic Resonance

Subject: Accountability in the Use of Augmented Intelligence for Prior Authorization

Referred to: Reference Committee J

---

Whereas, despite its potential to streamline the healthcare system, the use of AI (artificial intelligence/augmented intelligence) in prior authorization processes can lead to increased denials of necessary care, potentially causing harm and delays in treatment. For example, a 2024 Senate report noted that denial rates for post-acute care can be as much as 16 times higher than overall rates; and

Whereas, there is no standardized framework for using AI in prior authorization processes across the healthcare industry, which leads to inconsistencies in how AI tools are applied and the quality of their outputs; and

Whereas, over 60% of providers are concerned that health plans' use of AI is increasing prior authorization denials; and

Whereas, patients, particularly from vulnerable populations, face barriers to accessing care when AI algorithms deny treatments based on predefined rules that do not account for individual patient needs; and

Whereas, ai-driven prior authorization models lack transparency, thereby burdening providers who need to understand why a particular prior authorization request was denied or approved; and

Whereas, the lack of accountability in AI-driven prior authorization processes makes it difficult to hold payers or AI platform developers accountable for errors and incorrect or unethical decisions; and

Whereas, nearly half of providers believe payers' use of AI in prior authorization processes should be a top focus for regulatory action; and

Whereas, when there is interruption in therapies, there is the risk of formation of drug antibodies or loss of the drug's effectiveness; therefore be it

RESOLVED, that our American Medical Association will amend policy D-480.956, "Use of Augmented Intelligence for Prior Authorization," by addition and deletion to read as follows:

Our American Medical Association will work with stakeholders ~~advocates~~ to advocate for legislative and/or regulatory action for greater regulatory oversight ~~of~~ related to the use of augmented intelligence for review of patient claims and prior authorization requests, including whether insurers and/or contracted third parties are using a thorough and fair process that:

1. is based on accurate and up-to-date clinical criteria derived from national medical specialty societies' evidence-based guidelines and peer-reviewed clinical literature.
2. includes reviews by doctors and other health care professionals who are not incentivized to deny care and with expertise for the service under review.
3. ~~requires such reviews include human examination of patient records prior to a care denial~~
3. provides for transparency and accountability over the use of augmented intelligence for all medical service denials, to include a direct review of patient records by a qualified clinician.
4. requires direct review of the patient record by a qualified clinician of all medications flagged for denial by augmented intelligence platforms that were previously approved by payers.
5. provides robust appeals processes and guardrails to prevent algorithmic discrimination and ensure equitable access to care.

(Modify Current HOD Policy); and be it further

RESOLVED, that our AMA will report on actions taken by the 2026 Annual Meeting of the AMA House of Delegates. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/29/25

**REFERENCES**

1. U.S. Senate Permanent Subcommittee on Investigations 2024.10.17 PSI Majority Staff Report on Medicare Advantage
2. AMA prior authorization (PA) physician survey | AMA
3. AMA Augmented Intelligence Research | AMA

**RELEVANT AMA POLICY**

**Use of Augmented Intelligence for Prior Authorization D-480.956**
Our American Medical Association advocates for greater regulatory oversight of the use of augmented intelligence for review of patient claims and prior authorization requests, including whether insurers are using a thorough and fair process that: 1) is based on accurate and up-to-date clinical criteria derived from national medical specialty society guidelines and peer reviewed clinical literature, 2) includes reviews by doctors and other health care professionals who are not incentivized to deny care and with expertise for the service under review, and 3) requires such reviews include human examination of patient records prior to a care denial.
Policy Timeline
Res. 721, A-23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 824
(I-25)

Introduced by: New Jersey

Subject: Equitable Payment and Increased Access for In-Office Pediatric Lead Screening and Testing

Referred to: Reference Committee J

---

Whereas, early detection of lead exposure through screening and testing at 12 and 24 months and other age-appropriate times is a public health priority to prevent severe neurological and developmental harm for children; and

Whereas, a preventative lead service for children is mandated under the Medicaid Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) guidelines; and

Whereas, due to inadequate payment and lack of reimbursement by insurance plans not accounting for supplies, staff training, resources, and time taken in performing the service, many pediatric practices are forced to discontinue in-office lead services and refer patients to external labs contributing to a significant number of unfulfilled test orders; and

Whereas, barriers such as transportation challenges, time constraints, language barriers, and care coordination issues, especially for children with Medicaid, often prevent families from completing the referrals, leading to unfulfilled scripts and increased public health risks; and

Whereas, physicians are penalized for unfulfilled lab scripts that impact practice performance metrics, despite completing their responsibility by ordering the necessary tests; and

Whereas, equitable payment for in-office lead screening and testing, whether through a capillary blood test or a venous blood test, would promote in-office services and increase screening rates among vulnerable populations; therefore be it

RESOLVED, that our American Medical Association advocate for all public and private payers for equitable payment rates for in-office pediatric lead screening and testing to cover time, supplies, training, and administrative costs, including both point-of-care and other methods (Directive to Take Action); and be it further

RESOLVED, that our AMA support federal and state policies to reduce barriers to improve access to lead screening and testing by incentivizing completion of such services in physician offices (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for increased accountability among insurers to ensure that physicians do not face inappropriate disciplinary action, or decreased financial incentives or other payment, due to lab orders for lead screening that go unfulfilled for reasons outside the physician’s control. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/30/25

**RELEVANT AMA POLICY**

**Reducing Lead Poisoning H-60.924**

1. Our American Medical Association:
    a. supports regulations and policies designed to protect young children from exposure to lead;
    b. urges the Centers for Disease Control and Prevention to give priority to examining the current weight of scientific evidence regarding the range of adverse health effects associated with blood lead concentrations below the current "level of concern" in order to provide appropriate guidance for physicians and public health policy, and encourage the identification of exposure pathways for children who have low blood lead concentrations, as well as effective and innovative strategies to reduce overall childhood lead exposure;
    c. encourages physicians and public health departments to screen children based on current recommendations and guidelines and to report all children with elevated blood levels to the appropriate health department in their state or community in order to fully assess the burden of lead exposure in children. In some cases this will be done by the physician, and in other communities by the laboratories;
    d. promotes community awareness of the hazard of lead-based paints; and
    e. urges paint removal product manufacturers to print precautions about the removal of lead paint to be included with their products where and when sold.
2. Our AMA will call on the United States government to establish national goals to: (a) ensure that no child has a blood lead level >5 µg/dL (>50 ppb) by 2021, and (b) eliminate lead exposures to pregnant people and children, so that by 2030, no child would have a blood lead level >1 µg/dL (10 ppb).
3. Our AMA will call on the United States government in all its agencies to pursue the following strategies to achieve these goals:
    a. adopt health-based standards and action levels for lead that rely on the most up-to-date scientific knowledge to prevent and reduce human exposure to lead, and assure prompt implementation of the strongest available measures to protect pregnant people and children from lead toxicity and neurodevelopmental impairment;
    b. identify and remediate current and potential new sources of lead exposure (in dust, air, soil, water and consumer products) to protect children before they are exposed;
    c. continue targeted screening of children to identify those who already have elevated blood lead levels for case management, as well as educational and other services;
    d. eliminate new sources of lead introduced or released into the environment, which may entail banning or phasing out all remaining uses of lead in products (aviation gas, cosmetics, wheel weights, industrial paints, batteries, lubricants, and other sources), and the export of products containing lead, and setting more protective limits on emissions from battery recyclers and other sources of lead emissions;
    e. provide a dedicated funding stream to enhance the resources available to identify and eliminate sources of lead exposure, and provide educational, social and clinical services to mitigate the harms of lead toxicity, particularly to protect and improve the lives of children in communities that are disproportionately exposed to lead; and
    f. establish an independent expert advisory committee to develop a long-term national strategy, including recommendations for funding and implementation, to achieve the national goal of eliminating lead toxicity in pregnant people and children, defined as blood lead levels above 1 µg/dL (10 ppb).
4. Our AMA supports requiring an environmental assessment of dwellings, residential buildings, or child care facilities following the notification that a child occupant or frequent inhabitant has a confirmed elevated blood lead level, to determine the potential source of lead poisoning, including testing the water supply.
5. Our AMA advocates for accessible testing of domestic water supplies, prioritizing testing for lead in potable water used by pregnant people, newborns and young children, and with the provision of accessible water filters in homes found to have elevated lead levels in potable water.
6. Our AMA supports increased funding for lead pipe replacement and other steps to eliminate lead from public and private drinking water supplies.

7. Our AMA promotes community awareness and education campaigns on the causes and risks of lead in drinking water and steps that can be taken to eliminate these risks.
8. Our AMA supports the development and use of searchable registries of housing units known to have unresolved lead in the drinking water due to lead connectors to water mains or other sources of lead in the drinking water in cities with significant public lead exposure.
9. Our AMA urges healthcare providers to increase screening for lead exposure, particularly in areas known to have lead pipes, and particularly in underserved areas.
10. Our AMA calls for research into innovative and cost-effective methods for elimination of lead in public and private water supplies and lead from lead pipe connectors to such water supplies. CCB/CLRPD Rep. 3, A-14 Appended: Res. 926, I-16 Appended: Res. 412, A-17 Modified: Res. 432, A-24 Modified: Speakers Rep. 02, I-24

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 825
(I-25)

Introduced by: New Jersey

Subject: Ensuring Coverage for In-Office Point-of-Care (POC) Testing in Outpatient Medical Practices

Referred to: Reference Committee J

---

Whereas, timely diagnosis of common respiratory infections such as influenza, COVID-19, and RSV is essential to ensure appropriate treatment, reduce complications, and limit transmission in vulnerable populations; and

Whereas, in-office POC testing allows for immediate clinical decision-making during the visit, improving patient outcomes, reducing emergency room visits, and unnecessary prescriptions or follow-up visits; and

Whereas, payers have intermittent coverage for in-office molecular POC testing, at times requiring that specimen samples be sent to external laboratories leading to delayed diagnoses and reduction of appropriate, high-quality, timely care; and

Whereas, limited payer coverage for in-office molecular POC testing leads to increased urgent care usage where POC testing may be offered, breaking continuity of care of the medical home and increasing cost to the healthcare system; therefore be it

RESOLVED, that our American Medical Association advocate for all public and private payers to provide coverage and adequate payment for basic POC testing, when performed in physician offices and urgent care settings (Directive to Take Action); and be it further

RESOLVED, that the AMA advocates for the recognition of physician offices as the appropriate setting for POC testing to ensure timely and equitable access to diagnostic services for their patients. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/30/25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 826
(I-25)

Introduced by: New Jersey

Subject: Increase National Immunization Rates by Advocating for Equitable Vaccine Payments

Referred to: Reference Committee J

---

Whereas, Whereas, increasing immunization rates nationally is an essential public health need to avoid debilitating and life-threatening diseases for children and adults; and

Whereas, the current payment structure for vaccinations fails to reflect the acquisition cost and of administration of vaccines especially to children including clinical staff time, technical skill, administration effort, medical supplies, medical equipment, storage costs, and malpractice cost; and

Whereas, the periodic increase in the price of the immunization by the manufacturers may not reflect the update in the insurance provider database in a timely manner and continue to reimburse at the lower price; and

Whereas, the American Academy of Pediatrics (AAP) recommends that payment for vaccines be set at no less than 125% of the CDC-published private sector vaccine price to reflect the actual costs of acquisition and administration of the vaccine for the medical practices; and

Whereas, many practices are forced to limit or stop offering vaccinations due to out-of-pocket costs and financial strain, which reduces access and contributes to declining immunization rates, particularly in underserved and rural populations; therefore be it

RESOLVED, that our American Medical Association supports the establishment of national standards for immunization payment rates that ensure physicians are reimbursed at no less than 125% of the CDC private sector vaccine price. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 9/30/25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 827
(I-25)

| | |
|---|---|
| Introduced by: | Association for Clinical Oncology, American College of Rheumatology, American Society for Radiation Oncology, California Medical Association |
| Subject: | Opposition to Prior Authorization in Medicare Fee-for-Service, Burdensome Administrative Requirements |
| Referred to: | Reference Committee J |

---

Whereas, prior authorization (PA) and other utilization management programs are recognized by our American Medical Association (AMA) as among the most burdensome administrative processes in medicine, diverting physician and staff time and resources away from direct patient care; and

Whereas, data from AMA physician surveys demonstrate that on average, practices complete 39 PA requests per physician, per week, requiring spending an average of 12-13 hours per week on related administrative tasks; this administrative burden contributes significantly to physician burnout and practice closures, particularly among independent and smaller practices that lack the resources to manage excessive paperwork; and

Whereas, surveyed physicians report that the PA process often delays necessary care, negatively impacts clinical outcomes, and leads to patients abandoning a recommended course of treatment, resulting in worsening health conditions and increased costs to the health care system; and despite this high administrative burden, a significant number of PA requests are ultimately approved, indicating that the process is an ineffective and inefficient tool for fraud, waste, and abuse prevention; and

Whereas, the Centers for Medicare & Medicaid Services (CMS) has acknowledged the harms of PA and has worked with our AMA to reform the process in Medicare Advantage plans, making the expansion of PA into the Medicare Fee-for-Service (FFS) inconsistent with CMS' goals, and the Wasteful and Inappropriate Service Reduction Model, which would implement a technology-enabled (including augmented intelligence/artificial intelligence) PA and pre-payment review system in Medicare FFS, represents a direct expansion of these harmful policies; and

Whereas, our AMA has long-standing policies in place to reform PA, including a commitment to advocating for alternatives to PA and for legislation that ensures decisions are made by clinically appropriate peer reviewers; therefore be it

RESOLVED, that our American Medical Association opposes the use of prior authorization (PA) and pre-payment review in Medicare Fee-for-Service (FFS), including the proposed Wasteful and Inappropriate Service Reduction (WISeR) Model which would implement a technology-enabled review system (including augmented intelligence/artificial intelligence) (New HOD Policy); and be it further

RESOLVED, that our AMA will advocate against the implementation of the WISeR Model and any similar programs that impose new PA requirements in Medicare FFS, while continuing its efforts to educate Congress, the Centers for Medicare & Medicaid Services, and the public on

the harms of PA to both patients and physicians, leveraging data from its own surveys and the experiences of its members (Directive to Take Action); and be it further

RESOLVED, that our AMA will continue to advocate for a legislative and regulatory framework that streamlines administrative processes, prioritizes patient access to timely care, and replaces burdensome PA with clinically-sound alternatives, such as the adoption of "gold card" programs for high-performing providers and the greater use of evidence-based clinical guidelines. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/30/25

**REFERENCES**

1. CMS Testing Technology-Enabled Prior Authorization and Pre-Payment Review to Reduce Medicare Fraud, Waste, Abuse - ASCO
2. Fixing prior auth: Nearly 40 prior authorizations a week is way too many | AMA
3. 2025 ASCO Position Statement: The Use of Artificial Intelligence in Prior Authorization
4. 2022 ASCO Position Statement: Prior Authorization
5. CMS Launches New Model to Target Wasteful, Inappropriate Services in Original Medicare

## RELEVANT AMA POLICY

**Use of Augmented Intelligence for Prior Authorization D-480.956**
Our American Medical Association advocates for greater regulatory oversight of the use of augmented intelligence for review of patient claims and prior authorization requests, including whether insurers are using a thorough and fair process that:

1. is based on accurate and up-to-date clinical criteria derived from national medical specialty society guidelines and peer reviewed clinical literature.
2. includes reviews by doctors and other health care professionals who are not incentivized to deny care and with expertise for the service under review.
3. requires such reviews include human examination of patient records prior to a care denial.

**Prior Authorization and Utilization Management Reform H-320.939**

1. Our American Medical Association will continue its widespread prior authorization (PA) advocacy and outreach, including promotion and/or adoption of the Prior Authorization and Utilization Management Reform Principles, AMA model legislation, Prior Authorization Physician Survey and other PA research, and the AMA Prior Authorization Toolkit, which is aimed at reducing PA administrative burdens and improving patient access to care.
2. Our AMA will oppose health plan determinations on physician appeals based solely on medical coding and advocate for such decisions to be based on the direct review of a physician of the same medical specialty/subspecialty as the prescribing/ordering physician.
3. Our AMA supports efforts to track and quantify the impact of health plans' prior authorization and utilization management processes on patient access to necessary care and patient clinical outcomes, including the extent to which these processes contribute to patient harm.
4. Our AMA will advocate for health plans to minimize the burden on patients, physicians, and medical centers when updates must be made to previously approved and/or pending prior authorization requests.

**Prior Authorization Reform D-320.982**
Our American Medical Association will explore emerging technologies to automate the prior authorization process for medical services and evaluate their efficiency and scalability, while advocating for reduction in the overall volume of prior authorization requirements to ensure timely access to medically necessary care for patients and reduce practice administrative burdens.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 828
(I-25)

Introduced by: California, Arizona, Hawaii, Idaho, Montana, New Mexico, Washington, Association for Clinical Oncology

Subject: Creating a Public Scorecard on Insurer Delays in Care and Payment Caused by Prior Authorization

Referred to: Reference Committee J

---

Whereas, private and public insurers often impose inappropriate prior authorization that delays medically necessary care to patients and payment delays to physicians; and

Whereas, an AMA survey shows that 93% of physicians report care delays or disruptions associated with prior authorization, 91% say prior authorization has a negative effect on their patients' clinical outcomes, and physician office staff spend the equivalent of two days per week on burdensome prior authorization requests instead of spending time with patients; and

Whereas, an HHS Office of Inspector General (OIG) investigation found that Medicare Advantage plans inappropriately deny necessary care for tens of thousands of patients every year; and

Whereas, these delays are a significant source of frustration for patients and providers, with evidence showing that they contribute to adverse clinical outcomes and disrupt the physician-patient relationship; and

Whereas, publicizing data about delays in care authorization and related claims payment can inform patients and employers about insurer performance and encourage insurers to improve their practices; and

Whereas, the AMA has previously published scorecards regarding insurer payment delays, successfully promoting accountability and improvements in insurer practices; and

Whereas, the Centers for Medicare and Medicaid Services (CMS) recently adopted regulations requiring Medicare Advantage plans to respond to physician requests for prior authorization within certain timeframes and for plans to publicly report on the CMS website the number of services subject to prior authorization, the number of services approved, denied and overturned on appeal, and the timeframes; therefore be it

RESOLVED, that our American Medical Association continue to lead the advocacy effort and assist state medical associations with the implementation of timely, non-aggregated public reporting by private and public plans that engage in prior authorization related to the services subject to prior authorization, the number of services approved, denied and overturned on appeal, and the timeframes for responding to requests for authorization and paying physician claims (Directive to Take Action); and be it further

RESOLVED, that our AMA work with interested organizations in the development and publication of public and private plan scorecards related to prior authorization approvals,

denials, appeals, and the timeframes for responding to requests for authorization and processing physician payments to better inform patients, physicians, and purchasers of insurance. (Directive to Take Action)

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

Received: 9/30/25

**RELEVANT AMA POLICY**

**Prior Authorization Costs, AMA Update to CMS D-320.976**
Our American Medical Association will continue to conduct research on the costs associated with prior authorization by utilizing our AMA and other data sources.
[Res. 720, A-23]

**Mitigating the Impact of Excessive Prior Authorization Processes D-320.971**
1. Our AMA will actively and urgently generate a prior authorization database collecting and analyzing data including metrics reflecting denial rates, care delays, impact on patient care, and associated cost adversely affecting patients and physicians across major healthcare insurers.
2. Our AMA will strengthen and expand the existing public awareness campaign including but not limited to social media, print media, and editorials to highlight the negative impacts of abusive and obstructive prior-authorization requirements on patient care, and educate physicians AND patients on their rights and available resources.
[Res 704, A-25]

**Fair Reimbursement for Administrative Burdens D-320.978**
1. Our AMA will continue its strong state and federal legislative advocacy efforts to promote legislation that streamlines the prior authorization process and reduces the overall volume of prior authorizations for physician practices.
2. Our AMA will continue partnering with patient advocacy groups in prior authorization reform efforts to reduce patient harms, including care delays, treatment abandonment, and negative clinical outcomes.
3. Our AMA will oppose inappropriate payer policies and procedures that deny or delay medically necessary drugs and medical services.

[Res. 701, A-22 Modified: CMS Rep. 04, A-25]

**Insurer Accountability When Prior Authorization Harms Patients D-320-974**
1. Our American Medical Association advocates for increased legal accountability of insurers and other payers when delay or denial of prior authorization leads to patient harm, including but not limited to the prohibition of mandatory pre-dispute arbitration regarding prior authorization determinations and limitation on class action clauses in beneficiary contracts.
2. Our American Medical Association advocates that low-cost noninvasive procedures that meet existing standard Medicare guidelines should not require prior authorization.
3. Our AMA supports that physicians be allowed to bill insurance companies for all full time employee hours required to obtain prior authorization.
4. Our AMA supports that patients be allowed to sue insurance carriers which preclude any and all clauses in signed contracts should there be an adverse outcome as a result of an inordinate delay in care.

[Res. 711, A-24]

**Prior Authorization, Utilization Management Reform H-320.939**

1. Our American Medical Association will continue its widespread prior authorization (PA) advocacy and outreach, including promotion and/or adoption of the Prior Authorization and Utilization Management Reform Principles, AMA model legislation, Prior Authorization Physician Survey and other PA research, and the AMA Prior Authorization Toolkit, which is aimed at reducing PA administrative burdens and improving patient access to care.
2. Our AMA will oppose health plan determinations on physician appeals based solely on medical coding and advocate for such decisions to be based on the direct review of a physician of the same medical specialty/subspecialty as the prescribing/ordering physician.
3. Our AMA supports efforts to track and quantify the impact of health plans' prior authorization and utilization management processes on patient access to necessary care and patient clinical outcomes, including the extent to which these processes contribute to patient harm.
4. Our AMA will advocate for health plans to minimize the burden on patients, physicians, and medical centers when updates must be made to previously approved and/or pending prior authorization requests.

[CMS Rep. 08, A-17 Reaffirmation: I-17 Reaffirmed: Res. 711, A-18 Appended: Res. 812, I-18 Reaffirmed in lieu of: Res. 713, A-19 Reaffirmed: CMS Rep. 05, A-19 Reaffirmed: Res. 811, I-19 Reaffirmed: CMS Rep. 4, A-21 Appended: CMS Rep. 5, A-21 Reaffirmation: A-22]

**Utilization Review, Medically Necessity Determinations, Prior Authorization Decisions D-320.977**

a. Our American Medical Association will advocate for implementation of a federal version of a prior authorization "gold card" law, which aims to curb onerous prior authorization practices by many state-regulated health insurers and health maintenance organizations.

**b.** Our AMA will advocate that health plans should offer physicians at least one physician-driven, clinically-based alternative to prior authorization, including a "gold-card" or "preferred provider program."

[Res. 727, A-22 CEJA Rep. 01, A-23]

**Approaches to Increase Payer Accountability H-320.968**

Our AMA supports the development of legislative initiatives to assure that payers provide their insureds with information enabling them to make informed decisions about choice of plan, and to assure that payers take responsibility when patients are harmed due to the administrative requirements of the plan. Such initiatives should provide for disclosure requirements, the conduct of review, and payer accountability.

1. Disclosure Requirements. Our American Medical Association supports the development of model draft state and federal legislation to require disclosure in a clear and concise standard format by health benefit plans to prospective enrollees of information on:
    a. Coverage provisions, benefits, and exclusions.
    b. Prior authorization or other review requirements, including claims review, which may affect the provision or coverage of services.
    c. Plan financial arrangements or contractual provisions that would limit the services offered, restrict referral or treatment options, or negatively affect the physician's fiduciary responsibility to their patient.
    d. Medical expense ratios.
    e. Cost of health insurance policy premiums. (Ref. Cmt. G, Rec. 2, A-96; Reaffirmation A-97)
2. Conduct of Review. Our AMA supports the development of additional draft state and federal legislation to:
    a. Require private review entities and payers to disclose to physicians on request the screening criteria, weighting elements and computer algorithms utilized in the review process, and how they were developed.
    b. Require that any physician who recommends a denial as to the medical necessity of services on behalf of a review entity be of the same specialty as the practitioner who provided the services under review.
    c. Require every organization that reviews or contracts for review of the medical necessity of services to establish a procedure whereby a physician claimant has an opportunity to appeal a claim denied for lack of medical necessity to a medical consultant or peer

review group which is independent of the organization conducting or contracting for the initial review.

d. Require that any physician who makes judgments or recommendations regarding the necessity or appropriateness of services or site of service be licensed to practice medicine in the same jurisdiction as the practitioner who is proposing the service or whose services are being reviewed.
e. Require that review entities respond within 48 hours to patient or physician requests for prior authorization, and that they have personnel available by telephone the same business day who are qualified to respond to other concerns or questions regarding medical necessity of services, including determinations about the certification of continued length of stay.
f. Require that any payer instituting prior authorization requirements as a condition for plan coverage provide enrollees subject to such requirements with consent forms for release of medical information for utilization review purposes, to be executed by the enrollee at the time services requiring such prior authorization are recommended or proposed by the physician.
g. Require that payers compensate physicians for those efforts involved in complying with utilization review requirements that are more costly, complex and time consuming than the completion of standard health insurance claim forms. Compensation should be provided in situations such as obtaining preadmission certification, second opinions on elective surgery, and certification for extended length of stay.

3. Accountability. Our AMA believes that draft federal and state legislation should also be developed to impose similar liability on health benefit plans for any harm to enrollees resulting from failure to disclose prior to enrollment the information on plan provisions and operation specified under Section 1 (a)-(d) above.

[BOT Rep. M, I-90 Reaffirmed by Res. 716, A-95 Reaffirmed by CMS Rep. 4, A-95 Reaffirmation I-96 Reaffirmed: Rules and Cred. Cmt., I-97 Reaffirmed: CMS Rep. 13 , I-98 Reaffirmation I-98 Reaffirmation A-99 Reaffirmation I-99 Reaffirmation A-00 Reaffirmed in lieu of Res. 839, I-08 Reaffirmation A-09 Reaffirmed: Sub. Res. 728, A-10 Modified: CMS Rep. 4, I-10 Reaffirmation A-11 Reaffirmed in lieu of Res. 108, A-12 Reaffirmed: Res. 709, A-12 Reaffirmed: CMS Rep. 07, A-16 Reaffirmed in lieu of: Res. 242, A-17 Reaffirmed in lieu of: Res. 106, A-17 Reaffirmation: A-17 Reaffirmation: I-17 Reaffirmation: A-18 Reaffirmation: A-19 Reaffirmed: Res. 206, I-20 Reaffirmation: A-22 Modified: Speakers Rep. 02, I-24 Reaffirmed: Res. 226, A-25]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 829
(I-25)

Introduced by: California, Arizona, Hawaii, Idaho, Montana, New Mexico, Washington

Subject: Publicize Insurer Financial Gains from Delayed Care and Payment Caused by Prior Authorization

Referred to: Reference Committee J

---

Whereas, some Medicare Advantage and commercial plans may financially benefit from delays in authorizing care and processing claims by earning interest or withholding funds while patients and physicians wait for care or payment; and

Whereas, these delays can lead to patient harm, including worsened clinical outcomes, prolonged suffering, and unnecessary hospitalizations, while contributing to administrative burdens for physicians; and

Whereas, AMA survey data shows that 93% of physicians report care delays or disruptions associated with prior authorization; and

Whereas, New York Times Opinion interviewed more than 50 doctors and patients and their experiences suggest that "…insurance companies often weaponize prior authorization in order to control doctors and inflate their own profits;" and

Whereas, New York Times Opinion reported that the U.S. spends about $35 billion a year on the administrative costs of prior authorization and these resources could be devoted to patient care; and

Whereas, in 2019 a federal court found that the largest commercial insurer in the U.S. was abrogating the entire point of health insurance by systemically denying medically necessary behavioral health services for financial reasons; and

Whereas, an HHS Office of Inspector General (OIG) investigation of Medicare Advantage plans reports "widespread and persistent problems related to denials of care and payment."

Whereas, as the evidence continues to grow that some Medicare Advantage (MA) and commercial insurers routinely delay and deny care through excessive and inappropriate use of prior authorization, a recent survey revealed that enrollees in MA plans are more likely than Traditional Medicare enrollees to report delays in receiving care due to prior authorization practices; and

Whereas, a recent report by the Medicare Payment Advisory Commission (MedPAC) uncovered that Medicare Advantage is projected to cost taxpayers $88 billion more in 2024 than the government spent on Traditional Medicare; and

Whereas, increased transparency about the financial gains of delayed care authorization and claims processing can empower patients, physicians, employers, and policymakers to demand accountability and reform; therefore be it

RESOLVED, that our American Medical Association support efforts to investigate and publicize the financial benefit and profit to commercial insurers, and Medicare and Medicaid health plans that inappropriately use prior authorization to unnecessarily delay care for patients and payments to physicians. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 9/30/25

**RELEVANT AMA POLICY**

**Prior Authorization Costs, AMA Update to CMS D-320.976**
Our American Medical Association will continue to conduct research on the costs associated with prior authorization by utilizing our AMA and other data sources.
[Res. 720, A-23]

**Mitigating the Impact of Excessive Prior Authorization Processes D-320.971**

1. Our AMA will actively and urgently generate a prior authorization database collecting and analyzing data including metrics reflecting denial rates, care delays, impact on patient care, and associated cost adversely affecting patients and physicians across major healthcare insurers.
2. Our AMA will strengthen and expand the existing public awareness campaign including but not limited to social media, print media, and editorials to highlight the negative impacts of abusive and obstructive prior-authorization requirements on patient care, and educate physicians AND patients on their rights and available resources.
[Res 704, A-25]

**Fair Reimbursement for Administrative Burdens D-320.978**
1. Our AMA will continue its strong state and federal legislative advocacy efforts to promote legislation that streamlines the prior authorization process and reduces the overall volume of prior authorizations for physician practices.
2. Our AMA will continue partnering with patient advocacy groups in prior authorization reform efforts to reduce patient harms, including care delays, treatment abandonment, and negative clinical outcomes.
3. Our AMA will oppose inappropriate payer policies and procedures that deny or delay medically necessary drugs and medical services.

[Res. 701, A-22 Modified: CMS Rep. 04, A-25]

**Insurer Accountability When Prior Authorization Harms Patients D-320-974**
1. Our American Medical Association advocates for increased legal accountability of insurers and other payers when delay or denial of prior authorization leads to patient harm, including but not limited to the prohibition of mandatory pre-dispute arbitration regarding prior authorization determinations and limitation on class action clauses in beneficiary contracts.
2. Our American Medical Association advocates that low-cost noninvasive procedures that meet existing standard Medicare guidelines should not require prior authorization.
3. Our AMA supports that physicians be allowed to bill insurance companies for all full time employee hours required to obtain prior authorization.
4. Our AMA supports that patients be allowed to sue insurance carriers which preclude any and all clauses in signed contracts should there be an adverse outcome as a result of an inordinate delay in care. [Res. 711, A-24]

**Prior Authorization, Utilization Management Reform H-320.939**
1. Our American Medical Association will continue its widespread prior authorization (PA) advocacy and outreach, including promotion and/or adoption of the Prior Authorization and Utilization Management Reform Principles, AMA model legislation, Prior Authorization Physician Survey and

other PA research, and the AMA Prior Authorization Toolkit, which is aimed at reducing PA administrative burdens and improving patient access to care.
2. Our AMA will oppose health plan determinations on physician appeals based solely on medical coding and advocate for such decisions to be based on the direct review of a physician of the same medical specialty/subspecialty as the prescribing/ordering physician.
3. Our AMA supports efforts to track and quantify the impact of health plans' prior authorization and utilization management processes on patient access to necessary care and patient clinical outcomes, including the extent to which these processes contribute to patient harm.
4. Our AMA will advocate for health plans to minimize the burden on patients, physicians, and medical centers when updates must be made to previously approved and/or pending prior authorization requests.

[CMS Rep. 08, A-17 Reaffirmation: I-17 Reaffirmed: Res. 711, A-18 Appended: Res. 812, I-18 Reaffirmed in lieu of: Res. 713, A-19 Reaffirmed: CMS Rep. 05, A-19 Reaffirmed: Res. 811, I-19 Reaffirmed: CMS Rep. 4, A-21 Appended: CMS Rep. 5, A-21 Reaffirmation: A-22]

**Utilization Review, Medically Necessity Determinations, Prior Authorization Decisions D-320.977**

a. Our American Medical Association will advocate for implementation of a federal version of a prior authorization "gold card" law, which aims to curb onerous prior authorization practices by many state-regulated health insurers and health maintenance organizations.
**b.** Our AMA will advocate that health plans should offer physicians at least one physician-driven, clinically-based alternative to prior authorization, including a "gold-card" or "preferred provider program."

[Res. 727, A-22 CEJA Rep. 01, A-23]

**Approaches to Increase Payer Accountability H-320.968**

Our AMA supports the development of legislative initiatives to assure that payers provide their insureds with information enabling them to make informed decisions about choice of plan, and to assure that payers take responsibility when patients are harmed due to the administrative requirements of the plan. Such initiatives should provide for disclosure requirements, the conduct of review, and payer accountability.

1. Disclosure Requirements. Our American Medical Association supports the development of model draft state and federal legislation to require disclosure in a clear and concise standard format by health benefit plans to prospective enrollees of information on:
    a. Coverage provisions, benefits, and exclusions.
    b. Prior authorization or other review requirements, including claims review, which may affect the provision or coverage of services.
    c. Plan financial arrangements or contractual provisions that would limit the services offered, restrict referral or treatment options, or negatively affect the physician's fiduciary responsibility to their patient.
    d. Medical expense ratios.
    e. Cost of health insurance policy premiums. (Ref. Cmt. G, Rec. 2, A-96; Reaffirmation A-97)
2. Conduct of Review. Our AMA supports the development of additional draft state and federal legislation to:
    a. Require private review entities and payers to disclose to physicians on request the screening criteria, weighting elements and computer algorithms utilized in the review process, and how they were developed.
    b. Require that any physician who recommends a denial as to the medical necessity of services on behalf of a review entity be of the same specialty as the practitioner who provided the services under review.
    c. Require every organization that reviews or contracts for review of the medical necessity of services to establish a procedure whereby a physician claimant has an opportunity to appeal a claim denied for lack of medical necessity to a medical consultant or peer review group which is independent of the organization conducting or contracting for the initial review.
    d. Require that any physician who makes judgments or recommendations regarding the necessity or appropriateness of services or site of service be licensed to practice

medicine in the same jurisdiction as the practitioner who is proposing the service or whose services are being reviewed.

e. Require that review entities respond within 48 hours to patient or physician requests for prior authorization, and that they have personnel available by telephone the same business day who are qualified to respond to other concerns or questions regarding medical necessity of services, including determinations about the certification of continued length of stay.

f. Require that any payer instituting prior authorization requirements as a condition for plan coverage provide enrollees subject to such requirements with consent forms for release of medical information for utilization review purposes, to be executed by the enrollee at the time services requiring such prior authorization are recommended or proposed by the physician.

g. Require that payers compensate physicians for those efforts involved in complying with utilization review requirements that are more costly, complex and time consuming than the completion of standard health insurance claim forms. Compensation should be provided in situations such as obtaining preadmission certification, second opinions on elective surgery, and certification for extended length of stay.

3. Accountability. Our AMA believes that draft federal and state legislation should also be developed to impose similar liability on health benefit plans for any harm to enrollees resulting from failure to disclose prior to enrollment the information on plan provisions and operation specified under Section 1 (a)-(d) above.

[BOT Rep. M, I-90 Reaffirmed by Res. 716, A-95 Reaffirmed by CMS Rep. 4, A-95 Reaffirmation I-96 Reaffirmed: Rules and Cred. Cmt., I-97 Reaffirmed: CMS Rep. 13 , I-98 Reaffirmation I-98 Reaffirmation A-99 Reaffirmation I-99 Reaffirmation A-00 Reaffirmed in lieu of Res. 839, I-08 Reaffirmation A-09 Reaffirmed: Sub. Res. 728, A-10 Modified: CMS Rep. 4, I-10 Reaffirmation A-11 Reaffirmed in lieu of Res. 108, A-12 Reaffirmed: Res. 709, A-12 Reaffirmed: CMS Rep. 07, A-16 Reaffirmed in lieu of: Res. 242, A-17 Reaffirmed in lieu of: Res. 106, A-17 Reaffirmation: A-17 Reaffirmation: I-17 Reaffirmation: A-18 Reaffirmation: A-19 Reaffirmed: Res. 206, I-20 Reaffirmation: A-22 Modified: Speakers Rep. 02, I-24 Reaffirmed: Res. 226, A-25]

**Reference Committee K**

**Report(s) of the Council on Science and Public Health**

02 Regulation of Ionizing Radiation Exposure for Health Care Professionals
03 Plastic Pollution Reduction

**Resolutions**

901 Distinction Between Healthful and Unhealthful "Ultraprocessed" Foods
903 Nitrous Oxide Inhalant Abuse
904 Supporting Certification of the Public Health Workforce
905 Standardizing Brain Death Policies
906 Rethink the Medicare Annual Wellness Visit
907 In-Office Dispensing of Generic Medications
908 Support of Access to Insulin-Detemir
909 Clinical Significance of Sleepiness
911 Safeguarding NIH-Funded and Other Women's Health Research in Peer-Reviewed Publishing
912 Increasing Access through Federated Healthcare Data Architecture
917 Urging Comprehensive Research and Safety Testing of Industry-Engineered Food Additives (IEFAs), Including High Fructose Corn Syrup
918 Remove Outdated Barriers to Genetic Testing
919 Strengthening Trust through AMA-Based Leadership for Evidence-Based Vaccines (STABLE Vaccines)
920 Alcohol and Aging: Educating Physicians and Advocating for Safer Warnings
921 Prioritizing Deprescribing in Seniors
922 Addressing Health Impacts of Indian Boarding Schools
923 Enhancing Disaster Preparedness Mechanisms for People with Disabilities
924 Preserving Access to Gamete Donation and Gestational Carriers and Protecting Parental Rights
925 Evidence-Based Vaccine and Preventive Services Recommendations
926 Establishment of Federal and State Offices of Men's Health
927 Battlefield Acupuncture – An Educational Call to Arms
929 Protecting Access to Evidence-based Psychotropic Medication for the Treatment of Pediatric Mental Illness
930 Establishing Fire Risk Standards for Civilian and Non-Industrial Clothing
931 Preserving Evidence-Based, Equitable Grooming Standards in Military Service
932 Shared Decision-Making and Low Dose CT Lung Cancer Screening in Clinical Practice
933 Addressing Gaps in National Healthcare Safety Network (NHSN) Data Quality

REPORT 2 OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (I-25)
Regulation of Ionizing Radiation Exposure for Health Care Professionals
(Reference Committee K)

## EXECUTIVE SUMMARY

BACKGROUND AMA Policy H-455.975, "Regulation of Ionizing Radiation Exposure for Health Care Workers," was adopted at the 2024 House of Delegates (HOD) Interim Meeting and calls for our AMA to study how best to accomplish comprehensive protection from ionizing radiation for employees, taking into account variation in body types, pregnancy status, specifics of procedures being performed, as well as how exposure can be limited beyond PPE.

Resolution 505-A-25, "Mandating Properly Fitting Lead Aprons in Hospitals," was referred. That resolution asked that our American Medical Association collaborate with relevant stakeholders to ensure: (1) adequate stocking of diverse lead apron sizes for all radiation-exposed personnel and medical trainees, and (2) consistent implementation of evidence-based radiation safety principles to keep exposure as low as reasonably achievable in accordance with specialty society guidelines, in order to promote optimal protection practices.

METHODS. English language reports were selected from searches of the PubMed and Google Scholar databases using the search terms: "occupational exposure" and "ionizing radiation"; "health care" and "ionizing radiation"; "radiation safety" and "health care". Additional articles were identified by manual review of the reference lists of pertinent publications. Web sites managed by federal agencies and applicable professional organizations were also reviewed for relevant information.

DISCUSSION. Ionizing radiation can cause chemical changes in cells and damage DNA, thereby increasing the risk of developing certain health conditions. In health care settings, ionizing radiation can come from nuclear medicine and medical imaging equipment, such as x-ray, CT scan, fluoroscopy or PET scan machines. With the use of diagnostic imaging and radiation therapy in health care growing rapidly, there are concerns regarding the potentially increasing rate of occupational exposure to ionizing radiation for health care professionals. The health effects of high-dose and single-exposure radiation are generally understood, but the consequences of exposure to long term low-dose radiation are not as well-delineated. Data suggests that health care professionals exposed to ionizing radiation may experience an increased risk of cancer, cardiovascular disease, reproductive health effects, and the development of cataracts. However, the use of protective measures significantly reduces these risks. The regulatory landscape is complicated and there is a patchwork of entities overseeing different facets of nuclear material regulation in the United States. In many cases it is the states, radiation safety officers, and health care institutions that determine what implementation and operationalization of those regulations looks like resulting in variation across jurisdictions and facilities.

CONCLUSION. Despite the limited evidence on negative health effects associated with low-dose and very-low dose occupational radiation exposure in health care facilities, the precautionary principle as well as international guidance, federal and state regulation, and non-governmental and specialty society guidance supports continued use of personal protective equipment (PPE) that appropriately fits and covers all body types, genders, and pregnancy statuses as well as continued education and training on ways to reduce exposure. At the same time, continued research into the health effects of low level and very-low level ionizing radiation, the effectiveness of PPE and engineering controls designed to reduce exposure, and ways to improve PPE use fidelity are needed.

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 2-I-25

Subject: Regulation of Ionizing Radiation Exposure for Health Care Professionals

Presented by: Padmini Ranasinghe, MD, MPH, Chair

Referred to: Reference Committee K

---

AMA Policy H-455.975, "Regulation of Ionizing Radiation Exposure for Health Care Workers," was adopted at the 2024 Interim Meeting of the AMA House of Delegates (HOD). The policy asks the following:

1. Our American Medical Association encourages public and private healthcare institutions to ensure comprehensive coverage of different body types by providing readily available PPE that reduces exposure to as low as reasonably achievable for employees of all genders and pregnancy statuses.
2. Our AMA will work with the appropriate and interested parties to study how best to accomplish comprehensive protection from ionizing radiation for employees, taking into account variation in body types, pregnancy status, specifics of procedures being performed, as well as how exposure can be limited beyond PPE (personal protected equipment), with report back at I-25.

Furthermore, resolution 505-A-25, "Mandating Properly Fitting Lead Aprons in Hospitals," was referred. That resolution asked that our American Medical Association collaborate with relevant stakeholders to ensure:

1. Adequate stocking of diverse lead apron sizes for all radiation-exposed personnel and medical trainees, and
2. Consistent implementation of evidence-based radiation safety principles to keep exposure as low as reasonably achievable in accordance with specialty society guidelines, in order to promote optimal protection practices.

Given that both resolutions relate to the same topic, they will be addressed together in this report.

## METHODS

English language reports were selected from searches of the PubMed and Google Scholar databases using the search terms: "occupational exposure" and "ionizing radiation"; "health care" and "ionizing radiation"; "radiation safety" and "health care". Additional articles were identified by manual review of the reference lists of pertinent publications. Websites managed by federal agencies and applicable professional organizations were also reviewed for relevant information.

## DISCUSSION

Ionizing radiation is high-energy radiation that has enough energy to remove an electron (negative particle) from an atom or molecule. It can cause chemical changes in cells and damage DNA, thereby increasing the risk of developing certain health conditions. In health care settings, ionizing radiation can come from nuclear medicine and medical imaging equipment, such as x-ray,

© 2025 American Medical Association. All rights reserved.

fluoroscopy, CT scan, or PET scan machines. Diagnostic imaging in health care has been growing rapidly in the U.S. and around the world. Approximately 93 million CT scans are done on 62 million patients in the U.S. annually.[1] When considering X-rays, mammograms, PET scans, and fluoroscopic procedures, patients' exposures to medical radiation is not insignificant. At the current rate of CT scans usage, five percent of future cancers will be due to this imaging modality alone.[1] Most research and recommendations on radiation safety in health care focus on patients, aiming to minimize their exposure by reducing both the amount of radiation per test and the total number of tests they undergo over their lifetime.[2,3] The goal of the As Low As Reasonably Achievable (ALARA) radiation exposure principle includes the three basic strategies of decreasing time, increasing distance and using shielding to reduce radiation exposure. Multiple government agencies have education for both patients and physicians, focused on making sure imaging is necessary and uses the lowest dose of radiation possible.[4–6]

The growing use of imaging and interventional procedures that depend on ionizing radiation has raised concerns about the potential rise in occupational exposure to ionizing radiation among health care professionals. Radiology, cardiology, pulmonology, critical care, radiation oncology, thoracic surgery, orthopaedic surgery and anesthesiology are specialties that use fluoroscopy or other radiation-creating equipment regularly, thereby exposing health care professionals and staff in those specialties to radiation regularly. A study that assessed the occupational radiation exposure of doctors over a 25-year period at a National Health Services teaching hospital found that the occupational radiation exposure of radiologists and cardiologists, as measured by body and collar dosimeters, has decreased over the 25-year period.[7] There was a decrease in ionizing radiation exposure to the eye in the cardiologists' cohort, but an increase in ionizing radiation exposure to the eye in the radiologists' cohort.[7] Definitive trends in the surgeon/anesthesiologists' group were more difficult to establish, but there was a significant decrease in exposure demonstrated by body and hand dosimeter measurements, but an increase in eye exposure.[7]

Radiation suites are not the only areas where diagnostic imaging occurs in health care settings. For example, in emergency departments (EDs) portable X-rays are frequently done. A recent study found the radiation levels in a level 1 trauma ED to be well-below the limit and thus noted that specific safety interventions were unwarranted.[8] Furthermore, intraoperative imaging is playing a larger role with the rise of minimally invasive surgeries such as spinal procedures. Because direct visibility is not possible in these surgeries, spine surgeons rely on intraoperative imaging to confirm proper placement of medical devices.[9] With the use of ionizing radiation spanning multiple specialties outside of radiology, finding unifying guidance is difficult.

*Measuring Radiation Exposure*

Measuring radiation released from a machine is quite easy; measuring radiation absorbed into an organ is much more difficult.[10] Measuring radiation dose in an organ is not practical, so calculations are done to determine the dose estimate, which is the product of the radiation measurement from the machine and various factors to account for different organs. Placing one dosimeter inside and another outside a lead apron provides an assessment of exposure. The exposure of the outside dosimeter is a surrogate for exposure to those unprotected areas (i.e., the head and hands) and the one inside represents exposure to protected areas (i.e., heart, thyroid, genitals).

The International Commission on Radiological Protection has dose limits on occupational exposure: 20mSv/yr averaged over a 5-year defined period with no single year exceeding 50 mSv.[11] A 2010 Korean study found that the average yearly radiation dose under the apron for interventional pain specialists was 1.08 mSv and 20.32 mSv over the collar.[12] A British study looking at 25-years of radiation exposure found the yearly dose to be <1 mSV on body dosimeters

and 3.17-5.12 mSv on dosimeters in unprotected areas (e.g., hands).[7] It is clear that personal protective equipment (PPE) works when it is consistently used correctly. When environmental safety factors are employed (e.g., C-arm positioning) along with the ALARA principle, a physician's radiation exposure can stay within the allowable limits.

## HEALTH EFFECTS

The ill effects of high-dose radiation are generally understood, but the consequences of long-term exposure to low-dose radiation are not as well-delineated. While data suggests that health care professionals exposed to ionizing radiation may experience an increased risk of cancer, cardiovascular disease, reproductive health effects, and the development of cataracts, the use of protective measures significantly reduces these risks.

### *Cancer*

Although there is substantial evidence that exposure to ionizing radiation at moderate to high levels is associated with cancer, there is only limited information regarding risks at lower radiation doses. A review article examining 16 epidemiological studies published between 1975 and 2019, which looked at cancer risks in medical professionals exposed to ionizing radiation, found that medical personnel exposed to radiation before 1950, or those involved in fluoroscopically guided interventional procedures or radionuclide treatments, have higher cancer risks.[13] However, the strength of the evidence is moderate due to methodological limitations.

### *Cardiovascular Disease*

A recent systematic review and meta-analysis examining 93 studies found that exposure to low doses of ionizing radiation is linked to an increased risk of cardiovascular disease (CVD) in a dose-dependent manner.[14] However, more research is needed to determine the exact relationship between low-dose ionizing radiation exposure and CVD risk and to identify the underlying biological mechanisms. A 2024 meta-analysis of 27 articles also looked at low-dose radiation and cardiovascular effects.[15] Only one of the 27 studies included looked at physicians, but it found that compared to control individuals, physicians exposed to radiation had higher rates of capillary changes which may indicate early vascular damage.[15]

### *Radiation-induced cataracts*

The lens of the eye is among the most radiosensitive tissues and radiation-induced cataracts have long been recognized. However, consensus is lacking on the radiation exposure threshold responsible for cataract formation.[9] A systematic review and meta-analysis assessing the risk of developing a radiation-induced cataract in interventional cardiologists (ICs) found that posterior lens opacity was significantly higher in interventional cardiologists relative to the control group, suggesting that ICs are at high risk of developing radiation-induced cataracts.[16] Similarly, a systematic review found increased risk of occupational cataract in health care professionals operating medical imaging.[17] The study also found a dose-response relationship between ionizing radiation exposure and the prevalence of opacities.[17] An epidemiological study examining the risk of radiation-induced cataracts in ICs compared 106 exposed cardiologists to 99 unexposed non-medical workers and found a significantly higher rate of cataracts among the cardiologists, with 18 percent showing posterior subcapsular lens opacities, compared to only five percent in the control group.[18]

*Reproductive Health*

The reproductive system is especially vulnerable to ionizing radiation. Spermatogenic cells are particularly sensitive to radiation, and exposure can lead to varying degrees of infertility, depending on the dose received. Ionizing radiation also poses significant risks to female reproductive health due to the high radiosensitivity of ovarian follicles and the hormonal networks that regulate fertility.[19] Prenatal radiation exposure significantly increases the risk of miscarriage, stillbirths, and congenital anomalies.[20] There is some evidence that radiation safety concerns disproportionately deter women from pursuing specialties like interventional cardiology.[21,22] Sixty cardiologists who were pregnant as trainees reported higher rates of obstetrical complications compared to those reported among women in the general population:15 percent experienced miscarriage, eight percent low birth weight, three percent pre-term delivery, and seven percent other complications like pre-eclampsia, eclampsia and emergent C-section.[23] However, it is unclear what aspects of the training (e.g., radiation exposure, physical demands) are responsible for this increase as a 2013 study among medical and surgical residents found similar complication rates.[24] Interestingly, in the 2024 survey of cardiology trainees, most reported access to well-fitted lead, radiation shields, and dosimeters; however, they lacked access to dosimetry data.[23]

## REDUCING OCCUPATIONAL RADIATION EXPOSURE

Ways to reduce occupational exposure include time, distance and shielding. Shielding involves PPE, traditionally lead aprons, but there are other environmental methods like shields within the room. In looking at wearable PPE, a survey in Ireland revealed that most centers (72 percent) had only medium and large sized lead aprons, making arm-hole gaps and radiation of sensitive tissues a concern in those facilities.[25] Besides fit, there is concern for the weight of traditional lead aprons and how that weight can cause musculoskeletal problems in physicians over time, with several studies finding that operators in cardiac catheterization labs suffer from spinal problems.[26–29] Wearing lead aprons throughout a surgery that may take several hours or more is physically demanding and may cause some to question the benefit-risk ratio of PPE.[9] There has been interest in finding lighter-weight options that are just as effective. In one study, spine surgeons evaluated three types of non-lead materials and found the most effective one was only 30-40 percent of the weight of lead.[30] Another study found that non-lead aprons in general seemed to perform as well and were noted to be lighter.[31]

Some PPE, while considered effective, are often not used or used correctly, such as radiation glasses. For instance, one study found that PPE use was inconsistent and not always available (e.g., lead glasses were consistently used 10.2 percent and never used 61.1 percent of the time).[32] The same study found all forms of PPE were inconsistently used by 92.6 percent of participants and women were 4.3 times more likely to report that PPE was not available. Importantly, it has been suggested that PPE compliance was related to fit and availability.[33] Likewise, a study of orthopedic trainees found that reported barriers to PPE usage included lack of availability and perceived impracticality.[34] Finally, there is some evidence that inventorying and ensuring the availability of safety equipment, hands-on instruction to complement traditional didactics, lowering default frame rates, and converting to real-time dosimetry may reduce radiation exposure among vascular surgery trainees.[35]

*Educational gaps and professional society guidance*

With the exception of trainees in radiologic fields, the Accreditation Council for Graduate Medical Education (ACGME) is relatively silent on educating trainees on radiation safety. For Diagnostic

Radiology training programs, there is an ACGME directive on education for radionucleotide handling, but no specific requirements for radiation exposure safety. Other Radiology-based training programs have education on radiation safety listed, but other affected specialties, like cardiology, do not have it listed as a specific milestone requirement.[36] Training programs are left to develop their own guidance, leading to inconsistent education among trainees.[37]

Multiple national medical specialty societies have developed guidance for physicians and other health care professionals impacted by ionizing radiation (Appendix I). Medical physicists and radiation safety officers (RSOs) play a role in the development and maintenance of radiology suites. The American College of Radiology has created a manual for RSOs which addresses occupational exposure to ionizing radiation. RSOs play a key role in making sure policies are developed and implemented. The American College of Radiology-American Association of Physicists in Medicine's joint 2021 guidelines state that RSOs should have the "knowledge and responsibility to apply appropriate radiation protection regulations and has been assigned such responsibility by the licensee or registrant."[38]

## IONIZING RADIATION REGULATORY LANDSCAPE

The regulatory framework around ionizing radiation protection, use, disposal, safety, and monitoring is a patchwork of international guidance, federal, state, and local regulation and standards, as well as non-governmental and specialty society guidance.

### *International Standards*

The International Atomic Energy Agency (IAEA) provides high level guidance on radiation safety regulations and standards.[39] In 2006, the IAEA published the IAEA Safety Standards Series No. SF-1, which sets out the fundamental principles of protection and safety with an emphasis on the protection of human health and the environment from the hazardous effects of ionizing radiation.[40] These principles are further reinforced through the International Basic Safety Standards (BSS), which regulate radiation dose limits, protection procedures, and monitoring mechanisms across multiple sectors, including health care.[41] Similarly, the World Health Organization (WHO), the Joint Commission, and the International Commission on Radiological Protection (ICRP) provide guidelines on radiation safety in medical practice.[42–45] The WHO establishes maximum allowable radiation doses for both patients and medical personnel to mitigate harmful side effects. The WHO also leads the Global Initiative on Radiation Safety in Health Care Settings to mobilize the health sector towards safe and effective use of radiation in medicine, which provides a platform for collaboration between health authorities, radiation protection regulators, international agencies, professional societies, patient networks, and scientific bodies.[46] The ICRP provides safety guidance for medical applications, including dose monitoring and strategies for reducing radiation exposure.[44] The Joint Commission outlines radiation risks of diagnostic imaging and fluoroscopy and includes standards around radiation safety for healthcare organizations to meet accreditation requirements.[45]

### *Federal Legislation and Administrative Landscape*

There is copious federal legislation that outlines how multiple agencies, departments, councils, institutes, and commissions are responsible for setting requirements for use, storage, disposal, monitoring, auditing, and incident reporting of nuclear materials. (Appendix II). The result is a patchwork of entities overseeing different facets of nuclear material regulation in the United States. Although the federal regulatory landscape is complicated, the agencies most closely connected to radiation safety in health care settings and their respective roles are listed below:

- Nuclear Regulatory Commission (NRC) regulates civilian use of radioactive materials through licensing, setting dose and exposure limits, implementing monitoring, labeling, and notice requirements, and issuing penalties for noncompliance.[47]
- Environmental Protection Agency (EPA) sets generally applicable standards on the radioactivity in soil, water and air and provides federal guidance on recommendations for radiation protection including standardized dose limits, methods for dose and risk assessment.[48]
- Food and Drug Administration (FDA) regulates the manufacture, safety, and maintenance of medical devices that make or use radiation, electronic devices that emit radiation, and radiopharmaceuticals.[6,49,50]
- Occupational Safety and Health Administration (OSHA) sets standards for radiation protection in the workplace including exposure limits, exposure monitoring requirements, notification about radioactive hazards, and recordkeeping about radioactive hazards and exposures.[51]
- Department of Energy (DOE) oversees the treatment and disposal of much of the country's radioactive waste and is responsible for siting, building, and operating a geologic repository to dispose of nuclear waste.[52,53]
- National Institutes for Occupational Health and Safety (NIOSH) conducts epidemiological studies of the health effects of occupational exposure to ionizing radiation and evaluates exposures to ionizing radiation and reconstructs occupational radiation dose for certain workers with cancer who file claims under the Energy Employees Occupational Illness Compensation Program Act.[54,55]
- The National Council on Radiation Protection & Measurements (NCRP) formulates and disseminates information, guidance and recommendations on radiation protection and measurements.[56]

More detailed information about key legislation, statutory authority, published guidance reports, and agency, department, council, institute, and commission roles can be found in Appendices III, IV, V, and VI.

*Interagency collaboration*

There is a significant overlap in the radiation safety and protection work done by the agencies outlined above, which necessitates extensive agency collaboration. The Interagency Steering Committee on Radiation Standards (ISCORS) is comprised of eight Federal agencies, three Federal observer agencies and two state observer agencies. ISCORS facilitates consensus on acceptable levels of radiation risk to the public and workers and promotes consistent risk approaches in setting and implementing standards for protection from ionizing radiation.[57]

Despite collaborative efforts like ISCORS, interagency discrepancies still arise. For instance, OSHA's Ionizing Radiation standard (29 CFR part 1910) has not been revised from its original version, whereas the DOE (10 CFR part 835) and the NRC (10 CFR part 20) both have updated standards based on more recent radiation protection guidance from the ICRP (Publications 60, 26 and 30).[58–63] Consequently, many states, DOE, and NRC have cumulative annual dose limits, whereas OSHA uses quarterly dose limits. Specifically, each worker who is expected to receive more than 10 percent of the applicable annual dose limit (NRC) or more than 25 percent of the quarterly dose limit (OSHA) is required to wear one or more dosimeters. In response, OSHA issued a letter of interpretation explaining if an employer complied with the more current regulation at 10 CFR part 20 that it would be considered a de minimis condition because that standard is as or more

protective than the OSHA standard. Additionally, OSHA's dose limits are not different for pregnant workers compared to other workers. However, NCRP, ICRP, and the Conference of Radiation Control Program Directors (CRCPD) have each recommended lower doses for the fetus of workers exposed to radiation.[58,64]

Memorandums of Understanding (MOUs) are another mechanism of collaboration to facilitate efficient and effective radiation safety and protection between agencies. (Appendix VII). For instance, NRC and OSHA both have authority over occupational safety and health at NRC-licensed facilities; however, identifying boundaries between the nuclear and radiological safety that NRC regulates and industrial safety and health that OSHA regulates can be complicated.[65] The NRC is responsible for radiation and chemical hazards produced by radioactive materials and facility conditions that affect the safety of radioactive materials. However, NRC licensees are required to comply with OSHA's standards and regulations for all other conditions and OSHA has authority to regulate employee exposures from all radiation sources not regulated by the NRC (e.g., X-ray equipment, linear accelerators, accelerator-produced radioactive materials, electron microscopes, ion implanters, and naturally occurring radioactive materials).[65] Collectively the NRC and OSHA regulations establish: dose limits for staff; requirements for the wearing of dosimeters; requirements for the posting of warning signs; requirements for periodic employee training and hazard communication; requirements for comprehensive record keeping for exposure monitoring results; periodic facility radiation safety assessments and preventive interventions; and requirements for timely reporting of results of exposure monitoring and exposure incidents to individual employees, including exposures to staff that exceed regulatory limits.[59,60,65]

The federal regulatory landscape provides high-level standards (e.g., licensure requirements, exposure limits, use of PPE and dosimeters, and regular survey and recordkeeping) as well as nonbinding guidance on how to implement those standards. (Appendix III). However, in many cases it is the states, RSOs, and health care institutions that determine what implementation and operationalization of those regulations looks like.

*State Legislative Efforts*

States also play a significant role in the regulation of occupational exposure to ionizing radiation. Most states have a radiation control agency and/or radiation protection program, responsible for regulating radiation-producing machines (e.g., x-rays and linear accelerators)[51] In NRC agreement states, these agencies also regulate radioactive materials [51] Some states also regulate occupational exposure to ionizing radiation in part through licensing and certification of medical imaging and radiation therapy professionals. In addition, there are instances where Agreement States or those with State Plans, each as described below, take on the regulatory responsibilities of agencies like the NRC and OSHA within their state boundaries.[66,67] More information about state specific regulations, licensing, state radiation programs, and implementation is in Appendix VII.

NRC Agreement States have entered into an effective regulatory discontinuance agreement with the NRC, which allows them to regulate occupational exposure to radioactive materials within their borders. Agreement States exercise licensing, regulatory, and enforcement actions under direction of the governors in a manner that is compatible with the licensing and enforcement programs of the NRC. There are 39 NRC Agreement States, which administer about 75 percent of the more than 20,000 active source, byproduct, and special nuclear materials licenses in place in the United States.[68] The NRC periodically reviews the performance of each Agreement State to assure compatibility with NRC's regulatory standards. Other collaborative efforts between the NRC and Agreement States include: (1) National Materials Program (NMP), which is the collective framework of the NRC and Agreement States; (2) the Integrated Materials Performance Evaluation

Process (IMPEP), which ensures uniform nationwide regulation by reviewing the regulatory performance of both the NRC and the States using a common set of performance criteria; and (3) The Office of Nuclear Material Safety and Safeguards (NMSS), which establishes and maintains communications and working relationships between the NRC and States, local government, other Federal agencies and Native American Tribal Governments.[66,69,70]

Like NRC Agreement States, some states have OSHA approved State Plans in lieu of direct OSHA oversight. OSHA State Plans are required to have standards and enforcement programs that are at least as effective as OSHA's and may have different or more stringent requirements. There are 29 OSHA-approved State Plans operating state-wide occupational safety and health programs.[71]

*Non-Governmental Guidance*

In addition to the role of the federal and state legislative and agency oversight, there is also significant non-governmental guidance. The Conference of Radiation Control Program Directors (CRCPD) is a non-governmental nonprofit comprised primarily of state and local government radiation professionals (e.g., directors and staffs of regulatory programs from both Agreement and non-Agreement States) that regulate the use of radiation sources.[72,73] As such, the CRCPD provides a forum for the states to interact with the NRC and coordinate the regulation of radioactive materials that are not governed by the Atomic Energy Act (AEA). CRCPD has five councils and more than 70 working groups that research a variety of topics pertinent to radiation protection. Similarly, the Organization of Agreement States (OAS) is a professional organization that includes the directors and staff of Agreement State programs. OAS was established to facilitate communication between the NRC and the Agreement States. Both the CRCPD and the OAS participate in the National Materials Program. Additionally, the National Academy of Sciences (NAS) and United Nations Scientific Committee on the Effects of Atomic Radiation (UNSCEAR) publish a series of reports that provide much of the data used in setting radiation standards.[74] Finally, as noted above medical specialty societies also play an important role in providing guidance and setting policy on radiation safety in health care settings. (Appendix I)

*Regulatory standards and guidance for radiation safety in health care settings*

There is extensive federal, state, and local regulation of radiation safety in health care settings along with non-binding guidance and technical reports from international organizations, non-governmental organizations, and medical specialty societies. In general, the federal regulations provide high-level standards for the structure and function of a radiation protection program, but the implementation of those standards is often determined by the state regulations and the RSO with guidance from a variety of sources (e.g., ICRP, NMP, NMSS, OAS, CRCPD, NCRP, EPA,).

For instance, in order to obtain a license, either from the NRC or an Agreement State the facility must have a radiation protection program as outlined in 10 CFR Part 20.[60] At a minimum, a radiation protection program should include the following:

- Qualified staff (e.g., radiation safety officer, medical physicist, nuclear pharmacist).[75]
- Standard procedures (e.g., PPE that fits, a dosimetry program, area monitoring and surveys), engineering and administrative controls (e.g., proper labeling, shielding, interlock systems), and radiological controls (e.g., entry and exit controls, receiving, inventory control, storage, and disposal) to facilitate occupational doses and doses to members of the public that are as low as is reasonably achievable (ALARA).[58–61,76]

- Worker training on radiation protection, including health effects associated with ionizing radiation dose, and radiation protection procedures and controls to minimize dose and prevent contamination.[59,76]
- Emergency procedures to identify and respond to radiological emergency situations.
- Recordkeeping and reporting programs (e.g., dosimetry reports, notifications), internal audits, and regular external review (at least annually) of the radiation protection program content and implementation.[51,60,61,77]

However, the details of the type of PPE, dosimeters, manner of training, and methods for ensuring correct use are not outlined in the regulation. For instance, the regulation requires PPE that fits and is suitable for the assessed hazards; however, it does not necessarily stipulate lead aprons or protective glasses. Similarly, dosimeters are required, but the type and number used are up to the employer. This highlights the importance and value of uniform education and training standards for RSOs, and consistent guidance from medical specialty societies and international, federal, interstate, and non-governmental organizations.

## CONCLUSION

Ionizing radiation can have harmful health effects; however, the evidence on the health effects of low-dose and very-low dose occupational radiation exposure in health care facilities is limited. This is especially true as it relates to physicians and other health care professionals. Despite the limited evidence on negative health effects associated with low-dose and very-low dose occupational radiation exposure in health care facilities, the precautionary principle as well as international guidance, federal and state regulation, and non-governmental and specialty society guidance supports continued use of PPE that appropriately fits and covers all body types, genders, and pregnancy statuses as well as continued education and training on ways to reduce exposure. At the same time, continued research into the health effects of low level and very-low level ionizing radiation, the effectiveness of personal protective equipment and engineering controls designed to reduce exposure, and ways to improve PPE use fidelity are needed.

## CURRENT AMA POLICY

Current AMA policy encourages public and private healthcare institutions to ensure comprehensive coverage of different body types by providing readily available PPE that reduces exposure to as low as reasonably achievable for employees of all genders and pregnancy statuses. Additional policies are primarily focused on protecting patients from ionizing radiation. (See Appendix VIII).

## RECOMMENDATIONS

Your Council on Science and Public Health recommends that the following be adopted and the remainder of this report be filed.

That Policy H-455.975, "Regulation of Ionizing Radiation Exposure for Health Care Workers" be amended by addition and deletion to read as follows:

~~1.~~ Our American Medical Association encourages: (1) public and private health care institutions to ensure the availability of personal protective equipment (PPE) that provides comprehensive coverage of different body types ~~by providing readily available PPE that reduces~~ to reduce ionizing radiation exposure to as low as reasonably achievable for employees and trainees of all genders and pregnancy statuses; (2) continued research on the health effects of low level and very-low level ionizing radiation, the effectiveness of

PPE and administrative and engineering controls designed to reduce exposure (e.g., shielding, interlock systems, labeling,), barriers to PPE use (e.g., fit, availability, cost), and ways to improve PPE use fidelity (e.g., training, education, and access to appropriately sized and ergonomic PPE), and (3) education for all health care personnel, including trainees, exposed to ionizing radiation that includes awareness of and methods to limit radiation exposure to both patients and clinicians. Training programs should provide education specific to their specialties so trainees know which protective equipment and controls their facilities should have in place and know how to use them correctly.

~~2. Our AMA will work with the appropriate and interested parties to study how best to accomplish comprehensive protection from ionizing radiation for employees, taking into account variation in body types, pregnancy status, specifics of procedures being performed, as well as how exposure can be limited beyond PPE (personal protected equipment), with report back at I-25~~.

Fiscal Note: Minimal – less than $1,000.

**APPENDIXES**

***Appendix I: Specialty Societies Providing Guidance on Radiation Safety and PPE***

| |
|---|
| American Academy of Orthopaedic Surgeons[78] – Educational Materials and Articles[79] |
| American Association of Neurologic Surgeons[80] |
| American Association of Physicists in Medicine[81] |
| American College of Cardiology[82] – Consensus statement[83], Educational Materials[84] and JACC articles[26] |
| American College of Chest Physicians[85] |
| American College of Nuclear Medicine[86] |
| American College of Radiation Oncology[87] – Policy Statement on Radiation Therapy Supervision[88] |
| American College of Radiology[89] - Manual for Radiation Safety Officers[2] |
| American College of Surgeons[90] |
| American Orthopaedic Association[91] |
| American Orthopaedic Foot & Ankle Society[92] |
| American Roentgen Ray Society[93] - Webinars[94] |
| American Society of Anesthesiologists[95] |
| American Thoracic Society[96] |
| Association of Academic Radiology[97] |
| Association of Program Directors in Vascular Surgery[98] – Guidance for pregnant trainees[99] |
| Congress of Neurological Surgeons[100] |
| Health Physics Society[101] – Positions and Position Statements[102,103] |
| North American Spine Society[104] - Educational Materials[105] |
| Radiological Society of North America[106] - Educational Materials[107] |
| Society for Cardiovascular Angiography and Interventions[108] – Educational Materials[109] and a Campaign on Women and Safety[110] |
| Society for Pediatric Radiology[111] |
| Society of Critical Care Medicine[112] |
| Society of Interventional Radiology[113] - Toolkits[114] |
| Society of Nuclear Medicine and Molecular Imaging[115] |
| Society of Thoracic Surgeons[116] |

***Appendix II: Key Federal Legislation on Radiation***[117,118]

| | |
|---|---|
| Atomic Energy Act of 1954, as Amended[119] | The Atomic Energy Act (AEA) is the fundamental U.S. law on both the civilian and the military uses of nuclear materials. On the civilian side, it established the Atomic Energy Commission (AEC) to provide for both the development and the regulation of the uses of nuclear materials and facilities in the United States. The ensuing amendments and consequent legislation delegate regulatory authority to the NRC, EPA, and DOE. The AEA also authorizes States to adopt equivalent or more stringent alternatives to the Federal health and environmental protection standards with respect to byproduct material. |
| Energy Reorganization Act of 1974, as amended[120] | The Energy Reorganization Act split the functions of the AEC. The DOE was assigned responsibility for the development and production of nuclear weapons, promotion of nuclear power, and other energy-related work. The NRC was assigned the regulatory authority for civilian nuclear activities. Later amendment to the Act also provided protections for employees who raise nuclear safety concerns. |
| Reorganization Plans[121] | Reorganization Plan No. 3 of 1970 established the EPA and gave it a role in establishing "generally applicable environmental standards for the protection of the general environment from radioactive material."<br><br>Reorganization Plan No. 1 of 1980 strengthened the executive and administrative roles of the NRC Chairman. This Reorganization Plan also provided that all policy formulation, policy-related rulemaking, and orders and adjudications would remain vested with the full Commission. |
| Radiation Control for Health and Safety Act of 1968[122] | Under the Radiation Control for Health and Safety Act, the FDA (via amendments to Section 531-542 of the FD&C Act) is responsible for developing and administering performance standards, monitoring compliance, and conducting research for these electronic products including those in the medical sphere like diagnostic x-ray or ultrasound imaging devices, microwave or ultrasound diathermy devices, microwave blood warmers or sterilizers, laser coagulators, ultrasound phacoemulsifiers, x-ray or electron accelerators, sunlamps, ultraviolet dental curing devices, |
| Nuclear Waste Policy Act of 1982[123] | The Nuclear Waste Policy Act of 1982 delineates responsibilities of the DOE, NRC, and EPA with respect to nuclear waste treatment, disposal, and management. DOE has the responsibility to site, construct, operate, and close a repository for the disposal of spent nuclear fuel and high-level radioactive waste. EPA sets public health and safety standards for releases of radioactive materials from a repository. NRC promulgates regulations governing construction, operation, and closure of nuclear waste repositories. |
| Low-Level Radioactive Waste Policy | The Low-Level Radioactive Wast Policy Amendments Act gives States the responsibility to dispose of low-level radioactive waste generated within their borders and allows them to form compacts to locate facilities |

| | |
|---|---|
| Amendments Act of 1985[121] | to serve a group of States. The Act also requires the NRC to establish standards for determining when radionuclides are present in waste streams in sufficiently low concentrations or quantities as to be below regulatory concern. |
| Clean Air Act[124] | The Clean Air Act gives the federal government authority to regulate and limit air emissions and pollution. It authorizes EPA to establish National Ambient Air Quality Standards (NAAQS) to protect public health and public welfare and to regulate emissions of hazardous air pollutants (HAPs). Some HAPs are radionuclides. |
| Clean Water Act[125] | The Clean Water Act regulates the discharges of pollutants, including some radionuclides, into the waters of the United States. It authorizes EPA and states to set and enforce quality standards for surface waters. |
| Energy Policy Act[126] | The Energy Policy Act requires EPA to promulgate standards to ensure protection of public health from high-level radioactive wastes in a deep geologic repository that might be built under Yucca Mountain in Nevada. |
| The Safe Drinking Water Act[127] | The Sage Drinking Water Act requires EPA to set legal limits on the levels of certain radionuclides in drinking water. |
| Administrative Procedure Act (5 U.S.C. Chapters 5 through 8)[128] | This Act is the fundamental law governing the processes of Federal administrative agencies. Its original focus was on rulemaking and adjudication. It requires, for example, that affected persons be given adequate notice of proposed rules and an opportunity to comment on the proposed rules and that, in cases in which another statute requires that the agency provide a hearing "on the record," the parties are given adequate opportunity to present facts and argument and the hearing officer is impartial. The Act gives interested persons the right to petition an agency for the issuance, amendment, or repeal of a rule. It also provides standards for judicial review of agency actions. |
| National Environmental Policy Act[129] | Every proposal for a major Federal action significantly affecting the quality of the human environment requires a detailed statement on, among other things, the environmental impact of the proposed action and alternatives to the proposed action. |

***Appendix III: Federal Agency Roles Regarding Ionizing Radiation***

| | |
|---|---|
| NRC | 10 CFR Part 20 authorizes the NRC to regulate civilian use of radioactive materials (e.g., source material, special nuclear materials, and byproduct material) for things like commercial nuclear power plants and nuclear medicine through licensing, setting dose and exposure limits, implementing monitoring, labeling, and notice requirements, and issuing penalties for noncompliance. |
| EPA | 40 CFR Part 191 authorized the EPA to set generally applicable standards on the radioactivity in soil, water and air that comes from human use of radioactive elements for the protection of human health and the environment from radioactive materials. In addition to setting legally enforceable standards, the EPA issues federal guidance and technical reports with recommendations on radiation protection (e.g., standardized dose limits, methods for dose and risk assessment), which are used by federal and state agencies in developing radiation regulations and standards. |
| FDA | 21 CFR Parts 892 and 1020 gives the FDA authority to regulate the manufacture, safety, and maintenance of medical devices (e.g., linear accelerators, radiography, fluoroscopy, and CT equipment), electronic devices that emit radiation, and radiopharmaceutical through the Radiological Health Program and the Center for Devices and Radiological Health.[6,49,50,130] However, the States regulate the operation of these devices. FDA also publishes guidance documents that represent FDA's current thinking on a topic and provides a suggested or recommended approach to meet the requirements of a regulation or statute. The guidance documents are not legally binding, but they are a suggested or recommended approach to meet the requirements of a regulation or statute. |
| OSHA | 29 CRF 1910 authorizes OSHA to set standards for radiation protection in the workplace. This includes setting exposure limits, monitoring exposure with personnel monitoring equipment (e.g., film badges, pocket chambers, pocket dosimeters, or film rings), posting signage to notify employees of radiation and radioactive areas, disposal of radioactive, and recordkeeping. 29 CRF 1910 also requires, "protective equipment, including personal protective equipment for eyes, face, head, and extremities, protective clothing, respiratory devices, and protectives shields and barriers, shall be provided, used, and maintained in a sanitary and reliable condition." It is incumbent upon the employer to assess hazards, communicate to employees that these hazards exist, provide PPE that properly fits each employee, and train employees on appropriate use. Examples of commonly used PPE for radiation protection from X-rays and gamma rays include lead aprons/vests, lead thyroid collars, lead gloves, and safety goggles |
| DOE | The DOE is responsible for managing much of the country's tries radioactive waste (e.g., providing a repository for high-level waste, operating the Waste Isolation Pilot Plant (WIPP), and providing a disposal option for the portion of the NRC-regulated low-level waste that is not generally suitable for near-surface disposal). 10 CFR 961 establishes the contractual terms and conditions under which the Department of Energy (DOE) will make available nuclear waste disposal services. 10 CFR 835 establishes radiation protection standards, limits, and program requirements for protecting individuals from ionizing radiation resulting from the conduct of DOE activities. |
| NIOSH | The NIOSH mission is to develop new knowledge in the field of occupational safety and health and to transfer that knowledge into practice.[55] To facilitate this the NIOSH Division of Field Studies and Engineering, Field Research Branch conducts epidemiological studies of |

| | |
|---|---|
| | the health effects of occupational exposure to ionizing radiation and evaluate exposures to ionizing radiation. Similarly, the NIOSH Division of Compensation Analysis and Support reconstructs occupational radiation dose for certain workers with cancer who file claims under the Energy Employees Occupational Illness Compensation Program Act.[131,132] |
| NCRP | The National Council on Radiation Protection and Measurements (NCRP) seeks to formulate and widely disseminate information, guidance and recommendations on radiation protection and measurements which represent the consensus of leading scientific thinking.<br><br>The primary statutory goals of the NCRP under Public Law 88-376 are to: (1) collect, analyze, develop and disseminate in the public interest information and recommendations about protection against radiation and radiation measurements; (2) provide a means by which organizations concerned with the scientific and related aspects of radiation protection and of radiation quantities, units and measurements may cooperate for effective utilization of their combined resources, and to stimulate the work of such organizations; (3) develop basic concepts about radiation quantities, units and measurements, about the application of these concepts, and about radiation protection; and (4) cooperate with the International Commission on Radiological Protection, the Federal Radiation Council, the International Commission on Radiation Units and Measurements, and other national and international organizations, governmental and private, concerned with radiation quantities, units and measurements and with radiation protection.[133]<br><br>The NCRP has 138 reports and commentaries, but those reports require purchase.[134] Only their annual meeting proceedings and statements are free to the public. |

***Appendix IV: Code of Federal Regulations Authority and Statutory Language on Radiation Safety and Exposure Guidance***

**10 CFR Part 20**[60]

**§ 20.1003 Definitions.**

*ALARA* (acronym for "as low as is reasonably achievable") means making every reasonable effort to maintain exposures to radiation as far below the dose limits in this part as is practical consistent with the purpose for which the licensed activity is undertaken, taking into account the state of technology, the economics of improvements in relation to state of technology, the economics of improvements in relation to benefits to the public health and safety, and other societal and socioeconomic considerations, and in relation to utilization of nuclear energy and licensed materials in the public interest.

*Annual limit on intake* (ALI) means the derived limit for the amount of radioactive material taken into the body of an adult worker by inhalation or ingestion in a year. ALI is the smaller value of intake of a given radionuclide in a year by the reference man that would result in a committed effective dose equivalent of 5 rems (0.05 Sv) or a committed dose equivalent of 50 rems (0.5 Sv) to any individual organ or tissue. (ALI values for intake by ingestion and by inhalation of selected radionuclides are given in table 1, columns 1 and 2 of appendix B to §§ 20.1001-20.2401).

. . .

**§ 20.1101 Radiation protection programs.**

(a) Each licensee shall develop, document, and implement a radiation protection program commensurate with the scope and extent of licensed activities and sufficient to ensure compliance with the provisions of this part. (See § 20.2102 for recordkeeping requirements relating to these programs.)

(b) The licensee shall use, to the extent practical, procedures and engineering controls based upon sound radiation protection principles to achieve occupational doses and doses to members of the public that are as low as is reasonably achievable (ALARA).

(c) The licensee shall periodically (at least annually) review the radiation protection program content and implementation.

(d) To implement the ALARA requirements of § 20.1101 (b), and notwithstanding the requirements in § 20.1301 of this part, a constraint on air emissions of radioactive material to the environment, excluding Radon-222 and its daughters, shall be established by licensees other than those subject to § 50.34a, such that the individual member of the public likely to receive the highest dose will not be expected to receive a total effective dose equivalent in excess of 10 mrem (0.1 mSv) per year from these emissions. If a licensee subject to this requirement exceeds this dose constraint, the licensee shall report the exceedance as provided in § 20.2203 and promptly take appropriate corrective action to ensure against recurrence.

. . .

**§ 20.1201 Occupational dose limits for adults.**

(a) The licensee shall control the occupational dose to individual adults, except for planned special exposures under § 20.1206, to the following dose limits.

(1) An annual limit, which is the more limiting of—

(i) The total effective dose equivalent being equal to 5 rems (0.05 Sv); or

(ii) The sum of the deep-dose equivalent and the committed dose equivalent to any individual organ or tissue other than the lens of the eye being equal to 50 rems (0.5 Sv).

(2) The annual limits to the lens of the eye, to the skin of the whole body, and to the skin of the extremities, which are:

(i) A lens dose equivalent of 15 rems (0.15 Sv), and

(ii) A shallow-dose equivalent of 50 rem (0.5 Sv) to the skin of the whole body or to the skin of any extremity.

. . .

**§ 20.1501 General.**

(a) Each licensee shall make or cause to be made, surveys of areas, including the subsurface, that—

(1) May be necessary for the licensee to comply with the regulations in this part; and

(2) Are reasonable under the circumstances to evaluate—

(i) The magnitude and extent of radiation levels; and

(ii) Concentrations or quantities of residual radioactivity; and

(iii) The potential radiological hazards of the radiation levels and residual radioactivity detected.

(b) Notwithstanding § 20.2103(a) of this part, records from surveys describing the location and amount of subsurface residual radioactivity identified at the site must be kept with records important for decommissioning, and such records must be retained in accordance with §§ 30.35(g), 40.36(f), 50.75(g), 70.25(g), or 72.30(d), as applicable.

(c) The licensee shall ensure that instruments and equipment used for quantitative radiation measurements (e.g., dose rate and effluent monitoring) are calibrated periodically for the radiation measured.

(d) All personnel dosimeters (except for direct and indirect reading pocket ionization chambers and those dosimeters used to measure the dose to the extremities) that require processing to determine the radiation dose and that are used by licensees to comply with § 20.1201, with other applicable provisions of this chapter, or with conditions specified in a license must be processed and evaluated by a dosimetry processor

**10 CFR Part 35**[76]

**§ 35.2 Definitions.**

*Associate Radiation Safety Officer* means an individual who—

(1) Meets the requirements in §§ 35.50 and 35.59; and

(2) Is currently identified as an Associate Radiation Safety Officer for the types of use of byproduct material for which the individual has been assigned duties and tasks by the Radiation Safety Officer on—

(i) A specific medical use license issued by the Commission or an Agreement State; or

(ii) A medical use permit issued by a Commission master material licensee.

*Authorized medical physicist* means an individual who—
(1) Meets the requirements in §§ 35.51(a) and 35.59; or
(2) Is identified as an authorized medical physicist or teletherapy physicist on—
(i) A specific medical use license issued by the Commission or Agreement State;
(ii) A medical use permit issued by a Commission master material licensee;
(iii) A permit issued by a Commission or Agreement State broad scope medical use licensee; or
(iv) A permit issued by a Commission master material license broad scope medical use permittee.

*Authorized nuclear pharmacist* means a pharmacist who—
(1) Meets the requirements in §§ 35.55(a) and 35.59; or
(2) Is identified as an authorized nuclear pharmacist on—
(i) A specific license issued by the Commission or Agreement State that authorizes medical use or the practice of nuclear pharmacy;
(ii) A permit issued by a Commission master material licensee that authorizes medical use or the practice of nuclear pharmacy;
(iii) A permit issued by a Commission or Agreement State broad scope medical use licensee that authorizes medical use or the practice of nuclear pharmacy; or
(iv) A permit issued by a Commission master material license broad scope medical use permittee that authorizes medical use or the practice of nuclear pharmacy; or
(3) Is identified as an authorized nuclear pharmacist by a commercial nuclear pharmacy that has been authorized to identify authorized nuclear pharmacists; or
(4) Is designated as an authorized nuclear pharmacist in accordance with § 32.72(b)(4).

*Authorized user* means a physician, dentist, or podiatrist who—
(1) Meets the requirements in §§ 35.59 and 35.190(a), 35.290(a), 35.390(a), 35.392(a), 35.394(a), 35.490(a), 35.590(a), or 35.690(a); or
(2) Is identified as an authorized user on—
(i) A Commission or Agreement State license that authorizes the medical use of byproduct material;
(ii) A permit issued by a Commission master material licensee that is authorized to permit the medical use of byproduct material;
(iii) A permit issued by a Commission or Agreement State specific licensee of broad scope that is authorized to permit the medical use of byproduct material; or
(iv) A permit issued by a Commission master material license broad scope permittee that is authorized to permit the medical use of byproduct material.

*Radiation Safety Officer* means an individual who—
(1) Meets the requirements in §§ 35.50(a) or (c)(1) and 35.59; or
(2) Is identified as a Radiation Safety Officer on—
(i) A specific medical use license issued by the Commission or Agreement State; or
(ii) A medical use permit issued by a Commission master material licensee.

**§ 35.50 Training for Radiation Safety Officer and Associate Radiation Safety Officer.**

Except as provided in § 35.57, the licensee shall require an individual fulfilling the responsibilities of the Radiation Safety Officer or an individual assigned duties and tasks as an Associate Radiation Safety Officer as provided in § 35.24 to be an individual who—

(a) Is certified by a specialty board whose certification process has been recognized by the Commission or an Agreement State and who meets the requirements in paragraph (d) of this section. The names of board certifications that have been recognized by the Commission or an Agreement State are posted on the NRC's Medical Uses Licensee Toolkit web page. To have its certification process recognized, a specialty board shall require all candidates for certification to:

(1)

(i) Hold a bachelor's or graduate degree from an accredited college or university in physical science or engineering or biological science with a minimum of 20 college credits in physical science;

(ii) Have 5 or more years of professional experience in health physics (graduate training may be substituted for no more than 2 years of the required experience) including at least 3 years in applied health physics; and

(iii) Pass an examination administered by diplomates of the specialty board, which evaluates knowledge and competence in radiation physics and instrumentation, radiation protection, mathematics pertaining to the use and measurement of radioactivity, radiation biology, and radiation dosimetry; or

(2)

(i) Hold a master's or doctor's degree in physics, medical physics, other physical science, engineering, or applied mathematics from an accredited college or university;

(ii) Have 2 years of full-time practical training and/or supervised experience in medical physics—

(A) Under the supervision of a medical physicist who is certified in medical physics by a specialty board recognized by the Commission or an Agreement State; or

(B) In clinical nuclear medicine facilities providing diagnostic or therapeutic services under the direction of physicians who meet the requirements for authorized users in §§ 35.57, 35.290, or 35.390; and

(iii) Pass an examination, administered by diplomates of the specialty board, that assesses knowledge and competence in clinical diagnostic radiological or nuclear medicine physics and in radiation safety; or

(b)

(1) Has completed a structured educational program consisting of both:

(i) 200 hours of classroom and laboratory training in the following areas—

(A) Radiation physics and instrumentation;

(B) Radiation protection;

(C) Mathematics pertaining to the use and measurement of radioactivity;

(D) Radiation biology; and

(E) Radiation dosimetry; and

(ii) One year of full-time radiation safety experience under the supervision of the individual identified as the Radiation Safety Officer on a Commission or an Agreement State license or permit issued by a Commission master material licensee that authorizes similar type(s) of use(s) of byproduct material. An Associate Radiation Safety Officer may provide supervision for those areas for which the Associate Radiation Safety Officer is authorized on a Commission or

an Agreement State license or permit issued by a Commission master material licensee. The full-time radiation safety experience must involve the following—

(A) Shipping, receiving, and performing related radiation surveys;

(B) Using and performing checks for proper operation of instruments used to determine the activity of dosages, survey meters, and instruments used to measure radionuclides;

(C) Securing and controlling byproduct material;

(D) Using administrative controls to avoid mistakes in the administration of byproduct material;

(E) Using procedures to prevent or minimize radioactive contamination and using proper decontamination procedures;

(F) Using emergency procedures to control byproduct material; and

(G) Disposing of byproduct material; and

(2) This individual must obtain a written attestation, signed by a preceptor Radiation Safety Officer or Associate Radiation Safety Officer who has experience with the radiation safety aspects of similar types of use of byproduct material for which the individual is seeking approval as a Radiation Safety Officer or an Associate Radiation Safety Officer. The written attestation must state that the individual has satisfactorily completed the requirements in paragraphs (b)(1) and (d) of this section, and is able to independently fulfill the radiation safety-related duties as a Radiation Safety Officer or as an Associate Radiation Safety Officer for a medical use license; or

(c)

(1) Is a medical physicist who has been certified by a specialty board whose certification process has been recognized by the Commission or an Agreement State under § 35.51(a), has experience with the radiation safety aspects of similar types of use of byproduct material for which the licensee seeks the approval of the individual as Radiation Safety Officer or an Associate Radiation Safety Officer, and meets the requirements in paragraph (d) of this section; or

(2) Is an authorized user, authorized medical physicist, or authorized nuclear pharmacist identified on a Commission or an Agreement State license, a permit issued by a Commission master material licensee, a permit issued by a Commission or an Agreement State licensee of broad scope, or a permit issued by a Commission master material license broad scope permittee, has experience with the radiation safety aspects of similar types of use of byproduct material for which the licensee seeks the approval of the individual as the Radiation Safety Officer or Associate Radiation Safety Officer, and meets the requirements in paragraph (d) of this section; or

(3) Has experience with the radiation safety aspects of the types of use of byproduct material for which the individual is seeking simultaneous approval both as the Radiation Safety Officer and the authorized user on the same new medical use license or new medical use permit issued by a Commission master material licensee. The individual must also meet the requirements in paragraph (d) of this section.

(d) Has training in the radiation safety, regulatory issues, and emergency procedures for the types of use for which a licensee seeks approval. This training requirement may be satisfied by completing training that is supervised by a Radiation Safety Officer, an Associate Radiation Safety Officer, authorized medical physicist, authorized nuclear pharmacist, or authorized user, as appropriate, who is authorized for the type(s) of use for which the licensee is seeking approval.

**CFR 10 Part 835**[61]

**§ 835.1 Scope.**

(a) ***General.*** The rules in this part establish radiation protection standards, limits, and program requirements for protecting individuals from ionizing radiation resulting from the conduct of DOE activities.

(b) ***Exclusion.*** Except as provided in paragraph (c) of this section, the requirements in this part do not apply to:

(1) Activities that are regulated through a license by the Nuclear Regulatory Commission or a State under an Agreement with the Nuclear Regulatory commission, including activities certified by the Nuclear Regulatory Commission under section 1701 of the Atomic Energy Act;

(2) Activities conducted under the authority of the Deputy Administrator for Naval Reactors, as described in Pub. L. 98-525 and 106-65;

(3) Activities conducted under the Nuclear Explosives and Weapons Surety Program relating to the prevention of accidental or unauthorized nuclear detonations;

(4) DOE activities conducted outside the United States on territory under the jurisdiction of a foreign government to the extent governed by occupational radiation protection requirements agreed to between the United States and the cognizant government;

(5) Background radiation, radiation doses received as a patient for the purposes of medical diagnosis or therapy, or radiation doses received from participation as a subject in medical research programs; or

(6) Radioactive material on or within material, equipment, and real property which is approved for release when the radiological conditions of the material, equipment, and real property have been documented to comply with the criteria for release set forth in a DOE authorized limit which has been approved by a Secretarial Officer in consultation with the Director, Office of Environment, Health, Safety and Security.

(7) Radioactive material transportation not performed by DOE or a DOE contractor.

(c) Occupational doses received as a result of excluded activities and radioactive material transportation listed in paragraphs (b)(1) through (b)(4) and (b)(7) of this section, shall be included to the extent practicable when determining compliance with the occupational dose limits at §§ 835.202 and 835.207, and with the limits for the embryo/fetus at § 835.206. Occupational doses resulting from authorized emergency exposures and planned special exposures shall not be considered when determining compliance with the dose limits at §§ 835.202 and 835.207.

(d) The requirements in subparts F and G of this part do not apply to radioactive material transportation by DOE or a DOE contractor conducted:

(1) Under the continuous observation and control of an individual who is knowledgeable of and implements required exposure control measures, or

(2) In accordance with Department of Transportation regulations or DOE orders that govern such movements.

**§ 835.2 Definitions.**

. . .

*ALARA* means “As Low As is Reasonably Achievable,” which is the approach to radiation protection to manage and control exposures (both individual and collective) to the work force and to the general public to as low as is reasonable, taking into account social, technical, economic, practical, and public policy considerations. As used in this part, ALARA is not a dose limit but a process which has the objective of attaining doses as far below the applicable limits of this part as is reasonably achievable.

*Annual limit on intake (ALI)* means the derived limit for the amount of radioactive material taken into the body of an adult worker by inhalation or ingestion in a year. ALI is the smaller value of intake of a given radionuclide in a year by the reference man (ICRP Publication 23) that would result in a committed effective dose of 5 rems (0.05 sieverts (Sv)) (1 rem = 0.01 Sv) or a committed equivalent dose of 50 rems (0.5 Sv) to any individual organ or tissue. ALI values for intake by ingestion and inhalation of selected radionuclides are based on International Commission on Radiological Protection Publication 68, *Dose Coefficients for Intakes of Radionuclides by Workers*, published July, 1994 (ISBN 0 08 042651 4). This document is available from Elsevier Science Inc., Tarrytown, NY.

*Authorized limit* means a limit on the concentration of residual radioactive material on the surfaces or within the property that has been derived consistent with DOE directives including the as low as is reasonably achievable (ALARA) process requirements, given the anticipated use of the property and has been authorized by DOE to permit the release of the property from DOE radiological control.

. . .

**§ 835.202 Occupational dose limits for general employees.**

(a) Except for planned special exposures conducted consistent with § 835.204 and emergency exposures authorized in accordance with § 835.1302, the occupational dose received by general employees shall be controlled such that the following limits are not exceeded in a year:

(1) A total effective dose of 5 rems (0.05 Sv);

(2) The sum of the equivalent dose to the whole body for external exposures and the committed equivalent dose to any organ or tissue other than the skin or the lens of the eye of 50 rems (0.5 Sv);

(3) An equivalent dose to the lens of the eye of 15 rems (0.15 Sv); and

(4) The sum of the equivalent dose to the skin or to any extremity for external exposures and the committed equivalent dose to the skin or to any extremity of 50 rems (0.5 Sv).

(b) All occupational doses received during the current year, except doses resulting from planned special exposures conducted in compliance with § 835.204 and emergency exposures authorized in accordance with § 835.1302, shall be included when demonstrating compliance with §§ 835.202(a) and 835.207.

(c) Doses from background, therapeutic and diagnostic medical radiation, and participation as a subject in medical research programs shall not be included in dose records or in the assessment of compliance with the occupational dose limits.

**10 CFR Part 961**[135]

**§ 961.1 Purpose.**

This part establishes the contractual terms and conditions under which the Department of Energy (DOE) will make available nuclear waste disposal services to the owners and generators of spent nuclear fuel (SNF) and high-level radioactive waste (HLW) as provided in section 302 of the Nuclear Waste Policy Act of 1982 (Pub. L. 97-425). Under the contract set forth in § 961.11 of this part, DOE will take title to, transport, and dispose of spent nuclear fuel and/or high-level radioactive waste delivered to DOE by those owners or generators of such fuel or waste who execute the contract. In addition, the contract will specify the fees owners and generators of SNF and/or HLW will pay for these services. All receipts, proceeds, and revenues realized by DOE under the contract will be deposited in the

Nuclear Waste Fund, an account established by the Act in the U.S. Treasury. This fund will pay for DOE's radioactive waste disposal activities, the full costs of which will be borne by the owners and generators under contract with DOE for disposal services.

**21 CFR 892**[136]

**§ 892.1 Scope.**

(a) This part sets forth the classification of radiology devices intended for human use that are in commercial distribution.
(b) The identification of a device in a regulation in this part is not a precise description of every device that is, or will be, subject to the regulation. A manufacturer who submits a premarket notification submission for a device under part 807 cannot show merely that the device is accurately described by the section title and identification provision of a regulation in this part but shall state why the device is substantially equivalent to other devices, as required by § 807.87.
(c) To avoid duplicative listings, a radiology device that has two or more types of uses (e.g., use both as a diagnostic device and a therapeutic device) is listed in one subpart only.
(d) References in this part to regulatory sections of the Code of Federal Regulations are to chapter I of this title 21, unless otherwise noted.
(e) Guidance documents referenced in this part are available on the Internet at http://www.fda.gov/MedicalDevices/DeviceRegulationandGuidance/GuidanceDocuments/default.htm.

. . .

**§ 892.3 Effective dates of requirement for premarket approval.**
A device included in this part that is classified into class III (premarket approval) shall not be commercially distributed after the date shown in the regulation classifying the device unless the manufacturer has an approval under section 515 of the act (unless an exemption has been granted under section 520(g)(2) of the act). An approval under section 515 of the act consists of FDA's issuance of an order approving an application for premarket approval (PMA) for the device or declaring completed a product development protocol (PDP) for the device.
(a) Before FDA requires that a device commercially distributed before the enactment date of the amendments, or a device that has been found substantially equivalent to such a device, has an approval under section 515 of the act, FDA must promulgate a regulation under section 515(b) of the act requiring such approval, except as provided in paragraph (b) of this section. Such a regulation under section 515(b) of the act shall not be effective during the grace period ending on the 90th day after its promulgation or on the last day of the 30th full calendar month after the regulation that classifies the device into class III is effective, whichever is later. See section 501(f)(2)(B) of the act. Accordingly, unless an effective date of the requirement for premarket approval is shown in the regulation for a device classified into class III in this part, the device may be commercially distributed without FDA's issuance of an order approving a PMA or declaring completed a PDP for the device. If FDA promulgates a regulation under section 515(b) of the act requiring premarket approval for a device, section 501(f)(1)(A) of the act applies to the device.
(b) Any new, not substantially equivalent, device introduced into commercial distribution on or after May 28, 1976, including a device formerly marketed that has been substantially altered, is classified by statute (section 513(f) of the act) into class III without any grace period and FDA must have issued an order approving a PMA or declaring completed a PDP for the device before the device is commercially distributed unless it is reclassified. If FDA

knows that a device being commercially distributed may be a "new" device as defined in this section because of any new intended use or other reasons, FDA may codify the statutory classification of the device into class III for such new use. Accordingly, the regulation for such a class III device states that as of the enactment date of the amendments, May 28, 1976, the device must have an approval under section 515 of the act before commercial distribution.

**21 CFR 1020**[137]

**§ 1020.31 Radiographic equipment.**
The provisions of this section apply to equipment for radiography, except equipment for fluoroscopic imaging or for recording images from the fluoroscopic image receptor, or computed tomography x-ray systems manufactured on or after November 29, 1984.

. . .

**§ 1020.32 Fluoroscopic equipment.**
The provisions of this section apply to equipment for fluoroscopic imaging or for recording images from the fluoroscopic image receptor, except computed tomography x-ray systems manufactured on or after November 29, 1984.

**29 CFR Part 1904**[77]

**§ 1904.0 Purpose.**
The purpose of this rule (part 1904) is to require employers to record and report work-related fatalities, injuries, and illnesses.

**29 CFR Part 1910**[59]

**§ 1910.132 General requirements.**
(a) **Application.** Protective equipment, including personal protective equipment for eyes, face, head, and extremities, protective clothing, respiratory devices, and protective shields and barriers, shall be provided, used, and maintained in a sanitary and reliable condition wherever it is necessary by reason of hazards of processes or environment, chemical hazards, radiological hazards, or mechanical irritants encountered in a manner capable of causing injury or impairment in the function of any part of the body through absorption, inhalation or physical contact.
(b) **Employee-owned equipment.** Where employees provide their own protective equipment, the employer shall be responsible to assure its adequacy, including proper maintenance, and sanitation of such equipment.
(c) ***Design.*** All personal protective equipment shall be of safe design and construction for the work to be performed.
(d) ***Hazard assessment and equipment selection.***
(1) The employer shall assess the workplace to determine if hazards are present, or are likely to be present, which necessitate the use of personal protective equipment (PPE). If such hazards are present, or likely to be present, the employer shall:
(i) Select, and have each affected employee use, the types of PPE that will protect the affected employee from the hazards identified in the hazard assessment;
(ii) Communicate selection decisions to each affected employee; and,
(iii) Select PPE that properly fits each affected employee.

(2) The employer shall verify that the required workplace hazard assessment has been performed through a written certification that identifies the workplace evaluated; the person certifying that the evaluation has been performed; the date(s) of the hazard assessment; and, which identifies the document as a certification of hazard assessment.

(e) ***Defective and damaged equipment.*** Defective or damaged personal protective equipment shall not be used.

(f) ***Training.***

(1) The employer shall provide training to each employee who is required by this section to use PPE. Each such employee shall be trained to know at least the following:

(i) When PPE is necessary;

(ii) What PPE is necessary;

(iii) How to properly don, doff, adjust, and wear PPE;

(iv) The limitations of the PPE; and,

(v) The proper care, maintenance, useful life and disposal of the PPE.

. . .

(h) ***Payment for protective equipment.***

(1) Except as provided by paragraphs (h)(2) through (h)(6) of this section, the protective equipment, including personal protective equipment (PPE), used to comply with this part, shall be provided by the employer at no cost to employees.

(2) The employer is not required to pay for non-specialty safety-toe protective footwear (including steel-toe shoes or steel-toe boots) and non-specialty prescription safety eyewear, provided that the employer permits such items to be worn off the job-site.

**§ 1910.1096**

(b) ***Exposure of individuals to radiation in restricted areas.***

(1) Except as provided in paragraph (b)(2) of this section, no employer shall possess, use, or transfer sources of ionizing radiation in such a manner as to cause any individual in a restricted area to receive in any period of one calendar quarter from sources in the employer's possession or control a dose in excess of the limits specified in Table G-18:

TABLE G-18

| | Rems per calendar quarter |
|---|---|
| Whole body: Head and trunk; active blood-forming organs; lens of eyes; or gonads | 11/4 |
| Hands and forearms; feet and ankles | 183/4 |
| Skin of whole body | 71/2 |

. . .

(d) ***Precautionary procedures and personal monitoring.***

(1) Every employer shall make such surveys as may be necessary for him to comply with the provisions in this section. *Survey* means an evaluation of the radiation hazards incident to the production, use, release, disposal, or presence of radioactive materials or other sources of radiation under a specific set of conditions. When appropriate, such

evaluation includes a physical survey of the location of materials and equipment, and measurements of levels of radiation or concentrations of radioactive material present.
(2) Every employer shall supply appropriate personnel monitoring equipment, such as film badges, pocket chambers, pocket dosimeters, or film rings, and shall require the use of such equipment by:
(i) Each employee who enters a restricted area under such circumstances that he receives, or is likely to receive, a dose in any calendar quarter in excess of 25 percent of the applicable value specified in paragraph (b)(1) of this section; and
(ii) Each employee under 18 years of age who enters a restricted area under such circumstances that he receives, or is likely to receive, a dose in any calendar quarter in excess of 5 percent of the applicable value specified in paragraph (b)(1) of this section; and
(iii) Each employee who enters a high radiation area.

**40 CFR 191**[138]

**§ 191.03 Standards.**
(a) Management and storage of spent nuclear fuel or high-level or transuranic radioactive wastes at all facilities regulated by the Commission or by Agreement States shall be conducted in such a manner as to provide reasonable assurance that the combined annual dose equivalent to any member of the public in the general environment resulting from:
(1) Discharges of radioactive material and direct radiation from such management and storage and
(2) all operations covered by Part 190; shall not exceed 25 millirems to the whole body, 75 millirems to the thyroid, and 25 millirems to any other critical organ.
(b) Management and storage of spent nuclear fuel or high-level or transuranic radioactive wastes at all facilities for the disposal of such fuel or waste that are operated by the Department and that are not regulated by the Commission or Agreement States shall be conducted in such a manner as to provide reasonable assurance that the combined annual dose equivalent to any member of the public in the general environment resulting from discharges of radioactive material and direct radiation from such management and storage shall not exceed 25 millirems to the whole body and 75 millirems to any critical organ.

***Appendix V: Agency Reports***[134,139,140]

| | | |
|---|---|---|
| Federal Guidance Report No. 15[141] | Updates and expands the 1993 FDR No. 12 providing age-specific, reference person effective dose rate coefficients for 1,252 radionuclides based on external exposure to radionuclides distributed in air, water and soil for use in implementing radiation protection programs. | EPA - 2019 |
| Federal Guidance Report No. 14[142] | Provides recommendations for keeping patients ionizing radiation doses as low as reasonably achievable without compromising the quality of patient care. | EPA - 2014 |
| Federal Guidance Report No. 13[143] | Provides methods and data for estimating risks due to both internal and external radionuclide exposures. It includes coefficients for assessing cancer risks from environmental exposure to about 800 radionuclides. Both mortality and incidence risk coefficients are tabulated for inhalation, food and water ingestion, submersion in air and exposure to uniform soil concentrations. The age-averaged coefficients consider age-specific intake rates, dose modeling and risk modeling. | EPA - 1999 |
| Federal Guidance Report No. 12[144] | The external dose coefficients in this report are intended for use by federal agencies having regulatory responsibilities for protection of members of the public and/or workers. We also encourage their use by state and local authorities. This document provides exposure-to-dose coefficients for general application based on the 1987 Federal Radiation Protection Guidance. | EPA - 1993 |
| Radiation Protection Guidance to Federal Agencies for Occupational Exposure; Approval of Environmental Protection Agency Recommendations[145] | This guidance provides general principles and specifies the numerical primary guides for limiting worker exposure. It applies to all workers who are exposed to radiation in the course of their work, either as employees of institutions and companies subject to Federal regulation or as Federal employees. | EPA - 1987 |
| Radiation Protection Guidance for Federal Agencies (Federal Radiation Council)[146] | This guidance presents recommendations for population groups exposed to environmental sources of radiation. It provides Radiation Protection Guides (RPG); guidance on general principles of control applicable to all environmental radionuclides; and specific guidance in connection with exposure of population groups to radium-226, iodine-131, strontium-90, and strontium-89. | EPA - 1961 |
| Consolidated Guidance About Materials Licenses: Program-Specific Guidance About Medical Use Licenses, Final Report (NUREG-1556, Volume 9, Revision 3)[147] | This technical report contains information intended to provide program-specific guidance and assist applicants and licensees in preparing applications for materials licenses for the medical use of byproduct material. | NRC - 2019 |
| REGULATORY GUIDE 8.4 - PERSONNEL MONITORING DEVICE—DIRECT-READING POCKET DOSIMETERS [148] | This guide provides guidance acceptable to the U.S. Nuclear Regulatory Commission (NRC) staff for use in complying with the NRC's regulations on direct-reading pocket dosimeters; it includes specific performance standards for personnel monitoring but not for area monitoring. | NRC - 2011 |

| | | |
|---|---|---|
| REGULATORY GUIDE 8.2 - ADMINISTRATIVE PRACTICES IN RADIATION SURVEYS AND MONITORING [149] | This guide provides guidance acceptable to the U.S. Nuclear Regulatory Commission (NRC) staff for use in complying with the NRC's regulations for administrative practices associated with surveys and monitoring of ionizing radiation in licensed institutions; it is intended primarily for administrative and management personnel in organizations that are involved in, or are planning to initiate, activities involving the handling of radioactive materials or radiation. | NRC - 2011 |
| REGULATORY GUIDE 8.18 - INFORMATION RELEVANT TO ENSURING THAT RADIATION EXPOSURES AT MEDICAL INSTITUTIONS WILL BE AS LOW AS IS REASONABLY ACHIEVABLE[150] | This guide is directed specifically toward medical licensees and recommends methods that the staff of the U.S. Nuclear Regulatory Commission (NRC) considers acceptable to maintain exposures as low as is reasonably achievable (ALARA) in medical institutions. | NRC - 2011 |
| Radiation Dose Estimates for Radiopharmaceuticals (NUREG/CR-6345)[151] | The dose estimates were calculated using the MIRD Technique as implemented in the MIRDOSE3 computer code, developed by Oak Ridge Institute for Science and Education, Radiation Internal Dose Information Center. In this code, residence times for source organs are used with decay data from the MIRD Radionuclide Data and Decay Schemes to produce estimates of radiation dose to organs of standardized phantoms representing individuals of different ages. | NRC 1996 |
| Report No. 151: Structural Shielding Design and Evaluation for Megavoltage X- and Gamma-Ray Radiotherapy Facilities.[152] | This Report presents recommendations and technical information related to the design and installation of structural shielding for megavoltage x- and gamma-ray radiotherapy facilities. | NRCP - 2005 |
| Report No. 177: Radiation Protection in Dentistry and Oral & Maxillofacial Imaging.[153] | This Report provides radiation protection guidance for the use of x rays in dental practice, including the use of cone-beam computed tomography, digital-imaging devices, and handheld x-ray systems. The aim of this Report is to provide a practical radiation protection guide for dentists and their assistants. Information is presented in a clear and comprehensive format focusing on dental radiological practices. | NCRP - 2019 |
| Report No. 148: Radiation Protection in Veterinary Medicine.[154] | Report No. 148 is concerned with the protection of individuals who may be exposed to radiation emitted by x-ray equipment and both sealed and unsealed radioactive sources in the practice of veterinary medicine. To the extent that the animal patient exposure is reduced, there is usually a proportional decrease in the occupational exposure to personnel. The Report provides guidance for the development of an effective radiation safety program and recommendations for the design of radiological | NCRP - 2004 |

| | | |
|---|---|---|
| | facilities and for the use of radiographic, fluoroscopic and therapeutic equipment in veterinary medicine. Included are recommendations for the use of radiopharmaceuticals in diagnosis and therapy, and for the use of lasers and ultrasonic equipment. | |
| Report No. 147: Structural Shielding Design for Medical X-ray Imaging Facilities.[155] | Report No. 147 (2004) presents recommendations and technical information related to the design and installation of structural shielding for facilities that use x rays for medical imaging. The purpose of structural shielding is to limit radiation exposure to employees and members of the public. | NRCP - 2004 |
| Report No. 144: Radiation Protection for Particle Accelerator Facilities.[156] | The Report revises and expands on the earlier report and includes new information on source intensities, shielding, dosimetry, and the environmental aspects of particle accelerator operation. It is primarily concerned with radiological safety aspects that are special to the operation of particle accelerators having energies above about 5 MeV up to the highest energies available, while not neglecting low-energy neutron generators. The purpose of this Report is to provide design guidelines for radiation protection, and to identify those aspects of radiological safety that are of major, or even unique, importance to the operation of particle accelerator installations and to suggest methods by which safe operation may be achieved. | NCRP - 2003 |
| Report No. 133: Radiation Protection for Procedures Performed Outside the Radiology Department.[157] | Report No. 133 (2000) is an 81 page document with five sections, two appendices, a glossary, and references. Section 1 introduces sources of occupational radiation exposure and compares occupational exposures in medicine with other sources of occupational exposure. Section 2 describes radiologic medical procedures that are often performed outside the radiology department and categorizes the procedures according to their potential for occupational exposure. Section 3 addresses conditions that affect potential occupational exposure such as time, distance, shielding, and orientation of radiation source, patient and operator. Section 4 addresses medical personnel monitoring and Section 5 briefly addresses the responsibility of management to provide safe conditions for both employees and patients. | NCRP - 2000 |

***Appendix VI: Interagency MOUs regarding radiation safety***[158,159]

| | |
|---|---|
| OSHA and FDA (2024)[160] | The FDA and OSHA will share relevant information with each other, while ensuring that the exchange of such information complies with applicable law.<br><br>If FDA, in its inspections of facilities, has reason to believe that a potential violation of an employer's obligations under the OSH Act or an OSHA standard or regulation has occurred, FDA will provide this information to OSHA to the extent that is feasible.<br><br>If OSHA, in its investigations of facilities where FDA regulated products are produced, processed, manufactured or held has reason to believe that factors are present which may indicate a possible violation of FDA standards, OSHA will provide this information to FDA, to the extent feasible.<br><br>The FDA and OSHA agree to maintain a practicable process including procedures and criteria for information sharing and a plan for implementation.<br><br>The FDA and OSHA agree to develop and implement a plan for training appropriate employees based on the priorities and needs of each organization to meet the intention of this MOU. |
| DOE and EPA (2024)[161] | DOE will coordinate with EPA on the scope, objectives, research results, and associated funding of mutually agreed cooperative research and/or training activities. DOE will not make recommendations regarding future or potential EPA regulatory activities in response to technical information requests.<br><br>EPA will provide oversight and direction of its own work, funding authorization, and mission and objectives. EPA will coordinate with DOE on the scope, objectives, research results, and associated funding of mutually agreed cooperative research and/or training activities.<br><br>EPA will neither make recommendations regarding specific siting, design or facility concepts nor participate in any DOE site selection process. |
| NRC and FDA (2023)[162] | The NRC and the FDA agree to inform each other, as appropriate and permitted by law, as soon as possible, but no later than 30 calendar days whenever either agency identifies a significant product complaint, allegation, medical incident, or emergency that involves the products that are covered by this MOU or becomes aware through notification, inspection, or surveillance mechanisms at either agency of a significant potential public health problem such as a malfunction, failure, or medical incident involving a product covered by this MOU.<br><br>The Parties may consider performing joint inspections or other collaborations when appropriate and as permissible by law, and as resources permit. In addition, both Parties will discuss providing technical expertise for planning, performance, or review in areas of mutual interest, subject to program priorities and availability of funds and personnel.<br><br>FDA and NRC may assist each other to the extent appropriate and as permissible by law, and as resources allow, to investigate incidents, complaints, or other situations involving products covered by this MOU. |

| | |
|---|---|
| | Upon request by the FDA, the NRC will promptly notify NRC licensees and Agreement State Program Directors of any public health issues or other important user communications initiated by the FDA and intended for public dissemination.<br><br>the FDA and the NRC may share information concerning jointly regulated products, new technology or methods under development or review, including devices for which regulations or the NRC's 10 CFR Part 35, Subpart K guidance(s) are being, or has not yet been, developed and that are of mutual regulatory interest. |
| NRC and DOE (2023)[163] | Establishing Roles and Responsibilities for National Environmental Policy Act (NEPA) Implementation Requirements for Reactor Demonstration Projects Supported by DOE Addendum No. 7 to the Nuclear Energy Innovation Capabilities Act Memorandum of Understand. |
| NRC and OSHA (2013)[65] | NRC Responsibilities<br><br>The NRC is responsible for licensing and regulating the nation's civilian use of byproduct, source and special nuclear materials in order to assure the adequate protection of the public health and safety, promote the common defense and security, and to protect the environment. However, the NRC does not have statutory authority to protect against industrial safety and health hazards that do not involve the use or consequences of licensed radioactive materials.<br><br>OSHA Responsibilities<br><br>Under the OSH Act, every employer has a general duty to furnish each employee with employment and a place of employment that is free from recognized hazards that are causing or are likely to cause death or serious physical harm and to comply with all OSHA standards, rules, and regulations (29 U.S.C. 654(a) and 666). In order to minimize workplace hazards, NRC licensees are required to comply with OSHA's standards and regulations. OSHA has authority to regulate employee exposures from all radiation sources not regulated by the NRC. Examples of these radiation sources include x-ray equipment, some accelerators, incidental accelerator-produced radioactive materials, electron microscopes, betatrons, ion implanters, experimental particle physics research colliders (only when used to probe the fundamental properties of nature), and naturally occurring radioactive materials. |
| NRC and EPA (2002)[164] | For NRC-licensed sites at which NRC determines during the license termination process that there is radioactive ground-water contamination in excess of EPA's MCLs, or for which NRC contemplates either restricted release (10 CFR 20.1403) or the use of alternate criteria for license termination (10 CFR 20.1404), NRC will seek EPA's expertise to assist in NRC's review of a decommissioning or license termination plan. In addition, NRC will consult with EPA if either the planned level of residual radioactive soil concentrations in the proposed action or the actual residual level of radioactive soil concentrations found in the final site survey exceed the radioactive soil concentration in Table 1. With respect to all such sites, the NRC will consult with EPA on the application of the NRC decommissioning requirements and will take such action as the NRC determines to be appropriate based on its consultation with EPA. |

| | |
|---|---|
| | If the NRC requests EPA's consultation on a decommissioning plan or license termination plan, EPA will provide, within 90 days of NRC's notice to EPA, written notification of its views on the matter. |
| NRC and FDA (2002)[165] | The purpose of this Memorandum of Understanding (MOU) is to coordinate existing NRC and FDA regulatory programs for (1) medical devices, drugs, and biological products utilizing byproduct, source, or special nuclear material; and (2) the use of potassium iodide (KI) in response to events involving accidental release of radioactive iodine. These regulatory programs include activities for evaluating and authorizing the manufacture, sale, distribution, licensing, and labeled intended use of such products.<br><br>FDA is responsible for assuring the safety, effectiveness, and proper labeling of medical products, i.e., drugs, devices, and biological products.<br><br>NRC is responsible for licensing and regulating nuclear facilities and material and for conducting research in support of the licensing and regulatory process, as mandated by the Atomic Energy Act of 1954, as amended; the Energy Reorganization Act of 1974, as amended; and in accordance with the National Environmental Policy Act of 1969, as amended, and other applicable statutes. NRC responsibilities include protecting public health and safety, protecting the environment, and safeguarding materials in the interest of national security.<br><br>Upon request, FDA and NRC will assist each other, to the fullest extent possible, in the investigation of incidents or complaints involving products of mutual regulatory concern. Both agencies will make every reasonable effort to accommodate joint inspection or observer requests depending upon availability of personnel and current FDA or NRC priorities. Each agency will assign one or more persons to assure that investigations are coordinated in a manner that maximizes regulatory efficiency and minimizes duplication of effort. Each agency will promptly notify the other when there is a change in an assigned contact person. |
| OSHA and DOE (1994)[166] | DOE and OSHA will, to the fullest extent possible, cooperate and coordinate at all organizational levels to develop and carry out information exchange, technical and professional assistance, referrals of alleged violations, and related matters concerning compliance and law enforcement activity to ensure the health and well-being of the workforce and the general public.<br><br>Resolution of policy issues concerning agency jurisdiction and operations will be coordinated by appropriate DOE and OSHA staff with input from the Office of the Solicitor. DOE and OSHA will designate points of contact for carrying out interface activities.<br><br>The whistleblower protection provisions of the Energy Reorganization Act, 42 U.S.C. Section 5851, as well as those in section 11(c) of the OSH Act, 29 U.S.C. Section 660(c), are applicable to employees of USEC and contractors at USEC administered facilities. |
| FDA and OSHA (1974)[167] | FDA responsibilities:<br><br>Prior to the issuance of standards by FDA under the Radiation Control for Health and Safety Act to control the emissions of radiation from electronic products, representatives of FDA will consult representatives of OSHA, during |

| | |
|---|---|
| | the development stage of the standards, for advice to further assure that the FDA standards will be compatible with OSHA standards relating to radiation or other occupational safety and health hazards. If FDA in its routine compliance program involving an environment has reason to believe that occupational factors are present which may raise questions under the Act, FDA will advise OSHA of its findings.<br><br>OSHA responsibilities:<br><br>Prior to the issuance of standards developed under the Act related to radiation from electronic products, representatives of OSHA will consult with FDA during the developmental stage to assure that the radiation safety and health regulations established by OSHA are compatible with the Federal performance standard for electronic product radiation emissions established by FDA. If OSHA in its routine compliance program involving an occupational environment has reason to believe that there are factors present which may indicate a possible violation of FDA standards, OSHA will advise FDA of its findings.<br><br>Shared responsibilities of OSHA and FDA:<br><br>In States with an approved State plan under Section 18 of the Act, OSHA will encourage State safety and health officials to cooperate with State radiological health officials in the enforcement and the standard setting efforts relating to performance standards for electronic product radiation.<br><br>Exchange procedures and techniques used in determining compliance with the appropriate regulations promulgated by each agency.<br><br>Cooperate in the enforcement efforts and thereby avoid duplication of efforts for the purpose of assuring the full safety and health protection of both the employers and the public.<br><br>Meet on a quarterly basis, or more often as required, to implement and carry out this memorandum. |

## *Appendix VII: State Regulatory Landscape*[66,67,71,168]

| State | Agreement State | OSHA State Plan** | Dosage limit | Dosimetry requirements | PPE requirements (list specifics if documented in reg) | Licensure *** | State Radiation Protection Program or Agency | Radioactive Materials Program |
|---|---|---|---|---|---|---|---|---|
| Alabama | Yes | Federal Plan | NRC standard + 0.5 rem for pregnant women | NRC standard | No explicit PPE statute (NRC default). Respiratory equipment - NISOH certified. | Yes | Alabama Public Health: Radiation Control | Alabama Public Health: Radiation Control |
| Alaska | No | State Plan** | NRC standard + 0.5 rem for pregnant women | No state statute - NRC standard applies | No explicit PPE statute (NRC default) | Yes | Alaska Department of Health and Social Services, Division of Public Health: Radiological Health | NRC oversite |
| Arizona | Yes | Federal Plan | NRC standard + 0.5 rem for pregnant women | NRC standard | No explicit PPE statute (NRC default). Respiratory equipment - NISOH certified. | Yes | Arizona Department of Health Services: Bureau of Radiation Control | Arizona Bureau of Radiation Control |
| Arkansas | Yes | Federal Plan | NRC standard + 0.5 rem for pregnant women | NRC standard | No explicit PPE statute (NRC default). Respiratory equipment - NISOH certified. | Yes | Arkansas Department of Health: Radiation Control | Arkansas Department of Health: Radiation Control |
| California | Yes | State Plan** | NRC standard | No state statute - NRC standard applies | General PPE statute (NRC default or vague language). Respiratory equipment - NISOH certified. | Yes | California Department of Public Health: Division of Radiation Safety and Environmental Management | California Department of Public Health: Radiologic Health Branch |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Colorado | Yes | Federal Plan | NRC standard + 0.5 rem for pregnant women | NRC standard | Require 0.5 mm protection for direct radiation and 0.25 mm protection for scatter radiation. Respiratory equipment - NISOH certified. | Yes | Colorado Department of Public Health and Environment: Radiation Management | Colorado Department of Public Health and Environment: Radioactive Materials Unit |
| Connecticut | LOI * | State Plan** | OSHA standard + NRC standard (0.5 rem) for pregnant women | NRC standard | Require 0.5 mm protection of lead equivalent for direct radiation and 0.25 mm protection for scatter radiation. Mention of thyroid shields. | Yes | Connecticut Department of Energy and Environmental Protection: Radiation | NRC oversite |
| Delaware | No | Federal Plan | NRC standard + 0.5 rem for pregnant women | NRC standard | Require at least 0.5 mm protection of lead equivalent material from direct radiation and at least 0.25 mm lead equivalent material from secondary radiation. Respiratory equipment - NISOH certified. | Yes | Delaware Office of Radiation Control | NRC oversite |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Florida | Yes | Federal Plan | NRC standard + 0.5 rem for pregnant women | NRC standard. Finger or wrist dosimetric devices: shall be worn for analytical x-ray equipment workers and personnel maintaining analytical x-ray equipment. | Require at least 0.5 mm protection of lead equivalent material from direct radiation and at least 0.25 mm lead equivalent material from secondary radiation. Respiratory equipment - NISOH certified. | Yes | Florida Health: Radiation Control | Florida Health: Radioactive Materials |
| Georgia | Yes | Federal Plan | OSHA standard + NRC standard (0.5 rem) for pregnant women | State statute requiring radiographers - must wear a combination of a direct-reading dosimeter, an alarming ratemeter, and a personal monitoring device. No state statute for other employees -- NRC standard applies | Require at least 0.25 mm lead equivalent material from secondary radiation. Respiratory equipment - NISOH certified. | Yes | Georgia Environmental Protection Division: Radiation Protection Programs | Georgia Environmental Protection Division: Radiation Protection Programs |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Hawaii | No | State Plan** | | State statute requires radiographers to wear a direct reading pocket dosimeter, an alarm ratemeter, and either a film badge or a thermolumine scent dosimeter (TLD). NRC standard applies | Require at least 0.5 mm protection of lead equivalent material from direct radiation and at least 0.25 mm lead equivalent material from secondary radiation. | Yes | Hawaii Indoor and Radiological Health Branch | NRC oversite |
| Idaho | No | Federal Plan | OSHA standard | OSHA standard | Require at least 0.5 mm protection of lead equivalent material from direct radiation and at least 0.25 mm lead equivalent material from secondary radiation. | Yes | Idaho Department of Health and Welfare: X-ray Licensure | NRC oversite |
| Illinois | Yes | State Plan** | NRC standard + 0.5 rem for pregnant women | NRC standard | Require at least 0.25 mm lead equivalent material from secondary radiation. State law defines protective apron as one that is made of radiation attenuating materials, at least 0.25-mm lead equivalent. Respiratory equipment - NISOH certified. | Yes | Illinois Emergency Management Agency: Nuclear and Radiation Safety | Illinois Emergency Management Agency: Radioactive Materials |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Indiana | LOI *** | State Plan** | OSHA standard | OSHA standard. Finger or wrist dosimetric devices: required for analytical x-ray equipment workers or personnel maintaining such equipment. | Require at least 0.5 mm protection of lead equivalent material from direct radiation and at least 0.25 mm lead equivalent material from secondary radiation. Respiratory equipment - NVLAP certified. | Yes | Indiana State Department of Health: Medical Radiology Services Program | NRC oversite |
| Iowa | Yes | State Plan** | NRC standard + 0.5 rem for pregnant women | NRC standard | Require at least 0.5 mm protection of lead equivalent material from direct radiation and at least 0.25 mm lead equivalent material from secondary radiation. Respiratory equipment - NISOH certified. | Yes | Iowa Department of Public Health: Bureau of Radiological Health | Iowa Department of Public Health: Radioactive Materials Program |
| Kansas | Yes | Federal Plan | NRC standard + 0.5 rem for pregnant women | NRC standard State statute requiring radiographers must wear a combination of a direct-reading dosimeter, an alarming ratemeter, and a personal monitoring device. | No explicit PPE statute. (NRC default) | Yes | Kansas Department of Health and Environment: Radiation Control Program | Kansas Department of Health and Environment: Radioactive Materials and Licensing |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Kentucky | Yes | State Plan** | NRC standard + 0.5 rem for pregnant women | NRC standard | No statute delineating when PPE should be used, but there are definitions. Protective apron means an apron made of radiation absorbing materials of at least 0.25 mm lead equivalency and protective barrier means a barrier of radiation absorbing material used to reduce radiation exposure and Protective glove means a glove made of radiation absorbing materials at least 0.25 mm lead equivalent. | Yes | Kentucky Cabinet for Health and Family Services: Radiation Health Branch | Kentucky Cabinet for Health and Family Services: Radioactive Materials Program |
| Louisiana | Yes | Federal Plan | NRC standard + 0.5 rem for pregnant women | No state statute. NRC standard will apply | Require at least 0.5 mm protection of lead equivalent material from direct radiation and at least 0.25 mm lead equivalent material from secondary radiation. Mention of lead vests/aprons. Respiratory equipment - NISOH certified. | Yes | Louisiana Department of Environmental Quality: Emergency and Radiological Services Division | Louisiana Department of Environmental Quality: Emergency and Radiological Services Division |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Maine | Yes | State Plan** | NRC standard + 0.5 rem for pregnant women | NRC standard | Require at least 0.5 mm protection of lead equivalent material from direct radiation and at least 0.25 mm lead equivalent material from secondary radiation. | Yes | Maine Division of Environmental and Community Health: Radiation Control Program | Maine Division of Environmental and Community Health: Radioactive Materials Section |
| Maryland | Yes | State Plan** | NRC standard + 0.5 rem for pregnant women | No state statute. NRC standard will apply | No explicit PPE statute. (NRC default) | Yes | Maryland Department of the Environment: Radiological Health Program | Maryland Department of the Environment: Radioactive Materials Licensing |
| Massachusetts | Yes | State Plan** | NRC standard + 0.5 rem for pregnant women | NRC standard | Require at least 0.5 mm protection of lead equivalent material from direct radiation and at least 0.25 mm lead equivalent material from secondary radiation. | Yes | Massachusetts Radiation Control | Massachusetts Radiation Control: Radioactive Materials Licensing |
| Michigan | No | State Plan** | NRC standard + 0.5 rem for pregnant women | NRC standard | Require at least 0.5 mm protection of lead equivalent material from direct radiation and lead aprons, vests, and gloves mentioned. | Yes | Michigan Occupational Safety & Health Administration: Radiation Safety | NRC oversite |
| Minnesota | Yes | State Plan** | NRC standard + 0.5 rem for pregnant women | NRC standard | Require at least 0.5 mm protection of lead equivalent material from direct radiation and thyroid shields mentioned. | Yes | Minnesota Department of Health: Radiation Control | Minnesota Department of Health: Radioactive Materials |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Mississippi | Yes | Federal Plan | Annual limit: 5 rem the whole body, the head and trunk, active blood-forming organs, gonads, or lens of eye is; 7.5 rem to hands and forearms, feet and ankles, localized area of skin; and 1.5 rem to other organs. No statute for pregnancy. | Dosimeters should be worn whenever protective clothing or devices are worn | Require at least 0.5 mm protection of lead equivalent material from direct radiation and at least 0.25 mm lead equivalent material from secondary radiation. | Yes | Mississippi Division of Radiological Health | Mississippi Division of Radiological Health |
| Missouri | No | Federal Plan | Combined annual and quarterly limits: 5 rem annual/3 rem quarterly to the while body, head and trunk, major portion of the bone marrow, gonads, or lens of the eye; 30 rem annual/10 rem quarterly to the skin of a large body area; and 75 rem annual/25 rem quarterly to hands, forearms, feet and ankles. No statute for pregnancy. | Dosimeters required when there is any reasonable possibility of receiving a weekly dose ≤ 50 mrem | No explicit PPE statute (NRC default) | Yes | Missouri Department of Health & Senior Services: Radiation Control | NRC oversite |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Montana | No | Federal Plan | OSHA standard | OSHA standard | No explicit PPE statute (NRC default) | Yes | Montana Department of Public Health and Human Resources: Radiation Machine Registration | NRC oversite |
| Nebraska | Yes | Federal Plan | NRC aligned (annual limit: 5 rem (whole body), 15 rem (eye), and 50 rem (skin/extremities)) - 0.5 rem for pregnant women. | NRC standard | Require ≥ 0.5 mm protection of lead equivalent material in high risk settings and mention of lead aprons and thyroid shields. | Yes | Nebraska Department of Health & Human Services: Radiation Control | Nebraska Department of Health and Human Services: Radioactive Materials |
| Nevada | Yes | State Plan** | NRC aligned (annual limit: 5 rem (whole body), 15 rem (eye), and 50 rem (skin/extremities)) - 0.5 rem for pregnant women. | NRC standard | No explicit PPE statute (NRC default) | Yes | Nevada Radiation Control Program | Nevada Radioactive Material Program |
| New Hampshire | Yes | Federal Plan | NRC aligned (annual limit: 5 rem (whole body), 15 rem (eye), and 50 rem (skin/extremities)) - 0.5 rem for pregnant women. | NRC standard | Require at least 0.5 mm protection of lead equivalent material from direct radiation and at least 0.25 mm lead equivalent material from secondary radiation. Mention of lead aprons, eyewear, and thyroid shields. Respiratory equipment - NISOH certified. | Yes | New Hampshire Department of Health and Human Services: Radiological Health | New Hampshire Radioactive Materials Program |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| New Jersey | Yes | State Plan** | NRC standard + 0.5 rem for pregnant women | NRC standard | General PPE statute (NRC default or vague language) | Yes | State of New Jersey Department of Environmental Protection: Radioactive Materials Program | State of New Jersey Department of Environmental Protection: Radioactive Materials Program |
| New Mexico | Yes | State Plan** | NRC standard + 0.5 rem for pregnant women | NRC standard | No explicit PPE statute (NRC default) | Yes | New Mexico Environment Department: Radiation Control Bureau | New Mexico Environment Department: Radioactive Materials |
| New York | Yes | State Plan** | NRC standard + 0.5 rem for pregnant women | NRC standard | Require at least 0.5 mm protection of lead equivalent material from direct radiation and at least 0.25 mm lead equivalent material from secondary radiation. Mention of lead aprons, eyewear, thyroid shields, and other shielding. Respiratory equipment - NISOH certified. | Yes | New York State Department of Health: Radiological Health | New York State Department of Health: Radioactive Materials Licensing |
| North Carolina | Yes | State Plan** | NRC standard + 0.5 rem for pregnant women | NRC standard | General PPE statute (NRC default or vague language) | Yes | North Carolina Radiation Protection Section | North Carolina Radiation Protection Section |
| North Dakota | Yes | Federal Plan | NRC standard + 0.5 rem for pregnant women | NRC standard | No explicit PPE statute (NRC default) | Yes | North Dakota Radiation Control Program | North Dakota Radiation Control Program |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Ohio | Yes | Federal Plan | NRC standard + 0.5 rem for pregnant women | NRC standard | General PPE statute (NRC default or vague language). Mention of shielding requirements for equipment. | Yes | Ohio Department of Health; Radiological Health and Safety | Ohio Department of Health; Radioactive Materials Licensing and Inspection |
| Oklahoma | Yes | Federal Plan | NRC standard + 0.5 rem for pregnant women | NRC standard | No explicit PPE statute (NRC default) | Yes | Oklahoma Department of Environmental Quality: Radiation Management | Oklahoma Department of Environmental Quality: Radiation Management |
| Oregon | Yes | State Plan** | NRC standard + 0.5 rem for pregnant women | NRC standard | No explicit PPE statute (NRC default) | Yes | Oregon Radiation Protection Services | Oregon Radioactive Materials Licensing |
| Pennsylvania | Yes | Federal Plan | NRC standard + 0.5 rem for pregnant women | NRC standard | No explicit PPE statute (NRC default) | Yes | Pennsylvania Radiation Protection Programs | Pennsylvania Radioactive Materials Licensing Program |
| Rhode Island | LOI *** | Federal Plan | NRC standard + 0.5 rem for pregnant women | NRC standard | No explicit PPE statute (NRC default) | Yes | Rhode Island Department of Health: Radiological Health Program | Rhode Island Department of Health: Radioactive Material |
| South Carolina | Yes | State Plan** | NRC standard + 0.5 rem for pregnant women | NRC standard | No explicit PPE statute (NRC default) | Yes | Radioactive Materials (Title A) | Radioactive Material Licensing and Compliance |
| South Dakota | Yes | Federal Plan | NRC standard + 0.5 rem for pregnant women | NRC standard | No explicit PPE statute (NRC default) | Yes | South Dakota Department of Environment & Natural Resources: Radioactive Materials and Radiation Machines | NRC oversite |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Tennessee | Yes | State Plan** | NRC standard + 0.5 rem for pregnant women | NRC standard | General PPE statute (NRC default or vague language) | Yes | Tennessee Department of Environment & Conservation: Radiation | Tennessee Radioactive Material and X-Ray Permits |
| Texas | Yes | Federal Plan | NRC standard + 0.5 rem for pregnant women | NRC standard | Require at least 0.5 mm protection of lead equivalent material from direct radiation. Mention of lead aprons, eyewear, thyroid shields, and other shielding. | Yes | Texas Department of Health Services: Radiation Control Program | Texas Department of Health Services: Radiation Control Program |
| Utah | Yes | State Plan** | NRC standard + 0.5 rem for pregnant women | NRC standard | No explicit PPE statute (NRC default) | Yes | Utah Division of Waste Management and Radiation Control | Utah Radioactive Materials Regulatory Program |
| Vermont | Yes | State Plan** | NRC standard + 0.5 rem for pregnant women | NRC standard | No explicit PPE statute (NRC default) | Yes | Vermont Health and the Environment: Radiological Health | Vermont Radioactive Materials Program |
| Virginia | Yes | State Plan** | NRC standard + 0.5 rem for pregnant women | NRC standard | No explicit PPE statute (NRC default) | Yes | Virginia Department of Health: Radiological Health | Virginia Department of Health Radioactive Materials Program |
| Washington | Yes | State Plan** | NRC standard + 0.5 rem for pregnant women | NRC standard | No explicit PPE statute (NRC default) | Yes | Washington State Department of Health: Radiation Protection | Washington State Department of Health: Radioactive Materials |
| West Virginia | LOI *** | Federal Plan | NRC standard + 0.5 rem for pregnant women | NRC standard | No explicit PPE statute (NRC default) | Yes | West Virginia Radiological Health Program | NRC oversite |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Wisconsin | Yes | Federal Plan | NRC standard + 0.5 rem for pregnant women | NRC standard | General PPE statute (NRC default or vague language) | Yes | Wisconsin Department of Health Services: Radiation Protection | Wisconsin Department of Health Services: Radioactive Materials Program |
| Wyoming | Yes | State Plan** | NRC standard + 0.5 rem for pregnant women | NRC standard | No explicit PPE statute (NRC default) | Yes | Wyoming Homeland Security: Radiological Services | Wyoming Homeland Security: Radiological Services |

** Letter of Intent (LOI) state.*
*** State Plan includes private workers in addition to state and local government workers*
**** Licensure required for radiation oncologists and medical physicists*
*Dose:*
*NRC Standard - Annual limit of 15 rem to lens of the eye & 50 rem to skin/extremities*
*OSHA Standard - Quarterly limit: 1.25 rem to whole body (head and trunk; active blood-forming organs; lens of eyes; or gonads); 18.75 rem to hands forearms and ankles; and 7.5 rem to skin of whole body.*
*Dosimetry:*
*NRC Standard - Dosimeter required for: adults likely to receive ≤ 10% and minors likely to receive a deep dose ≤ 0.1 rem, a lens dose ≤ 0.15 rem, or a shallow dose ≤ 0.5 rem*
*OSHA Standard - Dosimeter required for individuals likely to receive an annual dose ≤ 25% of the limit; minors where they'll likely receive ≤ 5% of their limit quarterly.*

***Appendix VIII: Existing AMA policy on radiation***

**H-455.994 Risks of Nuclear Energy and Low-Level Ionizing Radiation**

1. Our American Medical Association supports the following policy on nuclear energy and low-level ionizing radiation. Usefulness of Nuclear Energy: Energy produced by nuclear reactors makes an important contribution to the generation of electricity in the US at present, and it will continue to do so in the foreseeable future. Investigation and research should continue in order to develop improved safety and efficiency of nuclear reactors, and to explore the potential of competing methods for generating electricity. The research should include attention to occupational and public health hazards as well as to the environmental problems of waste disposal and atmospheric pollution.
2. Research on Health Effects of Low Level Radiation: There should be a continuing emphasis on research that is capable of determining more precisely the health effects of low level ionizing radiation.
3. Uranium Mill Tailings: Uranium mill tailings should be buried or otherwise covered.
4. Radioactive Waste Disposal: There should be acceleration of pilot projects to evaluate techniques for the disposal of high-level radioactive wastes. The decommissioning of nuclear reactors is a source of nuclear waste which requires accelerated technological investigation and planning.
5. Occupational Safety: The philosophy of maintaining exposures of workers at levels "as low as reasonably achievable (ALARA)" is commended. The present federal standards for occupational exposure to ionizing radiation are adequate. The responsibilities of the various federal agencies regarding workers in the nuclear energy industry should be clarified; these agencies include the Departments of Energy, Defense, HHS, Labor and Transportation; and the NRC, VA and EPA.
6. Minimizing Exposures to Radiation: Each physician should attempt to minimize exposures of patients to ionizing radiation in accord with good medical practice.
7. Radiation Exposure Standards: The present standards for exposure of populations to ionizing radiation are adequate for the protection of the public.
8. Emergencies and Governmental Readiness: Government agencies at all levels should be prepared to respond to nuclear energy-related emergencies. There is need for improved public planning by the several federal agencies involved, including the Federal Emergency Management Agency (FEMA) and the agencies of state and local governments. Responsible officials should develop skills and undergo periodic retraining in order to be able to act appropriately during major radiation emergencies. Because emergency planning is a complex task involving aspects of health as well as problems related to utilities, state and local governments and the federal government (FEMA) would benefit from the cooperation of physicians and others in the health sciences.
9. Federal Radiation Emergency Planning Responsibilities: Federal groups such as the NRC and FEMA must work together closely to fulfill responsibilities in radiological emergency preparedness and in crisis management. There is a need for NRC and FEMA to define better the roles of community hospitals and of physicians.
10. Reactor Operators and Radiation Inspectors: There is a need for better training of operating personnel with regard to prevention and management of untoward reactor operating conditions. Selection, training, and ongoing performance evaluation of operating personnel, and of radiation inspectors, are key elements in the safety of reactor workers and of the public. Physicians should help develop methods of selecting and evaluating personnel in the nuclear power industry.
11. Radiation Training for Physicians: Physicians should be prepared to answer the questions of their patients about ionizing radiation, especially if there is a radiation emergency. Each

hospital should have adequately trained physicians and a plan and protocol for receiving and caring for radiation victims.

12. Radiation Education for the Public: Further education of the public about ionizing radiation is recommended.
13. Location of Nuclear Reactors: All nuclear reactors built in the future should be placed in areas of low population density; present reactors located in low density areas should be managed so that the populations surrounding them remain small.
14. Multiple Sources of Power Generation: AMA recommends the use of a diverse set of electricity generating methods and a continuing emphasis on the conservation of energy.
15. X-Ray Security Scanners:
    1. Our AMA believes that as of June 2013, no data exist to suggest that individuals, including those who are especially sensitive to ionizing radiation, should avoid backscatter security scanners due to associated health risks.
    2. Our AMA supports the adoption of routine inspection, maintenance, calibration, survey, and officer training procedures meant to ensure that backscatter security scanners operate as intended.
16. Our AMA supports continued authorization of federal radiation exposure compensation programs and expanded program eligibility to downwind individuals, communities, and tribes affected by the ongoing environmental harms of historic atomic weapons testing, including, but not limited to, residents of areas affected by the test of the first atomic bomb in New Mexico and uranium miners employed between 1942 through 1990. [CSA Rep. A, A-81Reaffirmed: CLRPD Rep. F, I-91Reaffirmed: Sunset Report, I-01Reaffirmed: CSAPH Rep. 1, A-11Appended: CSAPH Rep. 4, A-13Modified: CSAPH Rep. 8, A-23Modified: Res. 435, A-24]

**H-455.976 Monitoring Patient Exposure to Ionizing Radiation**
Our American Medical Association will support public health, radiology and radiation oncology specialty societies and all other interested parties to monitor the issue of radiation exposure to the American public and develop a plan, if appropriate, to allow the ongoing monitoring and quantification of radiation exposure sustained by individual patients in medical settings. [CSAPH Rep. 8, A-23]

**H-455.975 Regulation of Ionizing Radiation Exposure for Health Care Workers**
Our American Medical Association encourages public and private healthcare institutions to ensure comprehensive coverage of different body types by providing readily available PPE that reduces exposure to as low as reasonably achievable for employees of all genders and pregnancy statuses. Our AMA will work with the appropriate and interested parties to study how best to accomplish comprehensive protection from ionizing radiation for employees, taking into account variation in body types, pregnancy status, specifics of procedures being performed, as well as how exposure can be limited beyond PPE (personal protected equipment), with report back at I-25. [Res. 904, I-24]

**H-455.977 Ionizing Radiation Exposure in the Medical Setting**

1. Our American Medical Association will support appropriate specialty medical societies and other interested stakeholders to collaborate:
    a. For feasibility of monitoring and quantifying the cumulative radiation exposure sustained by individual patients in medical settings.
    b. Continue to educate physicians and the public on the appropriate use and risks of low linear energy transfer radiation in order to reduce unnecessary patient exposure in the medical setting.
2. Our AMA will continue to monitor the National Academy of Sciences' ongoing efforts to study the impact of low levels of low linear energy transfer radiation on human health.

3. Our AMA will support education and standards for all providers and medical personnel using ionizing and non-ionizing radiation that includes awareness of, and methods to avoid, patient over-radiation.
4. Our AMA will support policies that promote the safe use of medical imaging devices, informed clinical decision-making regarding the use of procedures that use radiation, and patient awareness of medical radiation exposure.
5. Our AMA will encourage the continued development and use of standardized electronic medical record systems that will help physicians track the number of imaging procedures a patient is receiving, in both the in-patient and out-patient settings, which will help physicians discuss the potential dangers of high level of radiation exposure with patients. [CSAPH Rep. 8, A-23].

**H-455.996 Nuclear Regulatory Commission Licensure Requirements for Physicians**
Our AMA urges the U.S. Nuclear Regulatory Commission to continue to require that the training requisite for licensure be documented, and that it contain elements of instruction in radiological physics, radiation biology, radiation safety, nuclear instrumentation, and the safe and effective clinical use of radionuclides in patients. [Res. 148, A-80Reaffirmed: CLRPD Rep. B, I-90Modified: Sunset Report, I-00Reaffirmed: CSAPH Rep. 1, A-10Reaffirmed: CSAPH Rep. 01, A-20]

**H-455.978 Nuclear Regulatory Commission Medical Use Program**
The AMA encourages the efforts of the Nuclear Regulatory Commission to assure that any regulations that affect the practice of nuclear medicine and radiology be science-based. [Sub. Res. 516, I-97Reaffirmed: CSAPH Rep. 3, A-07Reaffirmed: CSAPH Rep. 01, A-17]

**D-455.993 Interference with Practice of Medicine by the Nuclear Regulatory Commission**
Our AMA will express its opposition to the imminent proposed changes to the Section 10 CFR Part 35.390(b) by the Nuclear Regulatory Commission (NRC) which would weaken the requirements for Authorized Users of Radiopharmaceuticals (AUs), including shortening the training and experience requirements, the use of alternative pathways for AUs, and expanding the use of non-physicians, with AMA advocacy for such opposition during the open comment period ending July 3, 2019. [Res. 719, A-19]

**H-135.985 Environmental Protection and Safety in Federal Facilities**
The AMA urges physicians to contribute to the solution of environmental problems by serving as knowledgeable and concerned consultants to environmental, radiation, and public health protection agencies of state and local governments. [BOT Rep. T, I-87Reaffirmed: Sunset Report, I-97Reaffirmed: CSAPH Rep. 3, A-07Reaffirmed: CSAPH Rep. 01, A-17]

**H-455.988 Public Education on the Danger of Radiation Exposure**
Our American Medical Association supports public initiatives, such as the "Image Wisely" and "Image Gently" campaigns, which aim to increase awareness of radiation in the medical setting and reduce exposure. [Res. 121, A-86Reaffirmed: Sunset Report, I-96Reaffirmed: CSAPH Rep. 3, A-06Appended: Res. 921, I-11Modified: CSAPH Rep. 1, A-21]

**H-455.993 Treatment of Radiation Accident Victims**
1. Our American Medical Association encourages all acute care facilities, through their medical staffs, to review and become familiar with radiation accident contingency plans required by the JCAHO, particularly those facilities in areas where major radiation-emitting equipment is located.

2. Our AMA supports the development of guidelines for training and preparedness of medical staffs, proper treatment regimens and the maintenance and use of decontamination equipment for use at the time of radiation accidents. [Res. 36, I-81Reaffirmed: CLRPD Rep. F, I-91Reaffirmed: Sunset Report, I-01Reaffirmed: CSAPH Rep. 1, A-11Reaffirmed: CSAPH Rep. 1, A-21]

**H-460.938 Effects of Electric and Magnetic Fields**
Our American Medical Association will continue to monitor developments and issues related to the effects of electric and magnetic fields, even though no scientifically documented health risk has been associated with the usually occurring levels of electromagnetic fields.
Our AMA encourages research efforts sponsored by agencies such as the National Institutes of Health, U.S. Department of Energy, and the National Science Foundation to continue on exposures to

**REFERENCES**


1. Smith-Bindman R, Chu PW, Azman Firdaus H, et al. Projected Lifetime Cancer Risks From Current Computed Tomography Imaging. *JAMA Internal Medicine*. 2025;185(6):710-719. doi:10.1001/jamainternmed.2025.0505

2. Radiation Safety Resources. Accessed July 16, 2025. https://www.acr.org/Clinical-Resources/Clinical-Tools-and-Reference/radiology-safety/radiation-safety

3. CDC. Guidelines for ALARA – As Low As Reasonably Achievable. Radiation and Your Health. February 26, 2024. Accessed July 16, 2025. https://www.cdc.gov/radiation-health/safety/alara.html

4. US EPA O. Safer Choice Criteria for Fragrances. January 17, 2014. Accessed February 13, 2025. https://www.epa.gov/saferchoice/safer-choice-criteria-fragrances

5. CDC. Facts About X-Rays. Radiation and Your Health. February 20, 2024. Accessed July 16, 2025. https://www.cdc.gov/radiation-health/data-research/facts-stats/x-rays.html

6. Health C for D and R. Medical X-ray Imaging. FDA. August 15, 2023. Accessed July 16, 2025. https://www.fda.gov/radiation-emitting-products/medical-imaging/medical-x-ray-imaging

7. Sharkey AR, Gambhir P, Saraskani S, et al. Occupational radiation exposure in doctors: an analysis of exposure rates over 25 years. *British Journal of Radiology*. 2021;94(1127):20210602. doi:10.1259/bjr.20210602

8. Briggs B, Kalra S, Panacek E. Risk of Radiation Exposure to Emergency Department Personnel From Portable Radiographs. *J Emerg Med*. 2022;63(5):645-650. doi:10.1016/j.jemermed.2022.08.002

9. Jenkins NW, Parrish JM, Sheha ED, Singh K. Intraoperative risks of radiation exposure for the surgeon and patient. *Ann Transl Med*. 2021;9(1):84. doi:10.21037/atm-20-1052

10. Amis ES, Butler PF, Applegate KE, et al. American College of Radiology White Paper on Radiation Dose in Medicine. *Journal of the American College of Radiology*. 2007;4(5):272-284. doi:10.1016/j.jacr.2007.03.002

11. Frane N, Bitterman A. Radiation Safety and Protection. In: *StatPearls*. StatPearls Publishing; 2025. Accessed July 16, 2025. http://www.ncbi.nlm.nih.gov/books/NBK557499/

12. Kim TW, Jung JH, Jeon HJ, Yoon KB, Yoon DM. Radiation Exposure to Physicians During Interventional Pain Procedures. *Korean J Pain*. 2010;23(1):24-27. doi:10.3344/kjp.2010.23.1.24

13. Chartier H, Fassier P, Leuraud K, et al. Occupational low-dose irradiation and cancer risk among medical radiation workers. *Occup Med (Lond)*. 2020;70(7):476-484. doi:10.1093/occmed/kqaa130

14. Little MP, Azizova TV, Richardson DB, et al. Ionising radiation and cardiovascular disease: systematic review and meta-analysis. *BMJ*. Published online March 8, 2023:e072924. doi:10.1136/bmj-2022-072924

15. Manenti G, Coppeta L, Kirev IV, et al. Low-Dose Occupational Exposure to Ionizing Radiation and Cardiovascular Effects: A Narrative Review. *Healthcare*. 2024;12(2):238. doi:10.3390/healthcare12020238

16. Elmaraezy A, Ebraheem Morra M, Tarek Mohammed A, et al. Risk of cataract among interventional cardiologists and catheterization lab staff: A systematic review and meta-analysis. *Catheter Cardiovasc Interv*. 2017;90(1):1-9. doi:10.1002/ccd.27114

17. Della Vecchia E, Modenese A, Loney T, et al. Risk of cataract in health care workers exposed to ionizing radiation: a systematic review. *Med Lav*. 2020;111(4):269-284. doi:10.23749/mdl.v111i4.9045

18. Jacob S, Boveda S, Bar O, et al. Interventional cardiologists and risk of radiation-induced cataract: results of a French multicenter observational study. *Int J Cardiol*. 2013;167(5):1843-1847. doi:10.1016/j.ijcard.2012.04.124

19. Chougule A, Joan M. Ionizing radiation and reproductive health: Impacts and mitigation strategies. *J Reprod Health Med*. 2025;6. doi:10.25259/JRHM_33_2024

20. Kumar R, De Jesus O. Radiation Effects on the Fetus. In: *StatPearls*. StatPearls Publishing; 2025. Accessed August 22, 2025. http://www.ncbi.nlm.nih.gov/books/NBK564358/

21. Saada M, Sanchez-Jimenez E, Roguin A. Risk of ionizing radiation in pregnancy: just a myth or a real concern? *Europace*. 2023;25(2):270-276. doi:10.1093/europace/euac158

22. Cheney AE, Vincent LL, McCabe JM, Kearney KE. Pregnancy in the Cardiac Catheterization Laboratory. *Circulation: Cardiovascular Interventions*. 2021;14(4):e009636. doi:10.1161/CIRCINTERVENTIONS.120.009636

23. Haghighat L, Kalantarian S, DesJardin JT, Pellegrini CN. Evaluating Pregnancy Safety During Cardiology Training. *JAMA Cardiol*. 2024;9(10):946-947. doi:10.1001/jamacardio.2024.2294

24. Behbehani S, Tulandi T. Obstetrical Complications in Pregnant Medical and Surgical Residents. *Journal of Obstetrics and Gynaecology Canada*. 2015;37(1):25-31. doi:10.1016/S1701-2163(15)30359-5

25. Cremen SA, McNulty JP. The availability of appropriately fitting personal protective aprons and jackets for angiographic and interventional radiology personnel. *Radiography*. 2014;20(2):126-130. doi:10.1016/j.radi.2013.12.001

26. Tamirisa KP, Alasnag M, Calvert P, et al. Radiation Exposure, Training, and Safety in Cardiology. *JACC: Advances*. 2024;3(4):100863. doi:10.1016/j.jacadv.2024.100863

27. Andreassi MG, Piccaluga E, Guagliumi G, Del Greco M, Gaita F, Picano E. Occupational Health Risks in Cardiac Catheterization Laboratory Workers. *Circulation: Cardiovascular Interventions*. 2016;9(4):e003273. doi:10.1161/CIRCINTERVENTIONS.115.003273

28. Ross AM, Segal J, Borenstein D, Jenkins E, Cho S. Prevalence of Spinal Disc Disease Among Interventional Cardiologists. *American Journal of Cardiology*. 1997;79(1):68-70. doi:10.1016/S0002-9149(96)00678-9

29. Orme NM, Geske JB, Pislaru SV, et al. Occupational musculoskeletal pain in cardiac sonographers compared to peer employees: a multisite cross-sectional study. *Echocardiography*. 2016;33(11):1642-1647. doi:10.1111/echo.13344

30. Scuderi GJ, Brusovanik GV, Campbell DR, Henry RP, Kwon B, Vaccaro AR. Evaluation of non–lead-based protective radiological material in spinal surgery. *The Spine Journal*. 2006;6(5):577-582. doi:10.1016/j.spinee.2005.09.010

31. Kato M, Chida K, Munehisa M, et al. Non-Lead Protective Aprons for the Protection of Interventional Radiology Physicians from Radiation Exposure in Clinical Settings: An Initial Study. *Diagnostics (Basel)*. 2021;11(9):1613. doi:10.3390/diagnostics11091613

32. Rose A, Rae WID. Personal Protective Equipment Availability and Utilization Among Interventionalists. *Safety and Health at Work*. 2019;10(2):166-171. doi:10.1016/j.shaw.2018.10.001

33. Baudin C, Vacquier B, Thin G, et al. Radiation protection in a cohort of healthcare workers: knowledge, attitude, practices, feelings and IR-exposure in French hospitals. *J Radiol Prot*. 2024;44(2):021507. doi:10.1088/1361-6498/ad39f7

34. Nugent M, Carmody O, Dudeney S. Radiation safety knowledge and practices among Irish orthopaedic trainees. *Ir J Med Sci*. 2015;184(2):369-373. doi:10.1007/s11845-014-1121-4

35. Bhinder J, O'Brien-Irr M, Reilly B, et al. Understanding radiation exposure and improving safety for vascular surgery trainees. *Journal of Vascular Surgery*. 2023;77(1):269-278. doi:10.1016/j.jvs.2022.08.001

36. 141_CardiovascularDisease_2024. *Cardiovascular Disease*.

37. Kaplan DJ, Patel JN, Liporace FA, Yoon RS. Intraoperative radiation safety in orthopaedics: a review of the ALARA (As low as reasonably achievable) principle. *Patient Saf Surg*. 2016;10(1):27. doi:10.1186/s13037-016-0115-8

38. Clements JB, Amurao M, Becker MD, et al. Essential information for radiation safety officers at medical imaging facilities.

39. History. June 8, 2016. Accessed July 16, 2025. https://www.iaea.org/about/overview/history

40. Community EAE, Nations F and AO of the U, Agency IAE, et al. *Fundamental Safety Principles*. International Atomic Energy Agency; 2006:1-21. doi:10.61092/iaea.hmxn-vw0a

41. Commission E, Nations F and AO of the U, Agency IAE, et al. *Radiation Protection and Safety of Radiation Sources: International Basic Safety Standards*. International Atomic Energy Agency; 2014:1-436. doi:10.61092/iaea.u2pu-60vm

42. Vaziri S, Mirzaei M, Saba F, Salehi Zahabi K, Salehi Zahabi S, Arab-Zozani M. Hematological parameters and X-ray exposure among medical radiation workers: a systematic review and meta-analysis. *Expert Rev Hematol*. 2022;15(7):645-656. doi:10.1080/17474086.2022.2096001

43. Global Initiative on Radiation Safety in Health Care Settings. Accessed July 16, 2025. https://www.who.int/initiatives/global-initiative-on-radiation-safety-in-health-care-settings

44. ICRP. Accessed July 16, 2025. https://www.icrp.org/page.asp?id=9

45. Sentinel Event Alert 47: Radiation risks of diagnostic imaging and fluoroscopy | Joint Commission. Accessed August 21, 2025. https://www.jointcommission.org/en-us/knowledge-library/newsletters/sentinel-event-alert/issue-47

46. Lau L, Pérez M. 15th to 17th December, 2008 WHO Headquarters Geneva.

47. About NRC. NRC Web. Accessed July 16, 2025. https://www.nrc.gov/about-nrc.html

48. US EPA O. Radiation Protection. July 16, 2014. Accessed July 16, 2025. https://www.epa.gov/radiation

49. Health C for D and R. FDA Radiological Health Program. FDA. November 3, 2018. Accessed July 16, 2025. https://www.fda.gov/radiation-emitting-products/fda-radiological-health-program

50. Health C for D and R. Radiation-Emitting Products. FDA. September 10, 2024. Accessed July 16, 2025. https://www.fda.gov/radiation-emitting-products

51. Ionizing Radiation - Standards | Occupational Safety and Health Administration. Accessed July 16, 2025. https://www.osha.gov/ionizing-radiation/standards

52. Radiation Protection of the Public and the Environment. Energy.gov. Accessed July 16, 2025. https://www.energy.gov/ehss/radiation-protection-public-and-environment

53. Office USGA. Nuclear Waste Disposal | U.S. GAO. February 15, 2017. Accessed July 16, 2025. https://www.gao.gov/nuclear-waste-disposal

54. Radiation Dose Reconstruction Program | NIOSH | CDC. October 30, 2024. Accessed July 17, 2025. https://www.cdc.gov/niosh/ocas/default.html

55. Kelly-Reif K. NIOSH epidemiologic studies of radiation-exposed workers and opportunities for coordination of low-dose radiation research.

56. About - NCRP | Bethesda, MD. May 25, 2015. Accessed July 17, 2025. https://ncrponline.org/about/

57. US EPA O. Member and Observer Agencies. September 21, 2022. Accessed July 17, 2025. https://www.epa.gov/iscors/member-and-observer-agencies

58. Radiation Emergency Preparedness and Response - Overview | Occupational Safety and Health Administration. Accessed July 17, 2025. https://www.osha.gov/emergency-preparedness/radiation

59. 29 CFR Part 1910 -- Occupational Safety and Health Standards. Accessed July 18, 2025. https://www.ecfr.gov/current/title-29/part-1910

60. 10 CFR Part 20 -- Standards for Protection Against Radiation. Accessed July 17, 2025. https://www.ecfr.gov/current/title-10/part-20

61. 10 CFR Part 835 -- Occupational Radiation Protection. Accessed July 18, 2025. https://www.ecfr.gov/current/title-10/part-835

62. Smith H. Published on behalf of the lnternational Commission on Radiological Protection.

63. Lindell PB. Editor: F. D. SOWBY ICRP, Sutton, Surrey.

64. dpart.pdf. Accessed July 22, 2025. https://cdn.ymaws.com/www.crcpd.org/resource/resmgr/docs/SSRCRs/dpart.pdf

65. Worker protection at facilities licensed by the NRC (revision) | Occupational Safety and Health Administration. Accessed July 17, 2025. https://www.osha.gov/laws-regs/mou/2013-09-06

66. NRC: Office of Nuclear Material Safety and Safeguards - Agreement State Directory. Accessed July 17, 2025. https://scp.nrc.gov/asdirectory.html

67. State Plans | Occupational Safety and Health Administration. Accessed July 17, 2025. https://www.osha.gov/stateplans

68. Regulation of Radioactive Materials. NRC Web. Accessed July 17, 2025. https://www.nrc.gov/about-nrc/radiation/protects-you/reg-matls.html

69. NRC: State and Tribal Programs- National Materials Program. Accessed July 17, 2025. https://scp.nrc.gov/materials.html

70. Integrated Materials Performance Evaluation Program (IMPEP). Accessed July 17, 2025. https://scp.nrc.gov/impeptoolbox/impep.html

71. Links to State Plans' Safety and Health Standards and Regulations | Occupational Safety and Health Administration. Accessed July 17, 2025. https://www.osha.gov/stateplans/statestandards

72. CRCPD. CRCPD. July 2, 2025. Accessed July 17, 2025. https://crcpd.org/

73. About Us. CRCPD. July 2, 2025. Accessed July 17, 2025. https://crcpd.org/about-us/

74. Radiation: Standards and Organizations Provide Safety for Public and Workers. Nuclear Energy Institute. July 1, 2015. Accessed July 17, 2025. https://www.nei.org/resources/fact-sheets/radiation-standards-provide-safety

75. 10 CFR 35.50 -- Training for Radiation Safety Officer and Associate Radiation Safety Officer. Accessed July 17, 2025. https://www.ecfr.gov/current/title-10/part-35/section-35.50

76. 10 CFR Part 35 -- Medical Use of Byproduct Material. Accessed July 17, 2025. https://www.ecfr.gov/current/title-10/part-35

77. 29 CFR Part 1904 -- Recording and Reporting Occupational Injuries and Illnesses. Accessed July 21, 2025. https://www.ecfr.gov/current/title-29/part-1904

78. American Academy of Orthopaedic Surgeons AAOS. Accessed July 18, 2025. https://www.aaos.org/

79. Search - American Academy of Orthopaedic Surgeons. Accessed July 18, 2025. https://www.aaos.org/search/?q=radiation+safety

80. American Association of Neurological Surgeons. AANS. Accessed July 18, 2025. https://www.aans.org/

81. AAPM: The American Association of Physicists in Medicine. Accessed July 18, 2025. https://aapm.org/

82. Home. American College of Cardiology. Accessed July 18, 2025. https://www.acc.org/http%3a%2f%2fwww.acc.org%2f

83. Hirshfeld JW, Ferrari VA, Bengel FM, et al. 2018 ACC/HRS/NASCI/SCAI/SCCT Expert Consensus Document on Optimal Use of Ionizing Radiation in Cardiovascular Imaging: Best Practices for Safety and Effectiveness. *JACC*. 2018;71(24):e283-e351. doi:10.1016/j.jacc.2018.02.016

84. Search Results. American College of Cardiology. Accessed July 18, 2025. https://www.acc.org/http%3a%2f%2fwww.acc.org%2fsearch

85. CHEST. American College of Chest Physicians. Accessed July 18, 2025. https://www.chestnet.org/

86. American College of Nuclear Medicine (ACNM). Accessed July 18, 2025. https://acnmonline.org/ACNM/ACNM/Default.aspx

87. The American College of Radiation Oncology Inc. Accessed July 18, 2025. https://acro.org/

88. ACRO Statement on Radiation Therapy Supervision - The American College of Radiation Oncology Inc. Accessed July 18, 2025. https://acro.org/news/news.asp?id=671586&hhSearchTerms=%22radiation+and+safety%22

89. American College of Radiology. Accessed July 18, 2025. https://www.acr.org/

90. Home. ACS. Accessed July 18, 2025. https://www.facs.org/

91. Home Page 2025 - American Orthopaedic Association. Accessed July 18, 2025. https://www.aoassn.org/

92. Home. AOFAS. Accessed July 18, 2025. https://aofas.org

93. Home Page. Accessed July 18, 2025. https://www.arrs.org/ARRSLIVE/ARRSLIVE/Home-Page.aspx?iSession=2ecc9b92-e2ee-46f9-a5a1-08387aa72fb2

94. Web Lectures. Accessed July 18, 2025. https://www.arrs.org/ARRSLIVE/ARRSLIVE/Store/Web-Lectures.aspx?Category=WEB_LECTS

95. Home. Accessed July 18, 2025. https://www.asahq.org/

96. American Thoracic Society | Home. American Thoracic Society. Accessed July 18, 2025. https://site.thoracic.org/

97. Home. Accessed July 18, 2025. https://www.aur.org/

98. APDVS | Society for Vascular Surgery. Accessed August 22, 2025. https://vascular.org/apdvs

99. DiLosa KL, Cui CL, Reilly MA, et al. Guidance to mitigate occupational risks for the pregnant vascular surgery trainee. *JVS-Vascular Insights*. 2024;2:100126. doi:10.1016/j.jvsvi.2024.100126

100. Congress of Neurological Surgeons (CNS) – Advancing Neurosurgery - Congress of Neurological Surgeons (CNS). Accessed July 18, 2025. https://www.cns.org/Default.aspx

101. The Health Physics Society | Radiation Protection Professionals. HPS. Accessed July 22, 2025. https://hps.org/

102. HPS Position Statements. HPS. Accessed July 22, 2025. https://hps.org/hpspublications/positionstatements/

103. Positions. HPS. Accessed July 22, 2025. https://hps.org/hpspublications/positions/

104. Home. Accessed July 18, 2025. https://www.spine.org/

105. Search Results. Accessed July 18, 2025. https://www.spine.org/Search-Results?query=radiation%20safety#/radiation%20safety/0/score/desc/

106. RSNA. Accessed July 18, 2025. https://www.rsna.org/

107. radiation safety | RSNA Search. Accessed July 18, 2025. https://discover.rsna.org/search?bucket=News&filters=&page=1&sort=relevance&term=radiation%20safety

108. Home | SCAI. Accessed July 18, 2025. https://www.scai.org/

109. Search | SCAI. Accessed July 18, 2025. https://www.scai.org/search?keyword=radiation%20safety

110. WIN Radiation Safety | SCAI. Accessed July 18, 2025. https://scai.org/membership/career-development/women-innovations-win/win-radiation-safety

111. Society for Pediatric Radiology | SPR. Accessed July 22, 2025. https://www.spr.org/

112. Society of Critical Care Medicine | SCCM. Accessed July 18, 2025. https://www.sccm.org/

113. Society of Interventional Radiology (SIR) Home. Society of Interventional Radiology. Accessed July 18, 2025. https://www.sirweb.org/

114. Search. Society of Interventional Radiology. Accessed July 18, 2025. https://www.sirweb.org/search/

115. Home. Accessed July 22, 2025. https://snmmi.org/Web/Web/Home.aspx

116. Home Page | STS. Accessed July 18, 2025. https://www.sts.org/

117. US EPA O. Radiation Regulations and Laws. September 30, 2014. Accessed July 17, 2025. https://www.epa.gov/radiation/radiation-regulations-and-laws

118. Governing Legislation. NRC Web. Accessed July 17, 2025. https://www.nrc.gov/about-nrc/governing-laws.html

119. COMPS-1630.pdf. Accessed July 17, 2025. https://www.govinfo.gov/content/pkg/COMPS-1630/pdf/COMPS-1630.pdf

120. COMPS-1634.pdf. Accessed July 17, 2025. https://www.govinfo.gov/content/pkg/COMPS-1634/pdf/COMPS-1634.pdf

121. NUREG-0980 Vol 1 No 10 "Nuclear Regulatory Legislation 112th Congress; 2nd Session."

122. STATUTE-82-Pg1173.pdf. Accessed July 17, 2025. https://www.congress.gov/90/statute/STATUTE-82/STATUTE-82-Pg1173.pdf

123. nuclear-waste-policy-act.pdf. Accessed July 17, 2025. https://www.energy.gov/articles/nuclear-waste-policy-act

124. Clean Air Act: A Summary of the Act and Its Major Requirements. Accessed July 17, 2025. https://www.congress.gov/crs-product/RL30853

125. USCODE-2018-title33-chap26.pdf. Accessed July 17, 2025. https://www.govinfo.gov/content/pkg/USCODE-2018-title33/pdf/USCODE-2018-title33-chap26.pdf

126. BILLS-109hr6enr.pdf. Accessed July 17, 2025. https://www.govinfo.gov/content/pkg/BILLS-109hr6enr/pdf/BILLS-109hr6enr.pdf

127. USCODE-2011-title42-chap6A-subchapXII.pdf. Accessed July 17, 2025. https://www.govinfo.gov/content/pkg/USCODE-2011-title42/pdf/USCODE-2011-title42-chap6A-subchapXII.pdf

128. ML13274A490.pdf. Accessed July 17, 2025. https://www.nrc.gov/docs/ML1327/ML13274A490.pdf#page=69

129. ML13274A490.pdf. Accessed July 17, 2025. https://www.nrc.gov/docs/ML1327/ML13274A490.pdf#page=488

130. Health C for D and R. Guidance Documents (Medical Devices and Radiation-Emitting Products). FDA. May 28, 2025. Accessed July 18, 2025. https://www.fda.gov/medical-devices/device-advice-comprehensive-regulatory-assistance/guidance-documents-medical-devices-and-radiation-emitting-products

131. The Act/EEOICPA | NIOSH | CDC. September 13, 2024. Accessed July 18, 2025. https://www.cdc.gov/niosh/ocas/ocaseeoi.html

132. TITLE 42—THE PUBLIC HEALTH AND WELFARE.

133. Congressional Charter - NCRP | Bethesda, MD. May 25, 2015. Accessed July 18, 2025. https://ncrponline.org/about/congressional-charter/

134. Reports - NCRP | Bethesda, MD. Accessed July 22, 2025. https://ncrponline.org/product-category/reports/

135. 10 CFR Part 961 -- Standard Contract for Disposal of Spent Nuclear Fuel and/or High-Level Radioactive Waste. Accessed July 18, 2025. https://www.ecfr.gov/current/title-10/part-961

136. 21 CFR Part 892 -- Radiology Devices. Accessed July 18, 2025. https://www.ecfr.gov/current/title-21/part-892

137. 21 CFR Part 1020 -- Performance Standards for Ionizing Radiation Emitting Products. Accessed July 18, 2025. https://www.ecfr.gov/current/title-21/part-1020

138. 40 CFR Part 191 -- Environmental Radiation Protection Standards for Management and Disposal of Spent Nuclear Fuel, High-Level and Transuranic Radioactive Wastes. Accessed July 18, 2025. https://www.ecfr.gov/current/title-40/part-191

139. Occupational Health (Division 8): Regulatory Guides 8.1 - 8.20. NRC Web. Accessed July 22, 2025. https://www.nrc.gov/reading-rm/doc-collections/reg-guides/occupational-health/rg/division-8/division-8-1.html

140. US EPA O. Federal Guidance for Radiation Protection. November 25, 2014. Accessed July 22, 2025. https://www.epa.gov/radiation/federal-guidance-radiation-protection

141. US EPA O. Federal Guidance Report No. 15: External Exposure to Radionuclides in Air, Water and Soil. November 22, 2017. Accessed July 18, 2025. https://www.epa.gov/radiation/federal-guidance-report-no-15-external-exposure-radionuclides-air-water-and-soil

142. Federal Guidance Report No 14: Radiation Protection Guidance for Diagnostic and Interventional X-Ray Procedures.

143. Cancer Risk Coefficients for Environmental Exposure to Radionuclides Federal Guidance Report No. 13.

144. Federal Guidance Report No. 12: External Exposure to Radionuclides in Air, Water, and Soil.

145. 52-fr-2822.pdf. Accessed July 18, 2025. https://www.epa.gov/sites/default/files/2015-08/documents/52-fr-2822.pdf

146. FR-1961-09-26.pdf. Accessed July 18, 2025. https://www.govinfo.gov/content/pkg/FR-1961-09-26/pdf/FR-1961-09-26.pdf

147. Consolidated Guidance About Materials Licenses: Program-Specific Guidance About Medical Use Licenses. NRC Web. Accessed July 22, 2025. https://www.nrc.gov/reading-rm/doc-collections/nuregs/staff/sr1556/v9/index.html

148. ML101900087.pdf. Accessed July 22, 2025. https://www.nrc.gov/docs/ML1019/ML101900087.pdf

149. ML110460093.pdf. Accessed July 22, 2025. https://www.nrc.gov/docs/ML1104/ML110460093.pdf

150. ML102350460.pdf. Accessed July 22, 2025. https://www.nrc.gov/docs/ML1023/ML102350460.pdf

151. Radiation Dose Estimates for Radiopharmaceuticals (NUREG/CR-6345). NRC Web. Accessed July 22, 2025. https://www.nrc.gov/reading-rm/doc-collections/nuregs/contract/cr6345/index.html

152. Report No. 151 – Structural Shielding Design and Evaluation for Megavoltage X- and Gamma-Ray Radiotherapy Facilities (2005) - NCRP | Bethesda, MD. July 17, 2018. Accessed July 21, 2025. https://ncrponline.org/shop/reports/report-no-151-structural-shielding-design-and-evaluation-for-megavoltage-x-and-gamma-ray-radiotherapy-facilities-2005/

153. Report No. 177 – Radiation Protection in Dentistry and Oral & Maxillofacial Imaging (2019) (Supersedes Report No. 145) - NCRP | Bethesda, MD. January 27, 2018. Accessed July 21, 2025. https://ncrponline.org/shop/reports/report-no-177/

154. Report No. 148 – Radiation Protection in Veterinary Medicine (2004) - NCRP | Bethesda, MD. July 18, 2018. Accessed July 21, 2025. https://ncrponline.org/shop/reports/report-no-148-radiation-protection-in-veterinary-medicine-2004/

155. Report No. 147 – Structural Shielding Design for Medical X-Ray Imaging Facilities (2004) [supersedes Report No. 49] - NCRP | Bethesda, MD. July 18, 2018. Accessed July 21, 2025. https://ncrponline.org/shop/reports/report-no-147-structural-shielding-design-for-medical-x-ray-imaging-facilities-2004/

156. Report No. 144 – Radiation Protection for Particle Accelerator Facilities (2003) - NCRP | Bethesda, MD. July 18, 2018. Accessed July 21, 2025. https://ncrponline.org/shop/reports/report-no-144-radiation-protection-for-particle-accelerator-facilities-2003/

157. Report No. 133 – Radiation Protection for Procedures Performed Outside the Radiology Department (2000) - NCRP | Bethesda, MD. July 18, 2018. Accessed July 21, 2025. https://ncrponline.org/shop/reports/report-no-133-radiation-protection-for-procedures-performed-outside-the-radiology-department-2000/

158. Memoranda of Understanding - By Agency | Occupational Safety and Health Administration. Accessed July 18, 2025. https://www.osha.gov/laws-regs/mou/agency

159. Memoranda of Understanding. NRC Web. Accessed July 18, 2025. https://www.nrc.gov/reading-rm/doc-collections/memo-understanding/index.html

160. Memorandum of Understanding between The Food and Drug Administration U.S. Department of Health and Human Services and The Occupational Safety and Health Administration U.S. Department of Labor | Occupational Safety and Health Administration. Accessed July 18, 2025. https://www.osha.gov/laws-regs/mou/2024-01-26

161. mou-btwn-doe_epa-jan-23-2024.pdf. Accessed July 18, 2025. https://www.epa.gov/system/files/documents/2024-04/mou-btwn-doe_epa-jan-23-2024.pdf

162. ML23262B040.pdf. Accessed July 18, 2025. https://www.nrc.gov/docs/ML2326/ML23262B040.pdf

163. ML23213A147.pdf. Accessed July 18, 2025. https://www.nrc.gov/docs/ML2321/ML23213A147.pdf

164. mou2fin.pdf. Accessed July 18, 2025. https://www.nrc.gov/reading-rm/doc-collections/news/2002/mou2fin.pdf

165. Memorandum of Understanding Between the U.S. Nuclear Regulatory Commission and the U.S. Department of Health and Human Services Food and Drug Administration.

166. Gaseous Diffusion Plants | Occupational Safety and Health Administration. Accessed July 18, 2025. https://www.osha.gov/laws-regs/mou/1994-12-21

167. Authority of OSHA and FDA in establishing and enforcing standards relative to electronic product radiation | Occupational Safety and Health Administration. Accessed July 18, 2025. https://www.osha.gov/laws-regs/mou/1974-04-10

168. State Regulatory Library - American Society for Radiation Oncology (ASTRO). ASTRO. Accessed July 22, 2025. https://www.astro.org/advocacy/state-regulatory-library

REPORT 3 OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (I-25)
Plastic Pollution Reduction
(Reference Committee K)

## EXECUTIVE SUMMARY

BACKGROUND. AMA Policy H-135.901, "Addressing the Health Consequences of Microplastics in Humans," was adopted by the House of Delegates at the 2025 Annual Meeting and asked the AMA to study and report back with policy recommendations on ways to reduce plastic pollution and its impact on climate change and health, including but not limited to federal, state, and local taxes and limitations on the use of single-use plastic consumer products and other types of plastic, interventions to reduce microplastics, and alternatives to plastic.

METHODS. English language reports were selected from searches of the PubMed and Google Scholar databases using the search terms: "plastics" AND "health", "microplastics" AND "health," "plastics" AND "climate change," and "bioplastics" and "plastic waste management." Legal research tools, state legislative databases, and municipal websites were also searched to identify which jurisdictions have passed legislation on limiting plastic. Additional articles were identified by manual review of the reference lists of pertinent publications. Web sites managed by federal agencies and advocacy organizations were also reviewed for relevant information.

DISCUSSION. Plastic is an important component in a diverse range of products, many of which are crucial and, in some cases, lifesaving in our modern society. Nearly 98 percent of plastic produced is derived from fossil fuels, such as ethane, propane, and methane, through an industrial process called cracking. Plastic production has increased exponentially since 1950, and plastic production is anticipated to triple by 2060. A large driver of this exponential growth is the production of single use plastics. Challenges with plastic waste disposal have become increasingly problematic as global production has grown. While recycling strategies are effective for other materials, only a small percentage of plastic is currently recycled. If not recycled, disposal strategies for plastic include controlled or uncontrolled landfilling, open burning, thermal conversion, or export from high-income to low-income countries.

Plastics have negative repercussions on both the environment and human health at every stage of their life cycle, from extraction through production, to use and disposal. During the extraction and production phases of plastics, there are numerous environmental harms, occupational risks, and increased exposure to dangerous chemicals and pollutants for nearby communities. During its use phase, there are potential health risks from the microplastics degrading from the plastic product as well as exposure to the thousands of chemical additives in plastic. Once disposed of, plastic and microplastics accumulate in both soil systems and water environments where they have the potential to bioaccumulate within the food web. Plastic also contributes to greenhouse gas emissions (GHG) along the entirety of its life cycle and accounts for approximately four percent of all global GHG emissions.

CONCLUSION. Plastic poses serious environmental and human health concerns across its lifespan. Limits on the use of plastics, when possible, in particular single use plastics, are one of the most important strategies to reduce the burden of plastic pollution on both the environment and human health.

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 3-I-25

Subject: Plastic Pollution Reduction

Presented by: Padmini Ranasinghe, MD, MPH, Chair

Referred to: Reference Committee K

---

AMA Policy H-135.901, "Addressing the Health Consequences of Microplastics in Humans," was adopted by the House of Delegates (HOD) at the 2025 Annual Meeting and asks the following:

1. Our AMA recognizes the potential health risks associated with microplastics exposure and encourage increased research to better understand the human health effects of microplastics.
2. Our AMA supports the respective specialty medical societies with subject matter expertise and federal and state public health agencies, including the Centers for Disease Control and Prevention (CDC) and the Environmental Protection Agency (EPA), to develop evidence-based guidelines for monitoring and mitigating microplastic exposure in water, food, air, and other consumer products.
3. Our AMA will collaborate with relevant stakeholders to promote public education about microplastics, their sources, potential health risks, and possible strategies for reducing exposure.
4. Our AMA will study and report back with policy recommendations on ways to reduce plastic pollution and its impact on climate change and health, including but not limited to federal, state, and local taxes and limitations on the use of single-use plastic consumer products and other types of plastic, interventions to reduce microplastics, and alternatives to plastic. [Res. 429, A-25, Res. 418, A-25][1]

METHODS

English language reports were selected from searches of the PubMed and Google Scholar databases using the search terms "plastics" AND "health", "microplastics" AND "health," "plastics" AND "climate change," and "bioplastics" and "plastic waste management." A 2023 report by the Minderoo-Monaco Commission on Plastics and Human Health, an international and interdisciplinary group comprised of scientists, healthcare workers, and policy analysts, served as a primary reference for this report, as it synthesized and summarized health impacts from plastic across its life cycle, and included over 1500 references. Legal research tools, state legislative databases, and municipal websites were also searched to identify which jurisdictions have passed legislation on limiting plastic, supported by keyword combinations like "microbead ban," "plastic bag tax," and "single-use container legislation." Additional articles were identified by manual review of the reference lists of pertinent publications. Web sites managed by federal agencies and advocacy organizations were also reviewed for relevant information. Due to the technical nature of this report, a glossary of terms is provided at the end in Appendix A for easy reference.

© 2025 American Medical Association. All rights reserved.

## DISCUSSION

Plastic is a component in a wide array of everyday products. Plastic production has increased exponentially, particularly in the last two decades with the growth in the production and use of single-use plastics.[2] With this large growth in plastics, the associated waste has also grown, and plastic has increasingly come under scrutiny in terms of its negative environmental and health impacts. Only a small percentage of plastic is currently recycled, meaning most of it ends up in landfills or in the environment, such as in rivers, lakes or the ocean.[2] In this way, plastics have become pervasive and ubiquitous in our natural and built environments across the globe. There is also concern that as plastic degrades and breaks down, smaller plastic particles, otherwise known as microplastics, end up inside animals and humans alike, which is associated with its own negative impacts.[3] This report provides a brief summary of plastic production as well as the known health and environmental impacts from plastic, looking across the product lifespan. The report also addresses interventions and strategies to reduce plastic and plastic-related pollution and thereby reduce harm to human health and the environment.

### *What is plastic and what are microplastics?*

Plastic is an important component in a diverse range of products, many of which are crucial and, in some cases, lifesaving in our modern society. Plastics are ubiquitous in products within medicine, electronics, aerospace, construction, food packaging, and synthetic clothing, just to name a few. Its use in a wide variety of products is tied to its chemical structure and its relatively inexpensive production cost.[4] While there are many types of materials that are considered plastic, it is generally defined as a synthetic or semi-synthetic material that uses carbon-based polymers as its primary ingredient.[4] A polymer is a large molecule that is made up of many repeating, smaller units (or monomers), arranged in a chain-like or network-like chemical structure.[5] In the case of most synthetic plastics, the polymer chain is composed of carbon atoms found in a repeating pattern, often with side branches. Due to their chemical nature, plastic polymers are both very flexible and very durable. Plastics' flexibility allows them to be molded into many different forms, which is helpful from a product perspective. However, its durability is a major factor in their impact on our environment and health, in that they do not easily break down chemically.[6] Nearly 98 percent of synthetic plastic polymers are derived from fossil fuels, such as ethane, propane, and methane, through an industrial process called cracking.[4] Depending on the plastic fossil-fuel base, different industrial cracking processes are employed to create various plastic polymers.[4] A few examples of plastic polymers include polypropylene and polyethylene, with polyethylene being the most widely used plastic in the world.[7]

Following cracking, the manufacturing process to make a finished plastic product involves adding chemicals to the plastic polymer, which are used as both processing aids and additives. Processing aids are employed to improve efficiency and quality while additives provide a wide range of functional and aesthetic properties.[4,8] There are over 10,500 chemicals known to be used in the plastic manufacturing process, a majority of them additives for which there is little understanding of their overall safety and health impacts.[9] A few well-known and better studied additives include phthalates, bisphenols, brominated chemicals, and perfluoroalkyl and polyfluoroalkyl chemicals, also known as PFAS chemicals.[10] Phthalates are used in plastics to increase their flexibility, transparency, durability, and longevity.[11] Bisphenols make plastic hard and clear and are used as a protective coating on the inside of food and beverage cans.[11] Brominated chemicals are one class of chemicals that help reduce product flammability.[11] Lastly, PFAS chemicals are a common component in many plastic consumer products, such as food packaging, clothing, and cosmetics, as they help create grease-resistant and water-resistant surfaces.[10]

In 1950, global plastic production was less than two million tons and in 2019 it was 460 million tons (see Figure 1).[2] Plastic production is anticipated to triple by 2060.[4] There has been massive investment in

fossil fuel-based plastic production by major, multinational energy companies to create alternative revenue streams for products derived from fossil fuels, partly in response to growing demands for renewable energy.[4] Supplies of inexpensive natural gas, made possible through the expansion of shale fracking in the U.S., has also been fueling new investments in plastic manufacturing infrastructure in the U.S. and abroad.[12] Increased plastic production investment is notable in the U.S., China, Middle East, and Europe.[4] Single use plastics are a major driver of increased plastic production.[13] Single-use plastics are plastic items designed to be used once and then disposed of, as opposed to being reused or recycled. These include food packaging and containers, plastic bags, plastic straws, face masks, medical gloves, etc. The health care industry is a large user of single-use plastics and a contributor to plastic waste.[14] Nearly a quarter of the 14,000 tons of waste generated daily in U.S. health care facilities is plastic.[15]

Challenges with plastic waste disposal have become increasingly problematic as global production has grown. While recycling strategies are effective for other materials such as paper, glass and aluminum, only a small percentage of plastic is currently recycled (around nine percent globally and only about five percent in the U.S.).[2,4] To provide a point of comparison, about 68 percent of paper and paperboard, 25 percent of glass, and about 35 percent of aluminum containers and packaging is recycled in the U.S. (as of 2018).[16,17] If not recycled, disposal strategies for plastic include controlled or uncontrolled landfilling, open burning, thermal conversion, or export.[4] Large quantities of plastic are exported from high-income to low-income countries where it is landfilled.[18] It is estimated that somewhere between 75 to 80 percent of plastic is landfilled or is improperly discarded into the natural environment where it will persist for hundreds to thousands of years.[4,19] Additionally, around 14 percent is incinerated, which is associated with a number of environmental and health downsides, and some plastic is converted to energy in waste-to-energy facilities.[4] As plastics degrade in landfills and within the environment, they break down into smaller and smaller pieces, often referred to as microplastics. Microplastics are pieces of plastic that range in size but are defined as less than 5 millimeters, while nanoplastics are smaller than 1 micrometer.[20]

*Impacts of plastic on the environment and human health*

Plastics have negative repercussions on both the environment and human health at every stage of their lifecycle, from extraction through production, to use and disposal (see Figure 2). The following is not an exhaustive summary of all potential negative environmental and health impacts from plastics but is intended to provide a broad snapshot of impacts across the plastic life span. The Minderoo – Monaco Commission on Plastics and Human Health report includes a comprehensive analysis of plastic's health impacts across its lifecycle and is a useful resource for an-depth look at this issue.[4]

<u>Extraction and Production Phases</u>

During the extraction of fossil fuels and production of plastics, there are numerous environmental harms, occupational risks, and increased exposure to dangerous chemicals and pollutants for nearby communities. Since plastic is primarily derived from fossil fuels, individuals who work in the oil and gas industries are most affected and face severe occupational health risks and disparities in health outcomes. Workers in the fossil fuel industry have higher rates of other negative health outcomes due to increased exposure to dangerous chemicals, such as increased mortality from cardiovascular disease and several types of cancer, including mesothelioma.[21] Workers in fossil fuel industries also face substantial safety hazards, including but not limited to explosions and fires due to the ignition of flammable vapors or gases, falls from platforms or equipment, and transportation issues. Highway vehicle crashes are the leading cause of death among oil and gas extraction worker fatalities.[22]

Oil spills also pose significant environmental and human health harms. The U.S. National Oceanic and Atmospheric Administration reports that oil spills are relatively common, with thousands occurring each year, most of them small.[23] However, when large oil spills occur, they can be major disasters and

especially dangerous, such as the Exxon Valdez spill in 1989 or the Deepwater Horizon spill in 2010. Whether large or small, oil spills can have damaging effects, such as releasing toxic chemicals into the environment and covering local wildlife in oil, which can put them at physical risk.[23] The Deepwater Horizon oil spill is a useful case study for understanding the many public health impacts from oil spills. Clean-up workers experienced respiratory issues, skin rashes, headaches, and nausea.[24] Local communities impacted by the spill reported increased stress, anxiety, and depression, as well as economic hardship that was largely due to concerns about the safety of seafood and a decrease in tourism to the area, threatening their livelihoods.[24,25]

Early signs that plastics could cause health harm came from occupational settings in the 1970s. Workers in plastic manufacturing had elevated risks of angiosarcoma of the liver from working with vinyl chloride (a gas that is used primarily to make polyvinyl chloride, a hard plastic resin) as well as dermatitis and respiratory ailments from exposure to other chemicals used in the process.[26,27] Thousands of chemicals are used in plastic production and at least one third of the known chemicals have a high or medium concern as a human health hazard.[4] Workers within plastic manufacturing are exposed to chemicals at much higher levels than the general public, primarily through inhalation.[27]

Depending on the type of fossil fuel, populations living near extraction and production facilities may be at higher risk of adverse health outcomes. Fracking, for example, has been shown to contaminate surrounding water sources, create noise and air pollution, and trigger earthquakes.[28,29] Children living near fracking sites in Pennsylvania around their birth were two to three times more likely to be diagnosed with leukemia between the ages of two and seven than those who were not exposed to fracking at a young age.[29] Pregnant mothers living close to fracking sites in Pennsylvania had an increased risk of giving birth prematurely and of having high-risk pregnancies.[29] A recent study also found that pregnant women who live in counties with higher levels of fracking activities in Texas were at much higher risk of giving birth to children with specific birth defects.[30] Fracking sites are also disproportionately located in areas of poverty and minority communities.[28]

Use and Disposal Phases

During its use phase, there are potential health risks from microplastics degrading from the plastic product as well as the thousands of chemical additives in plastic. Humans are exposed to micro- and nano- plastics through food, water, and air.[3] Microplastics have been found throughout human tissues and bodily fluids, including the lungs, colon, spleen, kidneys, liver, heart, placenta, blood, great vessels, meconium, feces, and breastmilk.[3,31,32] Recent studies have also identified microplastics in the brain, indicating there is possibility of microplastics passing through the blood-brain barrier.[33,34] There are many factors that influence the potential toxicity of microplastics, including size, shape, and chemical properties. The potential physiological mechanisms for impact are complex, but include oxidative stress, neurotoxicity, metabolic dysfunction, and induction of immune responses within the body.[3] While research on the health impacts of microplastics in our body is still nascent, recent research found a four-fold increase in the risk of poor cardiovascular outcomes in patients with microplastics present in their carotid artery plaque.[35] The presence of microplastics in our bodies has also been associated with respiratory complications, endocrine disruption, inflammatory bowel disease symptom severity, narrowing of fetal capillaries, and stomach and esophageal cancers, although the biological mechanisms for these effects are not entirely clear at this time.[36]

Microplastics can also be viewed as “trojan horses” as they carry with them a complex array of chemicals which separate from the plastic and spread throughout our bodies via the circulatory system.[3] While health and safety information are lacking for most chemicals in plastic, at least four major categories of chemicals found in plastics have been more extensively studied in terms of health impacts. These include phthalates, bisphenols, PFAS, and flame-retardant additives.[11] The effects of these chemical additives are

known to affect nearly every organ system in the body of people of all ages, but particularly young children.[9]

A meta-analysis on human health impacts from several major classes of plastic-associated chemicals found they are associated with adverse health outcomes across a wide range of human health conditions.[10] Bisphenol A (BPA) is classified as an endocrine disrupting chemical and is associated with decreased anoclitoral distance in infants (an indicator of potential reproductive health issues later in life), type 2 diabetes in adults, insulin resistance in children and adults, polycystic ovary syndrome, obesity and hypertension in children and adults, and cardiovascular disease.[10,37] As public awareness of BPA has increased, manufacturers have switched to alternative bisphenol formulations, which have very similar chemical structures, and thus may have similar health effects but have yet to be studied.[11]

Phthalates, commonly used as plasticizers to make plastic more flexible and durable, are also well-known endocrine disruptors and impact reproductive systems.[38] Phthalates are associated with spontaneous pregnancy loss, decreased anogenital distance in boys, insulin resistance in children and adults, with additional associations between certain phthalates and decreased birth weight, type two diabetes in adults, precocious puberty in girls, reduced sperm quality, endometriosis, adverse cognitive development and intelligence quotient (IQ) loss, adverse fine motor and psychomotor development and elevated blood pressure in children and asthma in children and adults.[10] Some phthalates were removed from the market in Europe in the 1990s due to health concerns and various substitutes have been introduced but there are few studies assessing their health impacts.[11]

Polychlorinated biphenyls (PCBs) and polybrominated diphenyl ethers (PBDEs) are utilized as flame retardants in plastics. PCBs and PBDEs are associated with decreased birth weight and in general populations, PCBs are associated with type 2 diabetes in adults and endometriosis, bronchitis in infants, cardiovascular disease, non-Hodgkin's lymphoma and breast cancer.[10] In PCB-poisoned populations, exposure is associated with overall mortality, mortality from hepatic disease (men), cardiovascular disease in both men and women, and several cancers. PBDEs are adversely associated with children's cognitive development and IQ loss as well as changes in thyroid function.[11]

Lastly, PFAS exposure is associated with decreased birth weight, increased body mass index and overweight in children, attention deficit hyperactive disorder in girls, and allergic rhinitis.[10] Some PFAS have also been associated with changes in thyroid function.[10] Notably, PFAS chemicals have been found in measurable amounts in the blood of nearly all Americans based on data from the National Health and Nutrition Examination Survey since the late 1990s.[39] Recent estimates on the economic costs of health impacts from the chemicals in plastic demonstrate that U.S. health costs are around $249 billion in plastic-attributable disease burden in 2018, which are likely an underestimation due to limitations on not knowing the full extent of chemical exposure in the population.[40]

Once disposed of poor waste management contributes to plastic and microplastics accumulating in both soil systems and water environments. Plastic particles have been identified in environments across the globe, from Antarctica to the Arctic, in the peaks of the Himalayas to the deepest trenches of the ocean.[3] Plastic pollution is considered a planetary boundary threat (a term used to describe global change processes where human activities affect Earth system functioning in a substantial way) and is having negative effects on Earth ecosystems by contributing directly to climate change and negatively impacting biodiversity loss.[41,42] Microplastics within the soil can facilitate the proliferation of biological disease factors and impact water filtration and soil aeration, which may impact plant growth and productivity.[19] Additionally, the presence of microplastics has been detected in 1300 terrestrial and aquatic species from across the entire food chain web.[43] Plastic waste also accumulates in bodies of water, with some researchers estimating that a garbage truck’s worth of plastic enters the ocean every minute.[18] In water environments, plastic pollution is an increasingly visible and pervasive problem, as best evidenced by the

Great Pacific Garbage Patch, an area that due to ocean currents has brought together a large concentration of trash, primarily plastics.[44] While it is difficult to estimate its size with certainty, as it is constantly in motion, some studies have estimated that the Great Pacific Garbage Patch covers an area roughly twice the size of Texas.[45] Within the water, various organisms interact with plastics and microplastics, either ingesting it or getting entangled, which has resulted in more than 400,000 documented marine animal deaths.[46]

The health challenges of plastic waste disposal are not limited to microplastics in the soil and water. With nearly two billion people across the globe lacking solid waste collection services and plastic waste routinely being shipped from higher income countries to low- and middle-income countries under the guise of recycling, plastic waste is often incinerated in open burning pits, which is a primary method of disposal in many parts of the world.[47–49] The amount of plastic being burned is estimated to be roughly equivalent to the quantity entering the sea or soil.[47] Incineration of plastic waste is a major source of air pollution that contains many toxic substances including brominated compounds, dioxins, mercury, and black carbon, to name just a few.[48,50] Many of these compounds are known carcinogens, cause reproductive and development problems, increase the risk of heart disease, and aggravate respiratory disease, such as asthma and emphysema.[48,50]

*Relationship between plastic and climate change*

Plastic also contributes to greenhouse gas emissions (GHG) along the entirety of its life cycle and accounts for approximately four percent of all global GHG emissions (See Figure 3 in Appendix B).[4,51] Since plastic polymers are primarily derived from fossil fuels and the process of cracking is energy intensive, the production and manufacture of plastics account for a majority of the known GHG emissions over the plastic lifespan. Additionally, the end-of-life processes for plastic waste – which could be incineration or shipping from high-income countries to low and middle-income countries – also contributes to GHG emissions.[51]

There is increasing evidence that anthropogenic increases in GHG emissions in the last 150 years are increasing global surface temperatures which is impacting climate patterns.[52,53] These changes are causing regional and seasonal temperature extremes, reducing snow cover and sea ice, and intensifying heavy rainfall. Climate change has already caused irreversible damage. The consequences of unmanaged climate change include droughts, water scarcity, rising sea levels and flooding, severe fires, melting polar ice, temperature extremes, declining biodiversity, increased vector-borne diseases, and catastrophic storms, all of which impact health and safety.[54] For more details on how climate change impacts health, refer to previous AMA Council on Science and Public Health reports from 2022 and 2008, or view the AMA report, *Addressing the Public Health Crisis of Climate Change*.[54–56]

## STRATEGIES FOR REDUCING PLASTIC POLLUTION AND REDUCING HARM

Due to the overwhelming quantities of plastic being produced and the scale of the problem, meaningful action to reduce plastic pollution globally should focus on reducing the amount of plastic being produced in the first place through upstream policy and economic levers, as opposed to relying on individual behavior change. The Minderoo-Monaco report includes several recommendations for reducing plastic pollution, the primary one being the passage of a UN Global Plastics Treaty, which is in the process of being developed and debated.[4] One of the key components of this treaty would aim to create a global cap on plastic production. As of April 2024, the European Union approved new rules to reduce, reuse and recycle packaging, with certain single-use plastic packaging types banned as of 2030.[57] The types of packaging that will be banned include packaging for unprocessed fresh fruit and vegetables, for foods and beverages filled and consumed in cafés and restaurants, individual portions (e.g., condiments, sauces, creamer, sugar), miniature toiletry products, and very lightweight plastic carrier bags.[57] A summary of

U.S.-based legislation on plastics and single-use plastic bans is provided in a subsequent section. Additionally, as opposed to a linear use framework (production → use → disposal), it has been suggested that the modern plastic economy needs to be converted to a more sustainable, circular model. This requires a shift to an integrated waste management framework focused on the hierarchy of 'reduce, reuse, recycle, and recover,' which would help reduce the overwhelming strain of plastic pollution.[19,41]

*Improved waste management*

Recycling is an important strategy for addressing plastic waste. However, as the low recycling rate of plastic indicates, there are many barriers to making plastic recycling a more viable option. Challenges include the chemical diversity of plastic products, contamination of the plastic during collection, inadequate infrastructure, unknown toxins, and the downcycling of recycled plastics, all of which hinder the effectiveness and efficiency of plastic recycling processes.[58–60] As there are many types of plastic produced, with many containing multiple materials with other non-recyclable materials or complex structures and many used for food storage, there can be numerous contaminants with the plastic waste stream making it difficult to separate and process the plastic effectively.[58] The U.S. also has outdated and inadequate recycling infrastructure and collection systems to keep pace and efficiently manage plastic waste streams. Inadequate infrastructure coupled with a lack of consumer education and understanding on what materials can be recycled and how has led to very poor recycling rates in the U.S. and therefore leads to plastic accumulation in landfills and the environment.[58]

The regulatory and economic environment around waste management in the U.S. is also an important contributing factor. Recycling rates in Europe are on average considerably higher than the U.S. In 2021 the European Union achieved a 32.5 percent recycling rate for plastic waste, while a few countries were closer to the 50 percent recycling rate target that has been set (Germany and the Netherlands recycled 36 percent and 47 percent, respectively).[61] A contributing factor to this difference is the associated costs of end-of-life disposal methods, with most European Union citizens paying higher prices for both landfilling and incineration, which helps make recycling a more favorable option. As a result, this has led to more industrial processing and innovation, more recycled product uptake, and the structuring of collection and sorting methods that help reduce cross-contamination which makes recycling more efficient.[61] Additionally, the U.S. operates under a patchwork of state and local regulations when it comes to recycling as there is no overarching federal law on recycling.[62]

Another challenge with plastic recycling is that most of these processes result in "downcycling," where the recycled plastic is used to make lower-quality products compared to the original material and therefore even recycled plastics can only go through one or two recycling cycles before being unable to be used again versus glass or metal products which can go through several iterations of recycling (glass can be recycled an infinite number of times as its properties do not degrade over time).[59] Additionally, since various plastics could potentially contain thousands of different chemicals, recycling processes may increase the toxicity of the plastics due to the introduction of new chemicals or increase the concentration of existing ones.[59] Plastic recycling processes may also release microplastic pollution in the environment.[63] Lastly, the cost of collecting, sorting, and processing plastic waste can be high, and the domestic market demand for recycled plastic has not been sufficient to support a robust plastic recycling market.[58]

There are several potential solutions to address the challenges with plastic recycling, which include the promotion of innovative, circular design concepts with plastic products, technological and infrastructure improvements, consumer education, and creating market incentives for recycled products. Prior to production, better and innovative design that considers the entire life cycle of plastic, with recycling in mind, could aim to use fewer materials and make it easier to separate components, thus improving recyclability.[41] Recycling infrastructure investment is also seriously needed in the U.S. Expanding and

modernizing recycling facilities and collection systems is critical for managing the growing amount of plastic waste effectively.[58] To reduce microplastic pollution and other potential pollutants while recycling, additional environmental filtration controls are recommended to decrease the volume of air pollution and microplastics entering water systems.[63] These types of investment would also need to be coupled with the development of more advanced sorting systems to help separate different types of plastics more effectively for processing.[41,58] On the consumer side, better education on proper recycling practices and the importance of reducing plastic consumption can help reduce contamination and increase participation, which could also help create consumer demand for recycled plastic products.[58] Education coupled with incentives for recycling and recycled products could potentially help make recycled plastic more economically viable over the long term.

*Reformulation and alternatives*

As concerns over plastic have grown, so has interest in finding alternatives, such as bioplastics. Bioplastics are generally described as plastics made from non-fossil fuel,[1] renewable polymers derived from starches and proteins and break down via natural processes (i.e., they are biodegradable).[64,65] Currently, bioplastics account for roughly one percent of the overall global plastics market.[19,66] There are several advantages to bioplastics, including their ability to save fossil fuel resources, reduce greenhouse gas emissions, and improved end of life outcomes if they are compatible with existing recycling systems and biodegrade.[19,67]

However, the ability for bioplastics to become a more substantial alternative to synthetic plastics in the market over the medium or even long-term is unrealistic due to several factors. First, large scale production of bioplastics is more expensive compared to synthetic plastics derived from fossil oils, partially as a result of the increased supply of inexpensive natural gas, and therefore not economically viable currently.[68] Bioplastics are also not up to par on certain physical and chemical properties as compared to synthetic plastics, and exhibit poor functional quality due to high-water vapor permeability, oxygen permeability, fragility, low thermal resistance, low mechanical properties, vulnerability to degradation, and low processability.[68] Another challenge with bioplastics is that their production, which comes from agricultural products such as corn, competes with food production for consumption and increased production would require the use of arable land, fertilizers, and pesticides for crops, which can also have negative environmental repercussions, such as soil erosion and degradation.[19,67] There are also concerns that while bioplastics are "biodegradable," it is not well understood how they will adequately break down in open environments or outside of industrial composting facilities.[19] Lastly, bioplastics are also produced with the use of chemical additives to provide specific physical properties and therefore may pose a similar risk as some of the chemicals used in synthetic plastics without improved understanding of those chemicals and potential health harms.[19] While the market for bioplastics is expected to grow, there are still challenges that need to be overcome for bioplastics to occupy a larger share of the plastics market and contribute meaningfully to the reduction in plastic waste and pollution.

*Health Care Strategies*

Recommendations for reducing plastic waste in the health care sector include: increasing physician awareness and education around the health harms of plastics and microplastics; conducting organizational audits to identify ways to reduce the use of unnecessary single-use plastics; physicians raising awareness about impacts of plastic-associated chemicals on human and environmental health with patients and the public; and increased research on the health harms of microplastics and nanoplastics.[15,69,70] This could

[1] There are a few biodegradable fossil-fuel derived plastic polymers that can be categorized as a bioplastic. However, the majority are not and therefore the focus of this section is on renewable sources of bioplastic polymers from natural sources.

include conducting longitudinal biomonitoring studies in human populations, including high-risk populations, to assess microplastics exposure, as well as longitudinal observational studies in human populations, including high-risk populations, to assess the impacts of microplastic exposure on human health.[4,11] Strategies for reducing waste within health care settings are described in further detail in the AMA Council on Science and Public Health report, *Promoting the Use of Multi-Use Devices and Sustainable Practices in the Operating Room*, adopted at the 2023 Interim Meeting of the AMA House of Delegates.[71]

## U.S. POLICY AND REGULATORY LANDSCAPE

In the U.S., policies and regulations aimed at reducing single-use plastics, such as plastic bag bans or taxes, have been implemented, but these regulations or bans largely occur at the city or county level.[72] However, there are several jurisdictions with state-wide restrictions on plastic products (See Appendix C).[73] In general, most legislation around banning or restricting single use plastics is in the form of regulating plastic bags, though some states have begun regulating the use of other single-use plastic items, such as plastic bottles. This can range from an outright prohibition on plastic bags to allowing only plastic bags that meet certain requirements, to mandating a small charge per plastic bag a customer uses. Typically, there are also exceptions to these requirements that may include customers using SNAP benefits and/or some smaller retailers.[74,75] For places that implement a tax on single use plastic, such as a tax on plastic bags at grocery stores, they are generally used toward existing funds within the jurisdiction that pay for environmental clean-up or conservation efforts.[76] The effectiveness of single use plastic bans in the U.S. are, at this time, not well studied or documented. However, studies have indicated that plastic bag regulations lead to a 25 to 47 percent decrease in plastic bags at shoreline cleanups.[77,78] For a non-exhaustive, high-level summary of U.S. state and local regulations on single use plastics, which is intended to provide a snapshot of the range of current U.S. regulations, see Appendix C.

Some states have taken the opposite approach and enacted legislation that prohibits city and county governments from enacting restrictions on single-use plastics. These bans, sometimes referred to as "bans on bans," can be a total prohibition on any regulation or a prohibition on a total ban but may allow city and counties to impose a tax on single-use plastics.[79] Justification for these bans vary by state but some general reasons are plastic bags are largely reused, recycling is seen as a more effective solution, and plastic bags tend to carry less harmful bacteria than reusable bags.[79] Overall these justifications are not particularly compelling for several reasons. First, plastic recycling has proven to be an ineffective solution in reducing plastic waste in the U.S. Second, while reusable bags have been found to contain different types of bacteria, there have been very few known cases of reusable grocery bags being a source of infection and over 99 percent of bacteria can be removed through regular washing.[80,81] In fact, during the COVID-19 pandemic, there were claims that reusable grocery bags could carry and transmit the virus, but those assertions were found to be false.[82]

In terms of regulating the chemicals within plastic, at the state level, in September 2024, California passed legislation that will end the use of intravenous medical supplies that contain Di(2-ethylhexyl) phthalate (DEHP), a plasticizer chemical commonly added to polyvinyl chloride that is suspected of being a human carcinogen. The law will go into effect in 2030 and is anticipated to affect the entire U.S. market with a few other states already proposing similar bills.[83] A similar ban on DEHP in IV bags has also been adopted in the European Union.[84]

At the federal level, the Microbead-Free Waters Act of 2015 prohibits the manufacture and sale of rinse-off cosmetic products containing plastic microbeads, such as exfoliants and toothpaste, across the U.S., requiring states with existing bans to align with this standard.[85] While the U.S. Environmental Protection Agency (EPA) has yet to enact direct bans on microplastics, as of 2024 it was funding research, developing analytical methods, and prepared a National Strategy to Prevent Plastic Pollution.[20,86]

Additionally, the Agency for Toxic Substances and Disease Registry (ATSDR), in partnership with the Centers for Disease Control and Prevention (CDC), established a working group to investigate potential health impacts of microplastics, the current state of which is unknown due to recent federal funding cuts and agency reorganization.[87] Federal legislation such as the Save Our Seas Act and the Infrastructure Investment and Jobs Act provide funding support for microplastic monitoring, environmental cleanup efforts, and treatment technologies targeting emerging contaminants.[86] These federal initiatives complement state-level plastic regulations by addressing the growing concerns around microplastic pollution and its broader environmental and public health effects.

Additionally, S.3127, the "Break Free from Plastic Pollution Act," proposed in 2023 but not passed, was comprehensive federal legislation aimed at significantly reducing plastic pollution nationwide.[88] It proposed a national ban on certain single-use plastic products, including single-use plastic bags, straws, utensils, and foodware, while promoting producer responsibility and funding for waste management improvements. The bill proposed to require manufacturers to reduce plastic production and implement reuse and recycling programs.[88]

There have also been recommendations to improve the Toxic Substances Control Act (TSCA) to address the lack of safety information on chemical additives in plastic. TSCA is a federal law passed in in 1976 which provides the U.S. EPA with the authority to require reporting, record-keeping and testing requirements, and restrictions relating to chemical substances and/or mixtures.[89] As opposed to a "precautionary principle" approach, TSCA's framework assumes that a chemical is considered safe until proven unsafe and the onus of proving harm is on the U.S. EPA, as opposed to the chemical manufacturer. This approach is different from the European Union's chemical regulation approach, REACH (Registration, Evaluation, Authorisation and Restriction of Chemicals). Within the EU REACH program, the responsibility of data generation, risk assessment, and risk management is the responsibility of industry, and they are more proactive in restricting the use of chemicals that are suspected to be unsafe.[90]

The TSCA inventory includes 83,000 chemicals and is continually updated as new chemicals are commercially manufactured or imported. Out of these 80,000+ chemicals, the EPA has only banned nine chemicals in the past four decades, and only about 200 have been tested for safety.[91–93] Reform of TSCA was signed into law in 2016 by President Obama, which amended TSCA to require EPA to conduct risk evaluations of chemicals on a specified schedule starting with those likely to pose health risks (there was no requirement prior), to consider risks to "potentially exposed or susceptible subpopulations," and determine if a chemical poses an "unreasonable risk" without consideration of cost.[94] The 2016 legislation also required EPA to regulate any existing chemical determined to pose an unreasonable risk "to the extent necessary so that the chemical substance or mixture no longer presents such risk" and empowered the EPA to require manufacturers to perform additional safety testing if more data is needed.[91,94] Despite these amendments to TSCA, there is still concern that the legislation does not go far enough to proactively addressing health safety and concerns of chemicals in the U.S.[90,91]

Recommendations on how TSCA can further be improved to protect health and safety include: (1) considering all conditions of use and exposure pathways for chemicals, in other words, consider cumulative impacts of chemicals; (2) quantifying exposures across pathways and populations; (3) better identifying and protecting potentially exposed or susceptible subpopulations; (4) gathering health and toxicity data to fill data gaps; and (5) using validated systematic review methodology in chemical assessments.[91]

CURRENT AMA POLICY

AMA has existing policy supporting sustainability efforts in health care, which includes policy promoting multiple-use equipment versus single-use equipment, as well as policy calling for a ban on plastic microbeads. AMA has several policies on chemical additives common in plastics, including PFAS, BPA, and phthalates that call for continued research, robust evidence-based regulatory frameworks. In the case of Policy H-135.945, "Encouraging Alternatives to PVC/Phthalate Products in Health," the AMA calls for a phasing out of polyvinyl chloride products with Di(2-ethylhexyl) phthalates in health care settings.

Existing AMA Policy D-135.976, "Modernization of the Federal Toxic Substances Control Act (TSCA) of 1976" calls on the AMA to advocate for modernizing the TSCA to require chemical manufacturers to provide adequate safety information on all chemicals and give federal regulatory agencies reasonable authority to regulate hazardous chemicals in order to protect the health of all individuals, especially vulnerable populations; support the public disclosure of chemical use, exposure and hazard data in forms that are appropriate for use by medical practitioners, workers, and the public; and work with members of the Federation to promote a reformed TSCA that is consistent with goals of Registration, Evaluation, Authorisation, and Restriction of Chemicals (REACH).

Furthermore, resolution 429-A-25, "Addressing the Health Consequences of Microplastics in Humans," was adopted by the House of Delegates.[1] This new policy recognizes the potential health risk of microplastics, encouraged increased research on the topic, called on AMA to support respective medical specialties and other relevant organizations to develop evidence-based guidelines for monitoring and mitigating microplastic exposure in water, food, air, and other consumer products, and for AMA to collaborate with relevant parties to promote public education on microplastics.

## CONCLUSION

Plastic poses serious environmental and human health concerns across its lifespan because it is primarily derived from fossil fuels, contains thousands of chemicals added during its production, is not easily recycled, and very slowly degrades in the environment. Plastic production, and consequently the volume of plastic waste, has grown exponentially over the last fifty years, threatening ecosystems and public health across the globe. There are several policy levers that can be employed across all levels of government and within institutions to reduce the burden of plastic pollution, the most impactful being to limit the amount of plastic being produced and used in the first place. Other strategies include improved waste management and recycling systems as well as the use of bioplastics as an alternative to synthetic plastics. Additionally, more research is needed to better understand the effectiveness of policies that limit the use of single-use plastic products as well as the health impacts of microplastics and the chemicals found in plastics.

## RECOMMENDATIONS

The Council on Science and Public Health recommends that the following be adopted, and the remainder of the report be filed.

1. That Policy H-135.901, "Addressing the Health Consequences of Microplastics in Humans" be amended by addition and deletion to read as follows:

> ADDRESSING THE HEALTH CONSEQUENCES OF <u>PLASTICS AND</u> MICROPLASTICS IN HUMANS
>
> 1. Our American Medical Association recognize the potential health risks associated with <u>plastics and</u> microplastics ~~exposure~~ and encourage increased research to better understand the human health

effects and environmental impacts of plastics across their lifespan ~~microplastics,~~ including the chemicals used in plastic production.

2. Our AMA supports the development of ~~respective specialty medical societies with subject matter expertise and federal and state public health agencies, including the Centers for Disease Control and Prevention (CDC) and the Environmental Protection Agency (EPA), to develop~~ evidence-based guidelines for monitoring and mitigating microplastic exposure in water, food, air, and other consumer products.

3. Our AMA will collaborate with relevant stakeholders to promote public education about microplastics, their sources, potential health risks, and possible strategies for reducing exposure.

~~4. Our AMA will study and report back with policy recommendations on ways to reduce plastic pollution and its impact on climate change and health, including but not limited to federal, state, and local taxes and limitations on the use of single-use plastic consumer products and other types of plastic, interventions to reduce microplastics, and alternatives to plastic.~~

4. Our AMA supports policies to reduce plastic pollution, such as limits on single-use plastics (for example plastic bags), incentivizing non-plastic alternatives such as reusable bags, food containers, and packaging, incentivizing alternative reformulations of synthetic plastics (such as bioplastics), and improving recycling infrastructure and systems to better manage plastic waste.

2. That Policy D-135.976, "Modernization of the Federal Toxic Substances Control Act (TSCA) of 1976" be amended by addition and deletion to read as follows:

Our AMA will: (1) collaborate with relevant stakeholders to advocate for modernizing the Toxic Substances Control Act (TSCA) to require chemical manufacturers to provide adequate safety information on all chemicals and give federal regulatory agencies reasonable authority to regulate hazardous chemicals in order to protect the health of all individuals, especially vulnerable populations; (2) support the public disclosure of chemical use, exposure and hazard data in forms that are appropriate for use by medical practitioners, workers, and the public; (3) encourage the U.S. Environmental Protection Agency to consider the cumulative impacts of chemicals within their risk assessment process and quantify exposures across pathways and populations; ~~and~~ (~~3~~4) work with members of the Federation to promote a reformed TSCA that is consistent with goals of Registration, Evaluation, Authorisation, and Restriction of Chemicals (REACH), and (5) support the proactive restriction or phasing-out of chemicals suspected of posing significant health risks.

Fiscal Note: Minimal – less than $1,000.

APPENDIX A - GLOSSARY

| | |
|---|---|
| Bisphenols | Bisphenols represent a group of industrial chemicals used in plastic production to make hard, clear plastic (such as water bottles or baby bottles). They are also used as protective coatings on the inside of food and beverage cans. |
| Brominated chemicals | Compounds that contain bromine (a naturally occurring element), which helps reduce product flammability. |
| Cracking | A petrochemical process in which saturated hydrocarbons are broken down into smaller, often unsaturated, hydrocarbons known as olefins, that are then made into plastic resins.[51] |
| Ethane | A colorless, odorless, and flammable hydrocarbon gas, that is a key component of natural gas. |
| Ethylene | A colorless, flammable hydrocarbon gas that serves as a key industrial chemical in making plastics and industrial chemicals. |
| Fracking | Otherwise known as hydraulic fracking, this is a method of extracting natural gas and oil from deep shale rock formations using forced water, sand, and a mix of chemicals into horizontally drilled wells. |
| Hydrocarbons | Organic compounds composed entirely of carbon and hydrogen atoms; the primary components of fossil fuels. |
| Microplastics | Pieces of plastic that range in size but are less than 5 millimeters which are produced in two ways: (1) through the breakdown or degradation of larger plastic materials, or (2) intentionally manufactured at that size for use in consumer products. |
| Monomer | An individual network of atoms or molecules that are chemically united together to form a polymer. |
| Nanoplastic | Pieces of plastics smaller than 1 micrometer |
| Perfluoroalkyl and polyfluoroalkyl chemicals | Also known as PFAS chemicals, represent a large group of synthetic chemicals that are broadly defined by their chain of linked carbon and fluorine atoms. The strength of the carbon and fluorine chemical bond makes PFAS chemicals persistent with our environment and they do not break down easily, hence why they are known as “forever chemicals.” PFAS chemicals are a common component in many plastic consumer products, such as food packaging, clothing, and cosmetics, as they help create grease and water-resistant surfaces |
| Phthalates | A class of synthetic chemicals that are widely used in consumer products; are added to plastics to increase their flexibility, transparency, durability, and longevity. |
| Polymer | A large molecule that is made up of many repeating, smaller units (or monomers), and creates a network-like chemical structure. |
| Polypropylene | A versatile and widely used plastic found in many products, including food storage containers. Polyethylene is the most widely used plastic in the world found in many everyday products, such as plastic bags, plastic containers, and medical tubing. |
| Propylene | A colorless, flammable gas used as a chemical intermediate in the production of various substances, including polypropylene plastic applications. |
| Vinyl Chloride | A colorless, flammable gas that is primarily used to make hard plastic resin commonly found in plastic pipes and packaging materials |

APPENDIX B - FIGURES

**Figure 1. Historical Global Plastic Production[95]**

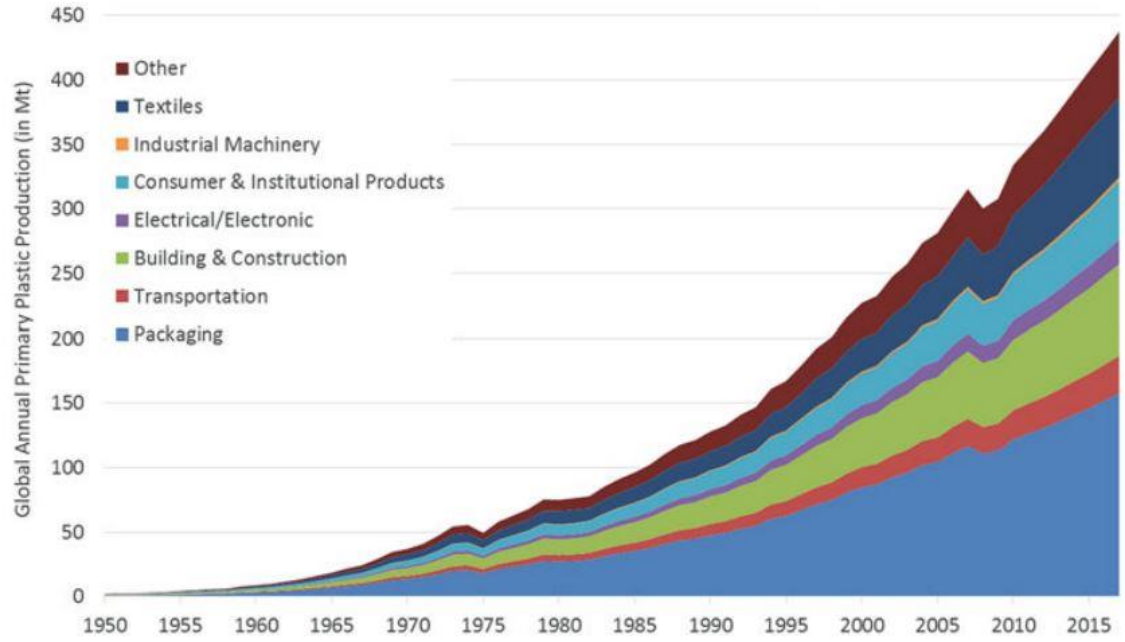



**Figure 2. Health Impacts of Plastic Across its Life Cycle[4]**

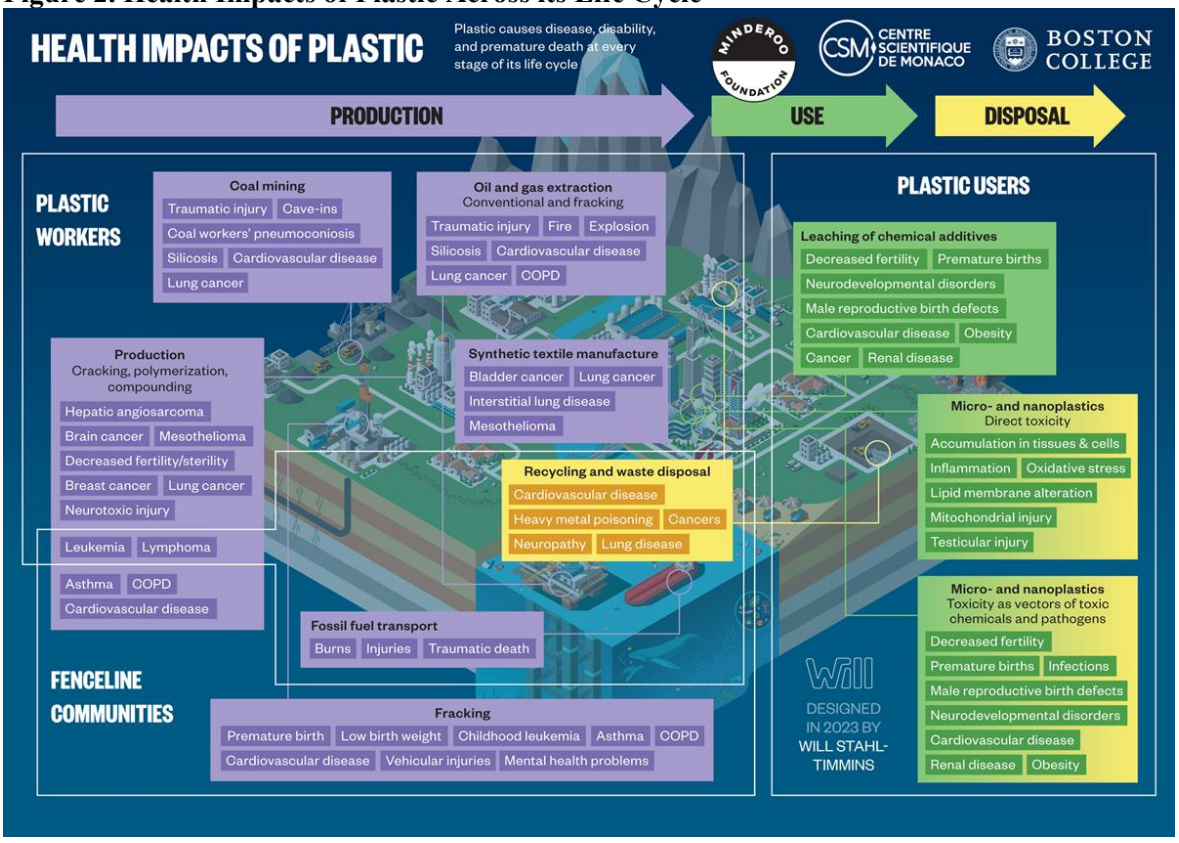
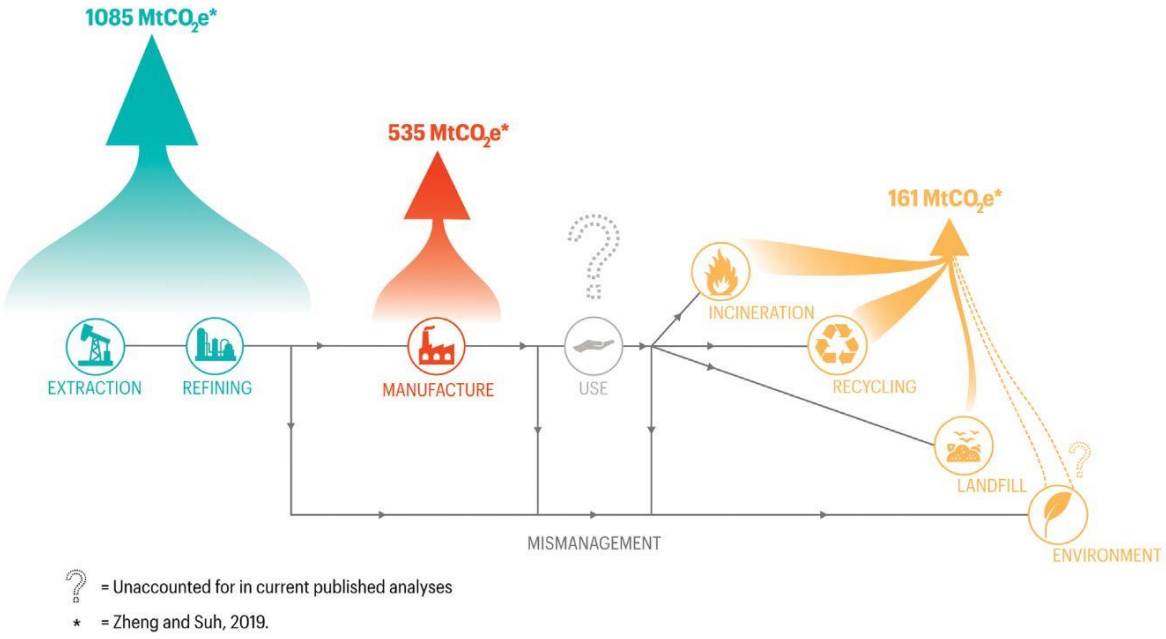


**Figure 3. Visualization of the estimated amounts of greenhouse gases released at each stage of the plastic life cycle.[51]**



APPENDIX C – ADOPTED U.S. STATE AND LOCAL LEGISLATION ON PLASTIC PRODUCTS AS OF JUNE 2025

| State | Summary of Legislation on plastics |
|---|---|
| Alaska | A majority of Alaskan communities, including Anchorage with code 15.95.020, have banned plastic bags unless they meet a certain requirement, such as being a certain thickness.[96] |
| Arizona | State law, SB 1241, bans any county, city, or town from "impos(ing) a tax, fee, assessment, charge" on "auxiliary containers" which includes bags, bottles, cups, and other containers made out of plastic.[97] |
| Arkansas | State law prohibits a municipality or county to "restrict, tax, prohibit, or otherwise regulate the use, disposition, or sale" of containers that are made out of plastic (Act 751 of the 93rd General Assembly).[98] |
| California | In August 2014, California became the first state to enact legislation imposing a statewide ban on single-use plastic bags at large retail stores. Additionally, by 2032, there must be a 25 percent decrease in single-use plastic packaging and food ware in the state, all single-use packaging and plastic ware must be recyclable or compostable and must recycle 65 percent of single-use plastic packaging and food ware.[99] |
| Colorado | With only a few exceptions, as of January 1, 2024, no store or retail food establishment can provide single-use plastic carryout bags to customers. There is also now a minimum of a 10-cent fee for recycled paper carryout bags.[100] |
| Connecticut | As of July 1, 2021, the state adopted a ban on stores providing or selling single-use checkout bags to customers (CT Gen Stat. Section 22a-246a).[101] |
| Delaware | As of Jan 1, 2021 store that has a single location of at least 7,000 square feet or has 3 or more locations each having at least 3,000 square feet of retail space cannot provide any single-use plastic carryout bags (Section 6099A). Additionally, other stores shall "adopt practices to eliminate the need for plastic carry out bags" and plastic bag manufacturers shall provide stores with recycling opportunities and educational programs for plastic bag and film recycling (7 DE Admin. Code 1301).[102,103] |
| Florida | State law prohibits local governments from regulating, taxing, or banning auxiliary containers, disposable plastic bags, or wrappings. However, Miami-Dade County circumvented this preemption by passing legislation that only applies to public places and eliminated single-use plastics and Styrofoam at Miami-Dade County facilities, including Miami International Airport.[104,105] |
| Georgia | Atlanta bans "non-compostable single-use serviceware" which includes plastic bags and plastic straws and South Fulton city bans single-use plastic bags in retail establishments.[106,107] |
| Hawaii | A few islands like Oahu have banned plastic bags and charge a minimum of 15 cents for recyclable or reusable bags.[108] |
| Idaho | State law prohibits any "regulation regarding the use, disposition or sale or any imposition of any prohibition, restriction, fee imposition or taxation" of containers that are designed for one-time use made out of plastic that is not made by the state legislature (Statute 67-2340).[109] |
| Illinois | Effective July 1, 2025, state legislation bans a hotel with 50 or more rooms to provide small, single-use plastic bottles with personal care products. Many cities have enacted their own legislation to either ban plastic single-use bags (see Evanston) or charge a small fee per single-use plastic bag (see, for example, Chicago).[75,110,111] |

| | |
|---|---|
| Indiana | State law, passed in 2016, bans local governments from taxing or restricting the use of disposable plastic bags by retailers.[112,113] |
| Iowa | State law prohibits counties to "adopt an ordinance, motion, resolution, or amendment that sets standards or requirements regarding the sale or marketing" of merchandise, including containers made out of plastic that are "used for consuming, carrying, or transporting" (HF 295).[114] |
| Kansas | Lawrence is the only city in Kansas with single-use plastic legislation. The city bans single-use disposable plastic bags with Ordinance No. 9996.[115] |
| Maine | With some limited exceptions, Maine bans retail establishments from providing single-use carry-out bags to customers (see 39 Maine Rev. Stat. Section 1611).[116] |
| Maryland | As of May 13, 2025, state law requires certain producers, including plastic producers, to increase recycling rates and develop more sustainable packaging designs (MD SB 901). Additionally, many counties and cities have banned retail establishments from providing single-use plastic carry-out bags.[117] |
| Massachusetts | As of June 2025, Massachusetts has pending legislation (Bill S2541) that would ban single-use plastic carry-out bags statewide and require a minimum 10-cent fee on paper or reusable bags, with half of the fee directed to environmental protection efforts. The bill also proposes limiting plastic use by requiring straws and plasticware only upon request, banning the sale of small plastic water bottles (1 liter or less) and 100ml plastic alcohol containers (with exceptions for health, safety, and emergencies), and prohibiting state agencies from purchasing single-use plastic bottles. Additional provisions include a statewide recycling program for large plastic items like car seats, mandatory "Do Not Flush" labels on non-flushable wipes, development of a public composting plan, creation of an Environmental Protection Trust Fund, and a Producer Responsibility Commission to recommend extended packaging waste reduction strategies.[118] |
| Michigan | State law bans municipalities from "regulating, prohibiting or adding fees to the use or sale" of single-use plastic products.[112] |
| Minnesota | State law prohibits any counties and cities from imposing any ban "upon the use of paper, plastic, or reusable bags for packaging of any item or good purchased from a merchant, itinerant vendor, or peddler" (section 471.9998). Alternatively, some cities have adopted a five-cent tax on single-use plastic bags (see, for example, Minneapolis, Duluth, and Edina).[119–121] |
| Mississippi | State law bans a county or municipality from regulating the use, disposition or sale or imposing a fee on packaging made out of plastic, regardless of if it's single-use or reusable (SB 2570).[112] |
| Missouri | State law prohibits any county, city, town or village to "impose any ban, fee, or tax upon the use of either paper or plastic bags for packaging of any item or good purchased from a merchant, itinerant vendor, or peddler" (Section 260.283).[122] |
| Montana | State law bans any local unit of government from adopting any policies that would prohibit, restrict, or regulate (including imposing a fee) on plastic products (HB 407).[123] |
| Nevada | Nevada has no statewide ban on single-use plastics, but several local jurisdictions have enacted restrictions, including a retailer plastic bag distribution ban effective January 1, 2022. Senate Bill 324 bans the sale of water in disposable plastic bottles (4 liters or less) in communities near Lake Tahoe.[124] |
| New Jersey | New Jersey currently enforces one of the most comprehensive statewide bans on single-use plastics through P.L. 2020, c.117, which became fully effective on May 4, 2022. The law prohibits single-use plastic carryout bags at all retail and food service establishments and bans paper bags in grocery stores over 2,500 square |

| | |
|---|---|
| | feet. Polystyrene foam food containers are also banned, with all exemptions having expired by May 2024. Plastic straws are allowed only upon customer request, per provisions in effect since November 4, 2021. The law is enforced through progressive penalties, ranging from warnings to fines of up to $5,000 per day. By 2023, it had already led to the elimination of 5.5 billion plastic bags and 110 million paper bags, while contributing to a 37% reduction in shoreline plastic litter and an 88% decrease in plastic straw distribution.[125] |
| New York | New York currently enforces a statewide ban on single-use plastic bags through the Bag Waste Reduction Act, effective since March 1, 2020. It prohibits retail and food service businesses from distributing plastic carryout bags and requires a minimum 5-cent charge for paper bags.[126] |
| North Carolina | State preemption law prohibits local governments from enacting their own plastic bag restrictions.[127] |
| Oregon | Oregon enforces a statewide ban on single-use plastic bags under House Bill 2509, effective January 1, 2023. The law prohibits most retailers, including grocery stores, restaurants, and other retail locations, from providing single-use plastic checkout bags and requires a minimum fee for paper alternatives. Senate Bill 543 expands Oregon's plastic reduction efforts by phasing out polystyrene foam food ware, packing peanuts, and coolers, and banning PFAS in food packaging starting January 1, 2025. By 2027, single-use plastic bags will be fully phased out at all checkout lanes statewide.[128] |
| Rhode Island | Rhode Island enforces a statewide ban on single-use plastic bags at retail establishments under the Plastic Waste Reduction Act, which took effect on January 1, 2024. The law establishes a uniform statewide standard and encourages consumers to use reusable bags. Paper bags may still be offered at some stores, but plastic checkout bags are not allowed.[129] |
| South Carolina | North Myrtle Beach became the 15th municipality to adopt a plastic bag ban, effective October 1, 2022. Charleston and at least 10 other coastal communities have banned plastic bags, straws, and foam containers.[130] |
| South Dakota | South Dakota prohibits local governments from regulating or banning single-use packaging under Codified Law 34A-6-92. This statute preempts municipal action on plastic bags, straws, beverage containers, and other packaging materials, aiming to maintain regulatory consistency statewide.[131] |
| Texas | Although some cities previously enacted local bans, a 2018 Texas Supreme Court ruling invalidated these ordinances, citing conflict with the state's Solid Waste Disposal Act. As a result, municipalities are prohibited from regulating the sale or use of containers, including plastic bags.[112] |
| Utah | Several municipalities such as Park City and Moab have implemented local restrictions on plastic bags and polystyrene containers. A 2023 update to Utah's bottle bill allows redemption center workers to sort containers by material type starting in 2025, supporting broader recycling efforts.[132] |
| Vermont | Vermont does not ban plastic bags outright but has passed legislation requiring retailers to charge a five-cent fee on both plastic and paper bags beginning July 1, 2024. The state has enacted laws and regulations to address single-use plastic bag usage, including a ban on plastic carry-out bags, the implementation of the five-cent fee on paper bags, and supporting public education initiatives to promote the use of reusable alternatives.[133,134] |
| Virginia | Virginia issued Executive Order 77, which mandates that all state agencies eliminate the use of disposable plastic bags and single-use foodware within 120 days of implementation. This executive order also required a full phase-out of |

| | |
|---|---|
| | other single-use plastics in state agencies and public universities by the year 2025. To note, this executive order was later repealed by a subsequent governor. Additionally, Virginia enacted legislation that bans single-use polystyrene foam containers statewide beginning July 1, 2025. Although the state does not currently have a plastic bag ban that applies broadly to retail businesses, House Bill 1757, passed in 2020, grants local governments the authority to enact their own fees or bans on plastic bags. Several municipalities in Virginia have already passed ordinances utilizing this authority, and enforcement is managed by the Virginia Department of Environmental Quality.[135] |
| Washington | Washington has enacted a statewide ban on single-use plastic bags that took effect on October 1, 2021, under Senate Bill 5323 passed in 2020. Retailers are prohibited from providing single-use plastic bags to customers and must charge an eight-cent fee for paper or reusable bag alternatives. A newer law signed in 2025 increases penalties related to plastic waste and permits retailers to offer thicker bags for sale beginning January 1, 2026, through the year 2028. Enforcement of these regulations is carried out by the Washington State Department of Ecology, and the law is recognized as one of the most comprehensive bans in the United States.[136] |
| Wisconsin | While municipalities previously had authority to regulate single use plastics, the 2015 Wisconsin Act 302 now prohibits local governments from enacting bans or fees.[137] |
| Wyoming | Local governments such as the Town of Jackson and Teton County have implemented ordinances banning single-use plastic bags and requiring a twenty-cent fee for paper or reusable alternatives. These fees support local waste reduction programs.[138] |

REFERENCES

1. American Medical Association. H-135.901 Addressing the Health Consequences of Microplastics in Humans. PolicyFinder. 2025. Accessed October 3, 2025. https://policysearch.ama-assn.org/policyfinder/detail/H-135.901?uri=%2FAMADoc%2FHOD.xml-H-135.901.xml
2. Ritchie H, Samborska V, Roser M. Plastic Pollution. *Our World Data*. Published online November 1, 2023. Accessed April 3, 2025. https://ourworldindata.org/plastic-pollution
3. Li Y, Tao L, Wang Q, Wang F, Li G, Song M. Potential Health Impact of Microplastics: A Review of Environmental Distribution, Human Exposure, and Toxic Effects. *Environ Health*. 2023;1(4):249-257. doi:10.1021/envhealth.3c00052
4. Landrigan PJ, Raps H, Cropper M, et al. The Minderoo-Monaco Commission on Plastics and Human Health. *Ann Glob Health*. 2023;89(1):23. doi:10.5334/aogh.4056
5. Perkins S. Explainer: What are polymers? Science News Explores. October 13, 2017. Accessed July 22, 2025. https://www.snexplores.org/article/explainer-what-are-polymers
6. Nandakumar A, Chuah JA, Sudesh K. Bioplastics: A boon or bane? *Renew Sustain Energy Rev*. 2021;147:111237. doi:10.1016/j.rser.2021.111237
7. Plastic Oceans International. Plastic: It's Not All the Same. Plastic Oceans International. Accessed July 22, 2025. https://www.plasticoceans.org/blog/7-types-of-plastic
8. ScienceDirect Topics. Processing Aid - an overview. Accessed July 7, 2025. https://www.sciencedirect.com/topics/engineering/processing-aid
9. Trasande L. The role of plastics in allergy, immunology, and human health: What the clinician needs to know and can do about it. *Ann Allergy Asthma Immunol Off Publ Am Coll Allergy Asthma Immunol*. 2025;134(1):46-52. doi:10.1016/j.anai.2024.06.029
10. Symeonides C, Aromataris E, Mulders Y, et al. An Umbrella Review of Meta-Analyses Evaluating Associations between Human Health and Exposure to Major Classes of Plastic-Associated Chemicals. *Ann Glob Health*. 2024;90(1):52. doi:10.5334/aogh.4459
11. Seewoo BJ, Goodes LM, Mofflin L, et al. The plastic health map: A systematic evidence map of human health studies on plastic-associated chemicals. *Environ Int*. 2023;181:108225. doi:10.1016/j.envint.2023.108225
12. Center for International Environmental Law. *Fueling Plastics: How Fracked Gas, Cheap Oil, and Unburnable Coal Are Driving the Plastics Boom*. Center for International Environmental Law; 2017. https://www.ciel.org/wp-content/uploads/2017/09/Fueling-Plastics-How-Fracked-Gas-Cheap-Oil-and-Unburnable-Coal-are-Driving-the-Plastics-Boom.pdf
13. Ye Y. We're drowning in single-use plastics. Here's why and what we can do about it. CU Boulder Today. April 18, 2024. Accessed April 17, 2025. https://www.colorado.edu/today/2024/04/18/were-drowning-single-use-plastics-heres-why-and-what-we-can-do-about-it
14. Plastic Pollution Coalition. Excessive Plastic in Healthcare: The Growing Crisis. Plastic Pollution Coalition. February 20, 2025. Accessed August 14, 2025. https://www.plasticpollutioncoalition.org/blog/2025/2/20/excessive-plastic-in-healthcare-the-growing-crisis
15. Jain N, LaBeaud D. How Should US Health Care Lead Global Change in Plastic Waste Disposal? *AMA J Ethics*. 2022;24(10):986-993. doi:10.1001/amajethics.2022.986
16. US EPA O. National Overview: Facts and Figures on Materials, Wastes and Recycling. October 2, 2017. Accessed August 31, 2023. https://www.epa.gov/facts-and-figures-about-materials-waste-and-recycling/national-overview-facts-and-figures-materials
17. US EPA O. Aluminum: Material-Specific Data. September 7, 2017. Accessed August 14, 2025. https://www.epa.gov/facts-and-figures-about-materials-waste-and-recycling/aluminum-material-specific-data
18. Tabuchi H, Saieed Z. The U.S. Sends Lots of Plastic Trash Overseas. Malaysia Just Said No Thanks. *The New York Times*. https://www.nytimes.com/2025/07/01/climate/plastic-recycling-malaysia-import-ban.html. July 1, 2025. Accessed July 1, 2025.

19. Ferreira-Filipe DA, Paço A, Duarte AC, Rocha-Santos T, Patrício Silva AL. Are Biobased Plastics Green Alternatives?—A Critical Review. *Int J Environ Res Public Health*. 2021;18(15):7729. doi:10.3390/ijerph18157729
20. U.S. EPA. Microplastics Research. April 22, 2022. Accessed April 3, 2025. https://www.epa.gov/water-research/microplastics-research
21. Yeoman K, Sussell A, Retzer K, Poplin G. Health risk factors among miners, oil and gas extraction workers, other manual labor workers, and non-manual labor workers, BRFSS 2013–2017, 32 States. *Workplace Health Saf*. 2020;68(8):391-401. doi:10.1177/2165079920909136
22. Occupational Safety and Health Administration. Oil and Gas Extraction - Hazards. Accessed July 14, 2025. https://www.osha.gov/oil-and-gas-extraction/hazards
23. National Oceanic and Atmospheric Administration. Oil spills. Accessed July 21, 2025. https://www.noaa.gov/education/resource-collections/ocean-coasts/oil-spills
24. Broadfoot M. Oil spill workers regain lung function. Environmental Factor, National Institute of Environmental Health Sciences. May 2020. Accessed July 21, 2025. https://factor.niehs.nih.gov/2020/5/papers/oil-spill
25. Lichtveld M, Sherchan S, Gam KB, et al. The Deepwater Horizon Oil Spill Through the Lens of Human Health and the Ecosystem. *Curr Environ Health Rep*. 2016;3(4):370-378. doi:10.1007/s40572-016-0119-7
26. Eckardt RE. Occupational and environmental health hazards in the plastics industry. *Environ Health Perspect*. 1976;17:103-106. doi:10.1289/ehp.7617103
27. National Cancer Institute. Vinyl Chloride - Cancer-Causing Substances. March 20, 2015. Accessed July 8, 2025. https://www.cancer.gov/about-cancer/causes-prevention/risk/substances/vinyl-chloride
28. Tyree TL. Environmental injustice: Fracking. *Public Health Nurs Boston Mass*. 2021;38(6):1015-1018. doi:10.1111/phn.12952
29. Nussbaum R. Yale environmental health expert discusses concerns about fracking. Accessed July 14, 2025. https://medicine.yale.edu/news-article/deziel/
30. Han J, Zhang B, Zhang X, Huang K, Fang V, Xu X. Associations between occurrence of birth defects and hydraulic fracturing activities in Barnett shale region, Texas. *Heliyon*. 2023;9(4):e15213. doi:10.1016/j.heliyon.2023.e15213
31. Horvatits T, Tamminga M, Liu B, et al. Microplastics detected in cirrhotic liver tissue. *EBioMedicine*. 2022;82:104147. doi:10.1016/j.ebiom.2022.104147
32. Landrigan PJ, Dunlop S, Treskova M, et al. The Lancet Countdown on health and plastics. *The Lancet*. 2025;0(0). doi:10.1016/S0140-6736(25)01447-3
33. Amato-Lourenço LF, Dantas KC, Júnior GR, et al. Microplastics in the Olfactory Bulb of the Human Brain. *JAMA Netw Open*. 2024;7(9):e2440018. doi:10.1001/jamanetworkopen.2024.40018
34. Nihart AJ, Garcia MA, El Hayek E, et al. Bioaccumulation of microplastics in decedent human brains. *Nat Med*. 2025;31(4):1114-1119. doi:10.1038/s41591-024-03453-1
35. Marfella R, Prattichizzo F, Sardu C, et al. Microplastics and Nanoplastics in Atheromas and Cardiovascular Events. *N Engl J Med*. 2024;390(10):900-910. doi:10.1056/NEJMoa2309822
36. eClinicalMedicine. Plastic pollution and health. *eClinicalMedicine*. 2023;60:102074. doi:10.1016/j.eclinm.2023.102074
37. Hafezi SA, Abdel-Rahman WM. The Endocrine Disruptor Bisphenol A (BPA) Exerts a Wide Range of Effects in Carcinogenesis and Response to Therapy. *Curr Mol Pharmacol*. 2019;12(3):230-238. doi:10.2174/1874467212666190306164507
38. Wang Y, Qian H. Phthalates and Their Impacts on Human Health. *Healthcare*. 2021;9(5):603. doi:10.3390/healthcare9050603
39. CDC. Human Exposure: PFAS Information for Clinicians - 2024. Per- and Polyfluoroalkyl Substances (PFAS) and Your Health. November 7, 2024. Accessed August 14, 2025. https://www.atsdr.cdc.gov/pfas/hcp/clinical-overview/human-exposure.html

40. Trasande L, Krithivasan R, Park K, Obsekov V, Belliveau M. Chemicals Used in Plastic Materials: An Estimate of the Attributable Disease Burden and Costs in the United States. *J Endocr Soc*. 2024;8(2):bvad163. doi:10.1210/jendso/bvad163
41. Prata JC, Silva ALP, da Costa JP, et al. Solutions and Integrated Strategies for the Control and Mitigation of Plastic and Microplastic Pollution. *Int J Environ Res Public Health*. 2019;16(13):2411. doi:10.3390/ijerph16132411
42. Stockholm Resilience Centre. Planetary boundaries. Stockholm University. September 19, 2012. Accessed July 16, 2025. https://www.stockholmresilience.org/research/planetary-boundaries.html
43. Thompson RC, Courtene-Jones W, Boucher J, Pahl S, Raubenheimer K, Koelmans AA. Twenty years of microplastic pollution research—what have we learned? *Science*. 2024;386(6720):eadl2746. doi:10.1126/science.adl2746
44. NOAA Office of Ocean Exploration and Research. What is the Pacific Garbage Patch? Ocean Exploration Facts. Accessed July 7, 2025. https://oceanexplorer.noaa.gov/facts/garbagepatch.html
45. Adkins F. Visualising the Great Pacific Garbage Patch. *BBC*. https://www.bbc.com/future/article/20240115-visualising-the-great-pacific-garbage-patch. January 16, 2024. Accessed July 15, 2025.
46. Awuchi CG, Awuchi CG. Impacts of Plastic Pollution on the Sustainability of Seafood Value Chain and Human Health. *Int J Adv Acad Res Sci Technol Eng*. 2019;5(11):46-138.
47. Pathak G, Nichter M, Hardon A, Moyer E. The Open Burning of Plastic Wastes is an Urgent Global Health Issue. *Ann Glob Health*. 90(1):3. doi:10.5334/aogh.4232
48. Verma R, Vinoda KS, Papireddy M, Gowda ANS. Toxic Pollutants from Plastic Waste- A Review. *Procedia Environ Sci*. 2016;35:701-708. doi:10.1016/j.proenv.2016.07.069
49. Cosier S. Burning plastic can affect air quality, public health. Environmental Factor, National Institute of Environmental Health Sciences. August 2022. Accessed July 17, 2025. https://factor.niehs.nih.gov/2022/8/science-highlights/burning-plastic
50. Plastics for Change. The Toxic Truth: Why Burning Plastic Waste Is a Health and Environmental Disaster. Plastics For Change. March 6, 2025. Accessed July 21, 2025. https://www.plasticsforchange.org/blog/can-plastic-waste-be-disposed-of-by-burning
51. Ford HV, Jones NH, Davies AJ, et al. The fundamental links between climate change and marine plastic pollution. *Sci Total Environ*. 2022;806(Pt 1):150392. doi:10.1016/j.scitotenv.2021.150392
52. Rebecca Lindsey, Luann Dahlman. Climate Change: Global Temperature. NOAA Climate.gov. January 18, 2024. Accessed July 17, 2024. http://www.climate.gov/news-features/understanding-climate/climate-change-global-temperature
53. Romanello M, di Napoli C, Green C, et al. The 2023 report of the Lancet Countdown on health and climate change: the imperative for a health-centred response in a world facing irreversible harms. Accessed July 23, 2024. https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(23)01859-7/fulltext
54. AMA Council on Science and Public Health. *Climate Change and Human Health*. American Medical Association; 2022. https://www.ama-assn.org/system/files/i22-csaph-report-02.pdf
55. American Medical Association. *Addressing the Public Health Crisis of Climate Change*. American Medical Association; 2024. https://www.ama-assn.org/system/files/addressing-the-public-health-crisis-of-climate-change.pdf
56. AMA Council on Science and Public Health. *Global Climate Change and Human Health*. American Medical Association; 2008. https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/about-ama/councils/Council%20Reports/council-on-science-public-health/i08-csaph-climate-change-health.pdf
57. European Parliament. New EU rules to reduce, reuse and recycle packaging. April 24, 2024. Accessed July 9, 2025. https://www.europarl.europa.eu/news/en/press-room/20240419IPR20589/new-eu-rules-to-reduce-reuse-and-recycle-packaging
58. US EPA O. The U.S. Recycling System. April 17, 2019. Accessed July 17, 2025. https://www.epa.gov/circulareconomy/us-recycling-system

59. Greenpeace. New Greenpeace Report: Plastic Recycling Is A Dead-End Street—Year After Year, Plastic Recycling Declines Even as Plastic Waste Increases. Greenpeace USA. Accessed August 31, 2023. https://www.greenpeace.org/usa/news/new-greenpeace-report-plastic-recycling-is-a-dead-end-street-year-after-year-plastic-recycling-declines-even-as-plastic-waste-increases/
60. Sullivan L. Recycling plastic is practically impossible — and the problem is getting worse. *NPR*. https://www.npr.org/2022/10/24/1131131088/recycling-plastic-is-practically-impossible-and-the-problem-is-getting-worse. October 24, 2022. Accessed July 17, 2025.
61. Ackerman J, Levin DB. Rethinking plastic recycling: A comparison between North America and Europe. *J Environ Manage*. 2023;340:117859. doi:10.1016/j.jenvman.2023.117859
62. National Council of State Legislatures. State and Federal Efforts to Revitalize Recycling. Accessed August 18, 2025. https://www.ncsl.org/environment-and-natural-resources/state-and-federal-efforts-to-revitalize-recycling
63. Brown E, MacDonald A, Allen S, Allen D. The potential for a plastic recycling facility to release microplastic pollution and possible filtration remediation effectiveness. *J Hazard Mater Adv*. 2023;10:100309. doi:10.1016/j.hazadv.2023.100309
64. ScienceDirect Topics. Bioplastics - an overview. Accessed June 30, 2025. https://www.sciencedirect.com/topics/agricultural-and-biological-sciences/bioplastics
65. Faizan Muneer, Nadeem H, Arif A, Zaheer W. Bioplastics from Biopolymers: An Eco-Friendly and Sustainable Solution of Plastic Pollution. *Polym Sci Ser C*. 2021;63(1):47-63. doi:10.1134/S1811238221010057
66. Statista. Bioplastics industry worldwide. Statista. Accessed July 21, 2025. https://www.statista.com/topics/8744/bioplastics-industry-worldwide/
67. Rosenboom JG, Langer R, Traverso G. Bioplastics for a circular economy. *Nat Rev Mater*. 2022;7(2):117-137. doi:10.1038/s41578-021-00407-8
68. Abe MM, Martins JR, Sanvezzo PB, et al. Advantages and Disadvantages of Bioplastics Production from Starch and Lignocellulosic Components. *Polymers*. 2021;13(15):2484. doi:10.3390/polym13152484
69. Ong H, Thiel CL, Singh H. Health Care Actions for Reducing Plastic Use and Pollution. *JAMA*. Published online September 23, 2024. doi:10.1001/jama.2024.17961
70. Bidashimwa D, Hoke T, Huynh TB, et al. Plastic pollution: how can the global health community fight the growing problem? *BMJ Glob Health*. 2023;8(Suppl 3):e012140. doi:10.1136/bmjgh-2023-012140
71. AMA Council on Science and Public Health. *Promoting the Use of Multi-Use Devices and Sustainable Practices in the Operating Room*. American Medical Association; 2023.
72. Mo C. Single-Use Plastics Regulations in the United States: An Overview. Compliance Gate. December 22, 2020. Accessed July 15, 2025. https://www.compliancegate.com/single-use-plastic-regulations-united-states/
73. National Council of State Legislatures. State Plastic Bag Legislation. February 8, 2021. Accessed July 21, 2025. https://www.ncsl.org/environment-and-natural-resources/state-plastic-bag-legislation
74. Village of Oak Park. Single Use Bag Initiative. Accessed July 21, 2025. https://www.oak-park.us/Community/Sustainability-Resilience/Sustainability-Initiatives-Policies/Single-Use-Bag-Initiative
75. City of Evanston. Retail Single Use Bag Tax. Accessed July 21, 2025. https://www.cityofevanston.org/government/departments/public-works/policies/retail-single-use-bag-tax
76. O'Connell-Domenech A. Where do plastic bag fees go? The Hill - Changing America. November 24, 2023. Accessed July 15, 2025. https://thehill.com/changing-america/sustainability/4322916-plastic-bag-fees-what-to-know/
77. Papp A, Oremus KL. Plastic bag bans and fees reduce harmful bag litter on shorelines. *Science*. 2025;388(6753):eadp9274. doi:10.1126/science.adp9274
78. Winters J. Science says plastic bag bans really do work. Grist. June 19, 2025. Accessed July 15, 2025. https://grist.org/science/plastic-bag-ban-beach-cleanups-ocean-conservancy-study/
79. American Recyclable Plastic Bag Alliance. Bag the Ban: Say no to bans and taxes on your grocery bags. Bag the Ban. 2019. Accessed July 15, 2025. https://www.bagtheban.com/

80. Barbosa J, Albano H, Silva CP, Teixeira P. Microbiological contamination of reusable plastic bags for food transportation. *Food Control*. 2019;99:158-163. doi:10.1016/j.foodcont.2018.12.041
81. Schnirring L. Bathroom-stored grocery bag fingered in norovirus outbreak. CIDRAP News. May 9, 2012. Accessed August 14, 2025. https://www.cidrap.umn.edu/foodborne-disease/bathroom-stored-grocery-bag-fingered-norovirus-outbreak
82. Synoracki O. Public Health Expert Refutes Safety of Disposables. Conservation Law Foundation. July 8, 2020. Accessed August 14, 2025. https://www.clf.org/blog/safety-of-disposables/
83. Wenzel E. California's ban on toxic IV bags marks a shift for health care plastics. Trellis. October 4, 2024. Accessed June 18, 2025. https://trellis.net/article/californias-ban-on-toxic-iv-bags-marks-a-shift-for-healthcare-plastics/
84. Erickson B. EU members agree to restrict 4 phthalates. *CEN Glob Enterp*. 2018;96(30):17-17. doi:10.1021/cen-09630-polcon2
85. U.S. FDA, Office of the Commissioner. The Microbead-Free Waters Act: FAQs. *FDA*. Published online August 22, 2024. Accessed July 15, 2025. https://www.fda.gov/cosmetics/cosmetics-laws-regulations/microbead-free-waters-act-faqs
86. U.S. Environmental Protection Agency. *National Strategy to Prevent Plastic Pollution*.; 2024. https://www.epa.gov/system/files/documents/2024-11/final_national_strategy_to_prevent_plastic_pollution.pdf
87. Carroll YI, Zarus G, Hunter C, Muianga C, Casillas G, Zarate-Bermudez M. NCEH/ATSDR Microplastic Working Group: Identifying and Addressing Data Needs to Evaluate Human Exposures to Microplastics. *ISEE Conf Abstr*. 2020;2020(1). doi:10.1289/isee.2020.virtual.P-1145
88. Sen. Merkley J [D O. Titles - S.3127 - 118th Congress (2023-2024): Break Free From Plastic Pollution Act of 2023. October 25, 2023. Accessed July 15, 2025. https://www.congress.gov/bill/118th-congress/senate-bill/3127/titles
89. US EPA O. Summary of the Toxic Substances Control Act. February 22, 2013. Accessed July 15, 2025. https://www.epa.gov/laws-regulations/summary-toxic-substances-control-act
90. Botos Á, Graham JD, Illés Z. Industrial chemical regulation in the European Union and the United States: a comparison of REACH and the amended TSCA #. *J Risk Res*. 2019;22(10):1187-1204. doi:10.1080/13669877.2018.1454495
91. Rayasam SDG, Koman PD, Axelrad DA, Woodruff TJ, Chartres N. Toxic Substances Control Act (TSCA) Implementation: How the Amended Law Has Failed to Protect Vulnerable Populations from Toxic Chemicals in the United States. *Environ Sci Technol*. 2022;56(17):11969-11982. doi:10.1021/acs.est.2c02079
92. Harrington T. RAeS study shows public concern about aviation emissions, but unwillingness to pay more for solutions. GreenAir News. April 11, 2025. Accessed May 5, 2025. https://www.greenairnews.com/?p=7118
93. Gartner E. Weak Laws and Weaker Governance Keep Toxic Chemicals on the Market. Earthjustice. April 7, 2016. Accessed July 15, 2025. https://earthjustice.org/article/weak-laws-and-weaker-governance-keep-toxic-chemicals-on-the-market
94. US EPA O. The Frank R. Lautenberg Chemical Safety for the 21st Century Act. June 9, 2016. Accessed July 15, 2025. https://www.epa.gov/assessing-and-managing-chemicals-under-tsca/frank-r-lautenberg-chemical-safety-21st-century-act
95. Streit-Bianchi M, Cimadevila M, Trettnak W, eds. *Mare Plasticum - The Plastic Sea: Combatting Plastic Pollution Through Science and Art*. 1st ed. Springer Cham; 2020. Accessed July 3, 2025. https://link.springer.com/book/10.1007/978-3-030-38945-1
96. Alaska Dept. of Environmental Conservation. Plastic Bag Bans. 2025. Accessed July 22, 2025. https://dec.alaska.gov/eh/solid-waste/plastic-bag-bans/
97. State of Arizona Senate. *S.B. 1241*.; 2015. https://www.azleg.gov/legtext/52leg/1r/bills/sb1241h.pdf
98. Representative Ray, Senator D. Sullivan. *Act 751: An Act to Amend the Law to Prohibit Municipalities and Counties from Restricting the Use of Auxiliary Containers, and for Other Purposes.*;

2021.
https://arkleg.state.ar.us/Home/FTPDocument?path=%2FACTS%2F2021R%2FPublic%2FACT751.pdf
99. State of California. California's Landmark Plastic Pollution Law Moves Forward. Governor of California. March 8, 2024. Accessed July 22, 2025. https://www.gov.ca.gov/2024/03/08/californias-landmark-plastic-pollution-law-moves-forward/
100. Colorado Department of Revenue, Taxation Division. Carryout Bag Fee. 2025. Accessed July 22, 2025. https://tax.colorado.gov/carryout-bag-fee
101. State of Connecticut. *Single-Use Checkout Bags*. Vol Title 22a, Chapter 446d.; 2019. Accessed July 22, 2025. https://law.justia.com/codes/connecticut/title-22a/chapter-446d/section-22a-246a/
102. Delaware. *Delaware Regulations - Administrative Code*. Vol Title 7-Natural Resources and Environmental Control. Accessed July 22, 2025. https://regulations.delaware.gov/AdminCode/title7/1301
103. Delaware Code Online. *Recycling and Waste Reduction*. Accessed July 22, 2025. https://delcode.delaware.gov/title7/c060/sc09/index.html#6099A
104. Lopez J. Miami-Dade County approves resolution to eliminate single-use plastics and styrofoam at County facilities. November 20, 2024. Accessed July 22, 2025. https://www.miamidade.gov/global/release.page
105. Greenprint Team. Everything You Need to Know About Florida's Plastic Bag Ban. Greenprint. February 3, 2025. Accessed August 18, 2025. https://greenprintproducts.com/florida-bag-ban/
106. City of Atlanta, Georgia. Ordinance 19-O-1418. 2019. Accessed July 22, 2025. https://atlantacityga.iqm2.com/Citizens/Detail_LegiFile.aspx?Frame=SplitView&MeetingID=3020&MediaPosition=&ID=18901&CssClass=
107. South Fulton, GA. CHAPTER 12. - SINGLE-USE PLASTICS REGULATIONS. Municode Library. October 8, 2019. Accessed July 22, 2025. https://library.municode.com/ga/south_fulton/codes/code_of_ordinances?nodeId=PT2COOR_TIT14EN_CH12SIEPLRE_S14-12001CIDEPR
108. Honolulu, O'ahu. *Plastic Bag Information Sheet*.; 2021. https://www1.honolulu.gov/opalaforms/PBB%20Tip%20Sheet%202021.pdf
109. Idaho Legislature. *Section 67-2340 – Idaho State Legislature*.; 2016. Accessed August 18, 2025. https://legislature.idaho.gov/statutesrules/idstat/title67/t67ch23/sect67-2340/
110. State of Illinois. *Small Single-Use Plastic Act.*; 2025. Accessed July 22, 2025. https://law.justia.com/codes/illinois/chapter-415/act-415-ilcs-195/
111. City of Chicago, IL. Checkout Bag Tax (2737). 2025. Accessed July 22, 2025. https://www.chicago.gov/content/city/en/depts/fin/supp_info/revenue/tax_list/CheckoutBagTax.html
112. PlasticBagLaws.org. Preemption Laws. PlasticBagLaws.org. Accessed August 18, 2025. https://www.plasticbaglaws.org/preemption
113. PackagingLaw.com. States Move to Enact Laws to Prevent Local Plastic Bag Bans and Taxes. June 20, 2016. Accessed August 18, 2025. https://www.packaginglaw.com/news/states-move-enact-laws-prevent-local-plastic-bag-bans-and-taxes
114. Iowa General Assembly. Iowa HF295 | 2017-2018 | 87th General Assembly. LegiScan. 2017. Accessed August 18, 2025. https://legiscan.com/IA/text/HF295/id/1577832
115. Plastic Free Lawrence. Ready for Reusables. 2023. Accessed July 22, 2025. https://plasticfreelawrence.org/
116. Maine Legislature. *Plastic Bag Reduction*.; 2019. Accessed July 22, 2025. https://legislature.maine.gov/legis/statutes/38/title38sec1611.html
117. Augustine, Love, Brooks, Hester, Kagan, Washington. *Environment - Packaging and Paper Products - Producer Responsibility Plans*.; 2025. Accessed July 22, 2025. https://www.billtrack50.com/billdetail/1816003
118. Commonwealth of Massachusetts. Bill S.2541 - Act to Reduce Plastics. June 23, 2025. Accessed August 18, 2025. https://malegislature.gov/Bills/194/S2541

119. City of Minneapolis. Bring Your Own Bag. 2025. Accessed July 22, 2025. https://www2.minneapolismn.gov/business-services/licenses-permits-inspections/business-licenses/bring-your-own-bag/
120. Edina, MN. Carryout Bag Fee. Accessed July 22, 2025. https://www.edinamn.gov/2047/Carryout-Bag-Fee
121. Van Daele K. Plastic Bag fee will begin on October 15. September 29, 2021. https://duluthmn.gov/media/WebSubscriptions/31/20210929-31-6577.pdf
122. Missouri Legislature. *Paper or Plastic Bags, Customers to Have Option, When — Political Subdivisions Prohibited from Imposing Ban, Fee, or Tax On.*; 2015. Accessed August 18, 2025. https://revisor.mo.gov/main/OneSection.aspx?section=260.283&bid=13924
123. Montana State Legislature. Montana HB407 | 2021 | Regular Session. LegiScan. Accessed August 18, 2025. https://legiscan.com/MT/bill/HB407/2021
124. Scheible M, Nguyen R. *SB324*.; 2025. Accessed July 24, 2025. https://www.leg.state.nv.us/App/NELIS/REL/83rd2025/Bill/12553/Overview
125. Shinske C, Hajna L, Grassi V. Murphy Administration Marks First Anniversary of Law Limiting Single-use Plastics in New Jersey. NJ Department of Environmental Protection News Releases. May 5, 2023. Accessed July 24, 2025. https://dep.nj.gov/newsrel/23_0027/
126. New York State Department of Environmental Conservation. Bag Waste Reduction Act: Information For Manufacturers And Retailers. 2020. Accessed August 18, 2025. https://dec.ny.gov/environmental-protection/recycling-composting/bag-waste-reduction-law/info-for-manufacturers-retailers
127. Article MHMG. Asheville was debating plastic bag ban, Durham a 10-cent fee. Then the state stepped in. Raleigh News & Observer. September 25, 2023. Accessed August 18, 2025. https://www.newsobserver.com/news/politics-government/article279610869.html
128. State of Oregon, Department of Environmental Quality. Single-Use Bag Ban. Accessed July 24, 2025. https://www.oregon.gov/deq/mm/production/Pages/Bags.aspx
129. Rhode Island Department of Environmental Management. DEM Reminds Public that Plastic Waste Reduction Act Regulations Go Into Effect in the New Year. December 14, 2023. Accessed August 18, 2025. https://dem.ri.gov/press-releases/dem-reminds-public-plastic-waste-reduction-act-regulations-go-effect-new-year
130. Grier CL. Does South Carolina Have A Plastic Bag Ban. EcologicLife.com. May 8, 2025. Accessed July 24, 2025. https://ecologiclife.com/is-it-illegal-to-use-plastic-bags-in-south.html
131. South Dakota Legislature. *Codified Law 34A-6-92*.; 2020. Accessed August 18, 2025. https://sdlegislature.gov/Statutes/34A-6-92
132. Salcido R. Banning Plastic. *Utah Law Rev*. 2024;2024(1):57-108.
133. State of Vermont, Department of Environmental Conservation. Single-Use Products Law. 2025. Accessed July 24, 2025. https://dec.vermont.gov/waste-management/solid/materials-mgmt/single-use-products-law
134. Tomanelli Z. VT Lawmakers Approve Nation's Strongest Anti-Plastic Pollution Legislation. Vermont Public Interest Research Group. May 22, 2019. Accessed July 24, 2025. https://www.vpirg.org/news/vt-lawmakers-approve-nations-strongest-anti-plastic-pollution-legislation/
135. Hafner K. Styrofoam containers will soon be banned in Virginia • Virginia Mercury. *Virginia Mercury*. https://virginiamercury.com/2025/06/23/styrofoam-containers-will-soon-be-banned-in-virginia/. June 23, 2025. Accessed July 24, 2025.
136. Seattle Public Utilities. Washington State Bag Requirements - Utilities | seattle.gov. 2021. Accessed July 24, 2025. https://www.seattle.gov/utilities/protecting-our-environment/sustainability-tips/waste-prevention/for-businesses/bag-requirements
137. Wisconsin State Legislature. Wisconsin Legislature: 2015 Wisconsin Act 302. March 30, 2016. Accessed August 18, 2025. https://docs.legis.wisconsin.gov/2015/related/acts/302
138. Lind K. Plastic bag ordinance reduces waste. *Jackson Hole News&Guide*. https://www.jhnewsandguide.com/news/town_county/plastic-bag-ordinance-reduces-

waste/article_ba03dd38-ae96-11ef-8dd6-6f984d5d88bb.html. December 11, 2024. Accessed July 24, 2025.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 901
(I-25)

Introduced by: Medical Society of the District of Columbia

Subject: Distinction Between Healthful and Unhealthful “Ultraprocessed” Foods

Referred to: Reference Committee K

---

Whereas, legislation is currently pending in the U.S. Congress to ban all “ultraprocessed foods” from the National School Lunch Program (H.R.2530, “Healthy Lunch for Healthy Kids Act”), without differentiating between “ultraprocessed” foods that serve public health needs and those that harm public health; and

Whereas, similar bills are pending in California and Pennsylvania, and the Make America Healthy Again Commission has described the consumption of “ultraprocessed foods” as a major public-health concern; and

Whereas, the term “ultraprocessed” has no universally accepted definition, leading to a July 25, 2025, federal Request for Information for suggestions on how to define the term, although it has been used to describe a wide range of products (e.g., sausage, burgers, sodas, breads, and cereals, among many others); and

Whereas, foods called “ultraprocessed” vary greatly in their health effects; in a large 2023 Harvard study, consumption of “ultraprocessed” cereals was associated with 22% reduced diabetes risk, fruit-based products were associated with 18% reduced risk, and yogurt was associated with a 9% reduced risk, while frequent consumption of animal-based “ultraprocessed” foods and sugar-sweetened beverages was associated with 44% and 15% increased risk of diabetes, respectively; and

Whereas, overly broad bans on “ultraprocessed” foods will hinder vital public health initiatives, including FDA-mandated addition of folic acid to cereal grain products, reducing spina bifida incidence; fortification of dairy milk and soymilk with vitamin D (a vitamin found in very few unfortified foods) and calcium, preventing rickets; and fortification of cereals with vitamin B12, reducing the risk of pernicious anemia; and

Whereas, overly broad bans on “ultraprocessed” foods will impede clinical management of nutrition-related conditions (e.g., the use of soymilk for breast cancer risk reduction, lactose intolerance, or dairy allergies and cholesterol-free meat substitutes for the management of lipid disorders); and

Whereas, in clinical trials, the inclusion of low-fat, plant-based “ultraprocessed” foods in intervention diets has been shown to not compromise weight loss or other health outcomes; and

Whereas, broad restrictions on “ultraprocessed” foods, without differentiating those that are healthful and those that are not, are likely to lead to (1) increased risk of nutritional deficiencies in children and adults, (2) increased risk of diabetes and cardiovascular disease, and (3) increased challenges for physicians and dietetic personnel guiding patients to healthful and convenient nutritional choices; and

Whereas, current AMA policy on “ultraprocessed” foods (H-150.914. Addressing the Health Impacts of Ultraprocessed Foods) inadvertently promotes the misunderstanding that all ultraprocessed foods are unhealthful and are to be avoided, potentially leading to serious adverse public health consequences; and

Whereas, a simple, one-word revision could transform AMA policy from one that runs counter to public health efforts to one that supports public health, allowing a differentiation between healthful processed foods that should remain in public nutrition programs and unhealthful processed foods that merit removal; therefore be it

RESOLVED, that our American Medical Association encourage public education on the difference between healthful “ultraprocessed” foods and unhealthful “ultraprocessed” foods (New HOD Policy); and be it further

RESOLVED, that our AMA amend AMA policy H-150.914, Addressing the Health Impacts of Ultraprocessed Foods, by deletion to remove the first appearance of the word “food,” so as to read “Our AMA supports and promotes public awareness and education about the differences between healthful ~~foods~~ and unhealthful ultraprocessed foods (UPF) and the benefits of minimally processed and unprocessed foods.” (Modify Current HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 9/15/25

**REFERENCES**

1. Presidential Commission to Make America Healthy Again. The MAHA Report. May 22, 2025. Available at: https://www.whitehouse.gov/wp-content/uploads/2025/05/MAHA-Report-The-White-Housepdf.
2. Chen Z, Khandpur N, Desjardins C, et al. Ultra-processed food consumption and risk of type 2 diabetes: three large prospective U.S. cohort studies. *Diabetes Care*. 2023;46:1335-44.
3. Dicken SJ, Dahm CC, Ibsen DB, et al. Food consumption by degree of food processing and risk of type 2 diabetes mellitus: a prospective cohort analysis of the European Prospective Investigation into Cancer and Nutrition (EPIC). *The Lancet Regional Health – Europe 2024*. https://doi.org/10.1016/j.lanepe.2024.101043.
4. Centers for Disease Control and Prevention. Racial/ ethnic differences in the birth prevalence of spina bifida—United States, 1995–2005. *MMWR Morb Mortal Wkly Rep*. 2009;57(53):1409–13.
5. Erlich MN, Ghidanac D, Blanco Mejia S, et al. A systematic review and meta-analysis of randomized trials of substituting soymilk for cow's milk and intermediate cardiometabolic outcomes: understanding the impact of dairy alternatives in the transition to plant-based diets on cardiometabolic health. *BMC Med*. 2024 Aug 22;22(1):336.
6. Crimarco A, Springfield S, Petlura C, et al. A randomized crossover trial on the effect of plant-based compared with animal-based meat on trimethylamine-N-oxide and cardiovascular disease risk factors in generally healthy adults: Study With Appetizing Plantfood-Meat Eating Alternative Trial (SWAP-MEAT). *Am J Clin Nutr*. 2020;112:1188-99.
7. Kahleova H, Znayenko-Miller T, Jayaraman A, et al. Vegan diet, processed foods, and body weight: a secondary analysis of a randomized clinical trial. *Nutr Metab (Lond)*. 2025 Mar 11;22(1):21.
8. Kahleova H, Himmelfarb J, Znayenko-Miller T, et al. Vegan diet, processed foods, and type 1 diabetes: A secondary analysis of a randomized clinical trial. *Nutr Metab Cardiovasc Dis*. 2025 Jun 13;104197.
9. Kahleova H, Znayenko-Miller T, Jayaraman A, et al. Processed foods in the context of a vegan diet, and changes in body weight and severe hot flashes in postmenopausal women: a secondary analysis of a randomized clinical trial. *Menopause.* 2025;32(9):1-5.

**RELEVANT AMA POLICY**

**H-150.914 Addressing the Health Impacts of Ultraprocessed Foods**
1. Our AMA supports and promotes public awareness and education about the differences between healthful foods and unhealthful ultraprocessed foods (UPF) and the benefits of minimally processed and unprocessed foods.
2. Our AMA supports federal, state, and local policies that promote and incentivize the production and distribution of healthier, affordable, minimally-processed and unprocessed foods.
3. Our AMA encourages the integration of nutrition education into all levels of medical education to empower clinicians to best counsel patients efficiently and effectively on reducing unhealthful UPF

consumption.
4. Our AMA supports increased funding to the FDA for research into the health impacts of ultraprocessed foods and strategies to mitigate their risks. [Res. 430, A-25]

**H-150.922 Reduction in Consumption of Processed Meats**
Our AMA supports: (1) reduction of processed meat consumption, especially for patients diagnosed or at risk for cardiovascular disease, type 2 diabetes, and cancer; (2) initiatives to reduce processed meats consumed in public schools, hospitals, food markets and restaurants while promoting healthy alternatives such as a whole foods and plant-based nutrition; (3) public awareness of the risks of processed meat consumption; and (4) educational programs for health care professionals on the risks of processed meat consumption and the benefits of healthy alternatives. [Res. 406, A-19]

**H-150.927 Strategies to Reduce the Consumption of Food and Beverages with Added Sweeteners**
1. Our American Medical Association acknowledges the adverse health impacts of sugar- sweetened beverage (SSB) consumption and food products with added sugars, and support evidence-based strategies to reduce the consumption of SSBs and food products with added sugars, including but not limited to, excise taxes on SSBs and food products with added sugars, removing options to purchase SSBs and food products with added sugars in primary and secondary schools, the use of warning labels to inform consumers about the health consequences of SSB consumption and food products with added sugars, and the use of plain packaging.
2. Our AMA encourages continued research into strategies that may be effective in limiting SSB consumption and food products with added sugars, such as controlling portion sizes; limiting options to purchase or access SSBs and food products with added sugars in early childcare settings, workplaces, and public venues; restrictions on marketing SSBs and food products with added sugars to children; and changes to the agricultural subsidies system.
3. Our AMA encourages hospitals and medical facilities to offer healthier beverages, such as water, unflavored milk, coffee, and unsweetened tea, for purchase in place of SSBs and apply calorie counts for beverages in vending machines to be visible next to the price.
4. Our AMA encourages physicians to
a. counsel their patients about the health consequences of SSB consumption and food products with added sugars and replacing SSBs and food products with added sugars with healthier beverage and food choices, as recommended by professional society clinical guidelines.
b. work with local school districts to promote healthy beverage and food choices for students.
5. Our AMA recommends that taxes on food and beverage products with added sugars be enacted in such a way that the economic burden is borne by companies and not by individuals and families with limited access to food alternatives.
6. Our AMA supports that any excise taxes are reinvested in community programs promoting health.
7. Our AMA will advocate for the end of tax subsidies for advertisements that promote among children the consumption of food and drink of poor nutritional quality, as defined by appropriate nutritional guiding principles. [CSAPH Rep. 03, A-17; Modified: Res. 429, A-22]

**H-150.929 Promotion of Healthy Lifestyles I: Reducing the Population Burden of Cardiovascular Disease by Reducing Sodium Intake**
1. Our American Medical Association calls for a step-wise, minimum 50% reduction in sodium in processed foods, fast food products, and restaurant meals to be achieved over the next decade.
2. Our AMA urges the FDA to publish future editions of their voluntary targets expeditiously to make further progress on sodium reduction.
3. Our AMA supports federal, state, and local efforts to set robust targets for reducing sodium levels in school meals, meals in health care facilities, and other meals provided by daily meal providers.
4. Our AMA will advocate for federal, state, and local efforts to reduce sodium levels in products from food manufacturers and restaurants to the greatest extent possible, without increasing levels of other unhealthy ingredients, such as added sugars or artificial ingredients.
5. Our AMA supports federal, state, and local efforts to require front-of-package warning labels for foods that are high in sodium based on the established recommended daily value.
6. Our AMA will assist in achieving the Healthy People 20302010 goal for sodium consumption, by will working with the FDA, the National Heart Lung Blood Institute, the Centers for Disease Control and Prevention, the American Heart Association, Academy of Nutrition and Dietetics, and other interested

partners to educate consumers about the benefits of reductions in sodium intake and other dietary approaches to reduce hypertension.
7. Our AMA supports the continuing education of physicians and other members of the health care team on counseling patients on lifestyle modification strategies to manage blood pressure, advocating for culturally relevant dietary models that reduce sodium intake.
8. Our AMA recommends that the FDA consider all options to promote reductions in the sodium content of processed foods.
9. Our AMA supports further study and evaluation of national salt reduction programs to determine the viability, industry engagement, and health and economic benefits of such programs.
10. Our AMA supports federal, state, and local efforts to regulate advertising of foods and products high in sodium, especially advertising targeted to children. [CSAPH Rep. 01, A-16; Modified: CSAPH Rep. 04, I-24]

**D-150.974 Support for Nutrition Label Revision and FDA Review of Added Sugars**
1. Our AMA will issue a statement of support for the newly proposed nutrition labeling by the Food and Drug Administration (FDA) during the public comment period.
2. Our AMA will recommend that the FDA further establish a recommended daily value (%DV) for the new added sugars listing on the revised nutrition labels based on previous recommendations from the WHO and AHA).
3. Our AMA will encourage further research into studies of sugars as addictive through epidemiological, observational, and clinical studies in humans.
4. Our AMA encourages the FDA to: (a) develop front-of-package warning labels for foods that are high in added sugars based on the established recommended daily value; and (b) limit the amount of added sugars permitted in a food product containing front-of-package health or nutrient content claims. [Res. 422, A-14; Appended: Res. 903, I-18]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 903
(I-25)

Introduced by: Tennessee

Subject: Nitrous Oxide Inhalant Abuse

Referred to: Reference Committee K

---

Whereas, flavored and unflavored nitrous oxide canisters are sold as food processing propellants for whipped cream and culinary food use on popular e-commerce websites, in tobacco and vape shops, and in gas stations; and

Whereas, the coercive branding on these nitrous oxide canisters bears far greater resemblance to vape or nicotine products than other food processing additives; and

Whereas, the misuse of these products by inhalation can lead to, among other symptoms, asphyxiation, blood clots, palpitations, paralysis, psychiatric disturbances, vitamin B12 deficiency, and in some cases, death; and

Whereas, recent social media trends have popularized the misuse and inhalation of nitrous oxide among children and adolescents across the United States with research results underscoring a significant increase over the last decade of nitrous oxide as an inhalant; therefore be it

RESOLVED, that our American Medical Association encourage and support the regulation of the branding of nitrous oxide canisters by U.S. Food and Drug Administration. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 9/18/25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 904
(I-25)

Introduced by: Mississippi

Subject: Supporting Certification of the Public Health Workforce

Referred to: Reference Committee K

---

Whereas, public health professionals play a crucial role in safeguarding population health, promoting wellness, and responding effectively to health crises, including pandemics, natural disasters, and health inequities; and

Whereas, the National Board of Public Health Examiners (NBPHE) was established in 2005 in response to a call from the Surgeon General for the credentialing and certification of public health workers, launching the Certified in Public Health (CPH) examination in 2008, and has since certified more than 14,000 professionals; and

Whereas, the CPH certification is voluntary and designed based on a rigorous Job Task Analysis (JTA), conducted every 5-7 years, to ensure alignment with current professional competencies in data analytics, leadership, communication, law and ethics, disease prevention, community engagement, policy advocacy, and population health outcomes; and

Whereas, leading public health organizations such as the American Public Health Association, the Council on Education in Public Health, the National Association of City and County Health Officials, and the Association of State and Territorial Health Officials support certification and are institutional members of the NBPHE; and

Whereas, the CPH certification process parallels well-established certification standards in medicine and is crucial for ensuring professional competency, credibility, continuous professional development, and preparedness in addressing evolving public health challenges; and

Whereas, physicians play an integral and leading role in public health initiatives and are well-positioned to promote high standards of professional competency within the public health workforce; and

Whereas, support from the American Medical Association would significantly enhance the recognition, adoption, and value of CPH certification across the healthcare and public health sectors; therefore be it

RESOLVED, that our American Medical Association support and endorse the Certified in Public Health (CPH) credential as a valuable certification for public health professionals (New HOD Policy); and be it further

RESOLVED, that our AMA encourage physicians engaged in public health practice to pursue and advocate for the CPH certification. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 9/22/25

**RELEVANT AMA POLICY**

**H-275.926 Medical Specialty Board Certifications Standards**

1. Our American Medical Association opposes any action, regardless of intent, that appears likely to confuse the public about the unique credentials of American Board of Medical Specialties (ABMS) or American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) board certified physicians in any medical specialty, or take advantage of the prestige of any medical specialty for purposes contrary to the public good and safety.
2. Our AMA opposes any action, regardless of intent, by organizations providing board certification for non-physicians that appears likely to confuse the public about the unique credentials of medical specialty board certification or take advantage of the prestige of medical specialty board certification for purposes contrary to the public good and safety.
3. Our AMA continues to work with other medical organizations to educate the profession and the public about the ABMS and AOA-BOS board certification process. It is AMA policy that when the equivalency of board certification must be determined, the certification program must first meet accepted standards for certification that include both
    a. a process for defining specialty-specific standards for knowledge and skills and
    b. offer an independent, external assessment of knowledge and skills for both initial certification and recertification or continuous certification in the medical specialty. In addition, accepted standards, such as those adopted by state medical boards or the Essentials for Approval of Examining Boards in Medical Specialties, will be utilized for that determination.
4. Our AMA opposes discrimination against physicians based solely on lack of ABMS or equivalent AOA-BOS board certification, or where board certification is one of the criteria considered for purposes of measuring quality of care, determining eligibility to contract with managed care entities, eligibility to receive hospital staff or other clinical privileges, ascertaining competence to practice medicine, or for other purposes. Our AMA also opposes discrimination that may occur against physicians involved in the board certification process, including those who are in a clinical practice period for the specified minimum period of time that must be completed prior to taking the board certifying examination.
5. Our AMA advocates for nomenclature to better distinguish those physicians who are in the board certification pathway from those who are not.
6. Our AMA encourages member boards of the ABMS to adopt measures aimed at mitigating the financial burden on residents related to specialty board fees and fee procedures, including shorter preregistration periods, lower fees and easier payment terms.
7. Our AMA encourages continued advocacy to federal and state legislatures, federal and state regulators, physician credentialing organizations, hospitals, and other interested parties to define physician board certification as the medical profession establishing specialty-specific standards for knowledge and skills, using an independent assessment process to determine the acquisition of knowledge and skills for initial certification and recertification.[Res. 318, A-07 Reaffirmation A-11 Modified: CME Rep. 2, I-15 Modified: Res. 215, I-19 Modified: Res. 316, I-22 Appended and Reaffirmed: CME Rep. 04, I-23 Reaffirmed in lieu of: Res. 302, A-24]

**H-275.924 Continuing Board Certification**

Our American Medical Association Principles on Continuing Board Certification

1. Changes in specialty-board certification requirements for CBC programs should be longitudinally stable in structure, although flexible in content.
2. Implementation of changes in CBC must be reasonable and take into consideration the time needed to develop the proper CBC structures as well as to educate physician diplomates about the requirements for participation.
3. Any changes to the CBC process for a given medical specialty board should occur no more frequently than the intervals used by that specialty board for CBC.
4. Any changes in the CBC process should not result in significantly increased cost or burden to physician participants (such as systems that mandate continuous documentation or require annual milestones).

5. CBC requirements should not reduce the capacity of the overall physician workforce. It is important to retain a structure of CBC programs that permits physicians to complete modules with temporal flexibility, compatible with their practice responsibilities.
6. Patient satisfaction programs such as The Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient survey are neither appropriate nor effective survey tools to assess physician competence in many specialties.
7. Careful consideration should be given to the importance of retaining flexibility in pathways for CBC for physicians with careers that combine clinical patient care with significant leadership, administrative, research and teaching responsibilities.
8. Legal ramifications must be examined, and conflicts resolved, prior to data collection and/or displaying any information collected in the process of CBC. Specifically, careful consideration must be given to the types and format of physician-specific data to be publicly released in conjunction with CBC participation.
9. Our AMA affirms the current language regarding continuing medical education (CME): “Each Member Board will document that diplomates are meeting the CME and Self-Assessment requirements for CBC Part II. The content of CME and self-assessment programs receiving credit for CBC will be relevant to advances within the diplomate’s scope of practice, and free of commercial bias and direct support from pharmaceutical and device industries. Each diplomate will be required to complete CME credits (AMA PRA Category 1 Credit”, American Academy of Family Physicians Prescribed, American College of Obstetricians and Gynecologists, and/or American Osteopathic Association Category 1A).”
10. In relation to CBC Part II, our AMA continues to support and promote the AMA Physician’s Recognition Award (PRA) Credit system as one of the three major credit systems that comprise the foundation for continuing medical education in the U.S., including the Performance Improvement CME (PICME) format; and continues to develop relationships and agreements that may lead to standards accepted by all U.S. licensing boards, specialty boards, hospital credentialing bodies and other entities requiring evidence of physician CME.
11. CBC is but one component to promote patient safety and quality. Health care is a team effort, and changes to CBC should not create an unrealistic expectation that lapses in patient safety are primarily failures of individual physicians.
12. CBC should be based on evidence and designed to identify performance gaps and unmet needs, providing direction and guidance for improvement in physician performance and delivery of care.
13. The CBC process should be evaluated periodically to measure physician satisfaction, knowledge uptake and intent to maintain or change practice.
14. CBC should be used as a tool for continuous improvement.
15. The CBC program should not be a mandated requirement for licensure, credentialing, recredentialing, privileging, reimbursement, network participation, employment, or insurance panel participation.
16. Actively practicing physicians should be well-represented on specialty boards developing CBC.
17. Our AMA will include early career physicians when nominating individuals to the Boards of Directors for ABMS member boards.
18. CBC activities and measurement should be relevant to clinical practice.
19. The CBC process should be reflective of and consistent with the cost of development and administration of the CBC components, ensure a fair fee structure, and not present a barrier to patient care.
20. Any assessment should be used to guide physicians’ self-directed study.
21. Specific content-based feedback after any assessment tests should be provided to physicians in a timely manner.
22. There should be multiple options for how an assessment could be structured to accommodate different learning styles.
23. Physicians with lifetime board certification should not be required to seek recertification.
24. No qualifiers or restrictions should be placed on diplomates with lifetime board certification recognized by the ABMS related to their participation in CBC.
25. Members of our House of Delegates are encouraged to increase their awareness of and participation in the proposed changes to physician self-regulation through their specialty organizations and other professional membership groups.
26. The initial certification status of time-limited diplomates shall be listed and publicly available on all American Board of Medical Specialties (ABMS) and ABMS Member Boards websites and

physician certification databases. The names and initial certification status of time-limited diplomates shall not be removed from ABMS and ABMS Member Boards websites or physician certification databases even if the diplomate chooses not to participate in CBC.

27. Our AMA will continue to work with the national medical specialty societies to advocate for the physicians of America to receive value in the services they purchase for Continuing Board Certification from their specialty boards. Value in CBC should include cost effectiveness with full financial transparency, respect for physicians' time and their patient care commitments, alignment of CBC requirements with other regulator and payer requirements, and adherence to an evidence basis for both CBC content and processes. [CME Rep. 16, A-09 Reaffirmed: CME Rep. 11, A-12 Reaffirmed: CME Rep. 10, A-12 Reaffirmed in lieu of Res. 313, A-12 Reaffirmed: CME Rep. 4, A-13 Reaffirmed in lieu of Res. 919, I-13 Appended: Sub. Res. 920, I-14 Reaffirmed: CME Rep. 2, A-15 Appended: Res. 314, A-15 Modified: CME Rep. 2, I-15 Reaffirmation A-16 Reaffirmed: Res. 309, A-16 Modified: Res. 307, I-16 Reaffirmed: BOT Rep. 05, I-16 Appended: Res. 319, A-17 Reaffirmed in lieu of: Res. 322, A-17 Modified: Res. 953, I-17 Reaffirmation: A-19 Modified: CME Rep. 02, A-19 Reaffirmed: Res. 310, I-22 Reaffirmed in lieu of: Res. 302, A-24 Reaffirmed in lieu of: Res. 316, A-24]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 905
(I-25)

Introduced by: Organized Medical Staff Section, Massachusetts

Subject: Standardizing Brain Death Policies

Referred to: Reference Committee K

---

Whereas, the core purpose of the AMA is to “promote the science and art of medicine and the betterment of public health." AMA policy provides the conceptual foundation and organizational framework for the activities that the Association undertakes to achieve its core purpose; and

Whereas, end-of-life issues are integral to the spectrum of healthcare delivery; and

Whereas, our American Medical Association currently has no established policy on standardized death determination; and

Whereas, before 1980, “the disparity between the common law determination of death and accepted medical practice pointed to the need for a uniform law. One goal of the Uniform Determination of Death Act was to close this disparity. The Uniform Law Commission (ULC) joined forces with the American Bar Association (ABA), the American Medical Association (AMA), and a Presidential Commission to provide a consistent basis for determining death. The President’s Commission was the Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. The ABA and the AMA approved the UDDA shortly after publication. Health care is generally a matter of state law. The Act intended to provide a standard for states to emulate”[1]; and

Whereas, the Uniform Determination of Death Act (UDDA) states that:

> “1. [Determination of Death]. An individual who has sustained either (1) irreversible cessation of circulatory and respiratory functions, or (2) irreversible cessation of all functions of the entire brain, including the brain stem, is dead. A determination of death must be made in accordance with accepted medical standards.
> 2. [Uniformity of Construction and Application]. This Act shall be applied and construed to effectuate its general purpose to make uniform the law with respect to the subject of this Act among states enacting it.”[2]

and

Whereas, the current status of determination of brain death/death by neurologic criteria (BD/DNC), by the Uniform Determination of Death Act is that such determination must be made in accordance with accepted medical standards, but the UDDA does not delineate those standards[3]; and

Whereas, today, there is variability in hospital policies about, and the practice of, BD/DNC determination within the United States which is in part due to the fact that there is no consensus amongst states as to a uniform standard[4]; and

Whereas, the accepted medical standards for BD/DNC determination “are only identified statutorily in Nevada and New Jersey and on a state health organization website in New York.

Lack of guidance about the accepted medical standards for BD/DNC determination contributes to variability across hospital BD/DNC determination policies, leading to medical, ethical and legal challenges"[5]; and

Whereas, as an example of states' handling of this issue, Massachusetts law states, "In addition to the rules of evidence in courts of general jurisdiction, the following rules relating to a determination of death and status apply: (1) Death occurs when an individual has sustained either (i) irreversible cessation of circulatory and respiratory functions or (ii) irreversible cessation of all functions of the entire brain, including the brain stem. A determination of death shall be made in accordance with accepted medical standards" but does not define what those medical standards are[6]; and

Whereas, the *New England Journal of Medicine* published an article on the history of BD/DNC without any more guidance or information[7]; and

Whereas, the Joint Commission indicated this is not within their purview, and deferred to the Centers for Medicare and Medicaid Services, who met to learn about this issue, but have taken no further action[8]; and

Whereas, the American Academy of Neurology (AAN), American Academy of Pediatrics (AAP), Child Neurology Society (CNS), and Society of Critical Care Medicine (SCCM) are the only national or international medical societies who have taken responsibility for writing guidelines on the determination of death by neurologic criteria in the United States since the 1980s[3, 9-12]; and

Whereas, a recent published update of BD/DNC consensus guidelines, "Pediatric and Adult Brain Death / Death by Neurologic Criteria Consensus Guideline; Report of the AAN Guidelines Subcommittee" has been a major step in codifying the contemporary state of determination in the United States, though additional information and changes in technology could invite future refinement of guidelines[13]; and

Whereas, the UDDA "was originally written in collaboration with the American Medical Association but they were not involved with the drafting committee; as the principal federal and state advocate on key health issues that impact physicians, patients, and healthcare institutions, they would be an ideal champion for revisions"[14]; and

Whereas, the American Medical Association is the best single organization to bring about a national consensus inclusive of medical and legal stakeholders of death determination; therefore be it

RESOLVED, that our American Medical Association collaborate with appropriate stakeholders to identify "accepted medical standards" for determination of brain death/death by neurologic criteria (BD/DNC) as required by the Uniform Determination of Death Act (Directive to Take Action); and be it further

RESOLVED, that our AMA encourage and support legislative and regulatory efforts to have one uniform set of standards for brain death/death by neurologic criteria used throughout the United States. (New HOD Policy)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/22/25

**REFERENCES**

1. McCall, M. (2023, June 7). *What is the Uniform Determination of Death Act (UDDA)?* FindLaw. https://www.findlaw.com/healthcare/patient-rights/what-is-the-uniform-declaration-of-death-act-or-udda.html
2. Uniform Law Commission. (2021, November 17). *Determination of Death Act*. Uniform Law Commission. https://www.uniformlaws.org/viewdocument/final-act-49?CommunityKey=155faf5d-03c2-4027-99ba-ee4c99019d6c&tab=librarydocuments
3. Greer, D.M et al. (2023). Pediatric and adult brain death/death by neurologic criteria consensus guideline: Report of the AAN Guidelines Subcommittee, AAP, CNS, and SCCM. *Neurology*. 101 (24). 1112-1132.
4. Landau, D., Kirschen, M.P., Greer, D. et al. (2025). States do not delineate the “accepted medical standards” for brain death/death by neurologic criteria determination. *Neurocritical Care*. https://link.springer.com/article/10.1007/s12028-024-02209-6
5. *Ibid*
6. Evidence of Death or Status, 190B § 1-107, https://malegislature.gov/Laws/GeneralLaws/PartII/TitleII/Chapter190B/ArticleI/Section1-107
7. Wijdicks, E.F.M. (2001). The diagnosis of brain death. *The New England Journal of Medicine*. 344 (16): 1215-1221.
8. Landau, D., Kirschen, M.P., Greer, D. et al. (2025). States do not delineate the "accepted medical standards" for brain death/death by neurologic criteria determination. Neurocritical Care. https://link.springer.com/article/10.1007/s12028-024-02209-6
9. Merkin Academy of Pediatrics Task Force on Brain Death in Children. (1987). Guidelines for the determination of brain death in children. *Pediatrics*. 80 (2): 298-300.
10. Wijdicks, E.F.M. (1995). Determining brain death in adults. *Neurology*. 45: 1003-1011.
11. Wijdicks, E.F.M. et al. (2010). Evidence-based guideline update: Determining brain death in adults. *Neurology*. 74: 1911-1918.
12. Nakagawa, T.A. et al. (2012). Guidelines for the determination of brain death in infants and children: An update of the 1987 task for recommendations-executive summary. *Annals of Neurology*. 71 (4): 573-85.
13. Greer, D.M et al. (2023). Pediatric and adult brain death/death by neurologic criteria consensus guideline: Report of the AAN Guidelines Subcommittee, AAP, CNS, and SCCM. Neurology. 101 (24). 1112-1132.
14. Landau, D., Kirschen, M.P., Greer, D. et al. (2025). States do not delineate the "accepted medical standards" for brain death/death by neurologic criteria determination. Neurocritical Care. https://link.springer.com/article/10.1007/s12028-024-02209-6

## RELEVANT AMA POLICY

### 6.1.6 Anencephalic Newborns as Organ Donors

Permitting parents of an anencephalic newborn to donate their child’s organs has been proposed as a way to increase the organ supply for pediatric transplantation.
However, organ donation in these circumstances also raises concerns, particularly about the accuracy of diagnosis and the potential implications for other vulnerable individuals who lack decision-making capacity and are not able to participate in decisions to donate their organs,
although anencephalic newborns are thought to be unique among other brain- damaged beings because they lack past consciousness and have no potential for future consciousness.
In the context of prospective organ donation from an anencephalic newborn, physicians may ethically:
(a) Provide ventilator assistance and other medical therapies that are necessary to
sustain organ perfusion and viability until such time as a determination of death can be made in accordance with accepted medical standards.
(b) Retrieve and transplant the organs of an anencephalic newborn only after such determination of death, and in accordance with ethics guidance for transplantation and for medical decisions for minors.
AMA Principles of Medical Ethics: I,III,V
*The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.*

Citation: Issued: 2016.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 906
(I-25)

Introduced by: Private Practice Physicians Section

Subject: Rethink the Medicare Annual Wellness Visit

Referred to: Reference Committee K

---

Whereas, the Medicare annual wellness visit (AWV) was established by the Patient Protection and Affordable Care Act (ACA) with the laudable goal of encouraging preventive care and reducing the cost of healthcare by addressing health issues before they become serious or costly; and

Whereas, the AWV does not include disease management and need not include a physical exam; and

Whereas, physician organizations' prioritization of the AWV appears to hamper patients with urgent medical issues from securing timely appointments with their physicians; and

Whereas, this often forces patients with urgent needs to seek care in emergency rooms, urgent care centers, or from physician assistant and nurse practitioners, which can result in inflated healthcare costs and compromised quality of care; and

Whereas, since the implementation of the AWV in 2011, there is little evidence to demonstrate improvement in patient outcomes; and

Whereas, patients drawn in by emails encouraging an AWV likely lead to the overutilization of primary care visits that are in short supply by low-risk, highly health-conscious individuals, diverting time and resources from patients with higher-risk conditions or acute needs; and

Whereas, replacing the AWV with a more thorough annual comprehensive examination would offer patients the opportunity to have their healthcare needs met expeditiously, utilize limited primary care services more efficiently, and would likely be more effective in improving patient outcomes; and

Whereas, physician reimbursement for an annual comprehensive examination should be greater than reimbursement for the AWV to reflect the increase in scope and encourage its acceptance and utilization; therefore be it

RESOLVED, that our American Medical Association advocate for a thoughtful reevaluation of the Medicare annual wellness visit and consider replacing it with an annual comprehensive examination that would integrate preventive care services, a thorough physical exam, and the management of acute or chronic health conditions. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/22/25

**RELEVANT AMA POLICY**

**Providers and the Annual Wellness Visit H-330.879**
1. Our AMA supports that the Medicare Annual Wellness Visit (AWV) is a benefit most appropriately provided by a physician or a member of a physician-led health care team that establishes or continues to provide ongoing continuity of care.
2. Our AMA supports that, at a minimum, any clinician performing the AWV must enumerate all relevant findings from the visit and make provisions for all appropriate follow-up care.
3. Our AMA supports that the Centers for Medicare & Medicaid Services (CMS) provide a means for physicians to determine whether or not Medicare has already paid for an AWV for a patient in the past 12 months.
4. Our AMA encourages CMS to educate Medicare enrollees, that, in choosing their primary care physician, they are encouraged to make their AWVs with their primary care physician in order to facilitate continuity and coordination of their care

Citation: CMS Rep. 03, I-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 907
(I-25)

Introduced by: Florida, South Carolina, Tennessee, Oklahoma

Subject: In-Office Dispensing of Generic Medications

Referred to: Reference Committee K

---

Whereas, many insurance companies require PAs for inexpensive generic medications, which in many cases can be purchased for less than a patient's insurance copay, resulting in waste of both physician and patient time; and

Whereas, in-office dispensing of generic medications can reduce the need for prior authorizations, eliminating administrative delays and lowering overall system costs; and

Whereas, patients may pay less for certain generic medications when purchased directly from their physician compared to using their insurance benefits; and

Whereas, one in five new prescriptions are never filled, and in-office dispensing of generic medications may improve medication adherence; and

Whereas, physician dispensing is permitted in most states and has been shown in one study to be at least equivalent in quality to pharmacist dispensing; therefore be it

RESOLVED, that our American Medical Association consider developing educational material for physicians interested in dispensing generic medications to reduce patient costs, improve access, and decrease unnecessary prior authorization requirements (Directive to Take Action); and be it further

RESOLVED, that our AMA encourage medical associations in states with restrictive dispensing laws to advocate for legislation allowing physicians to dispense generic medications to patients. (New HOD Policy)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/24/25

**REFERENCES**

1. Blome A, Kaigh C, Shaffer C, et al. Emergency department medication dispensing reduces return visits and admissions. Am J Emerg Med. 2020;38(11):2387-2390. doi:10.1016/j.ajem.2020.08.082.
2. Neiman AB, Ruppar T, Ho M, et al. CDC Grand Rounds: Improving medication adherence for chronic disease management — Innovations and opportunities. MMWR Morb Mortal Wkly Rep. 2017;66(45). doi:10.15585/mmwr.mm6645a2.
3. PLP. State laws for physician dispensing. PLP Resources website. https://plprx.com/resources/dispensing-regulations/. Accessed August 14, 2025.
4. Rachamin A, Meier R, Valeri F, Rosemann T, Muheim L. Physician-dispensing as a determinant of clinical and process measurements in patients at increased cardiovascular risk: A cross-sectional study in Swiss general practice. Health Policy. 2021;125(10):1305-1310. doi:10.1016/j.healthpol.2021.07.014.

## RELEVANT AMA POLICY

### 9.6.6 Prescribing & Dispensing Drugs & Devices

In keeping with physicians' ethical responsibility to hold the patient's interests as paramount, in their role as prescribers and dispensers of drugs and devices, physicians should:
(a) Prescribe drugs, devices, and other treatments based solely on medical considerations, patient need, and reasonable expectations of effectiveness for the particular patient.
(b) Dispense drugs in their office practices only if such dispensing primarily benefits the patient.
(c) Avoid direct or indirect influence of financial interests on prescribing decisions by:
(i) declining any kind of payment or compensation from a drug company or device manufacturer for prescribing its products, including offers of indemnification;
(ii) respecting the patient's freedom to choose where to fill prescriptions. In general, physicians should not refer patients to a pharmacy the physician owns or operates.
AMA Principles of Medical Ethics: II,III,IV,V; Issued: 2016

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 908
(I-25)

Introduced by: Utah

Subject: Support of Access to Insulin-Detemir

Referred to: Reference Committee K

---

Whereas, insulin-detemir (known also under its branded name of Levemir) has been widely available and safely used for over 20 years, including in populations such as pregnant individuals and athletes for whom its properties are particularly well-suited; and

Whereas, insulin-detemir is currently no longer available in the United States, due to the decision of the manufacturer to discontinue its domestic production and sales here; and

Whereas, the manufacturer has signaled its intention to discontinue production of insulin-detemir worldwide in favor of focusing on other products that are more profitable, which will leave no available insulin-detemir anywhere in the world; and

Whereas, insulin-detemir has been off-patent now for six years, but no other company has been able to gain approval of a biosimilar version because of the immense expense of the current process; and

Whereas, if the manufacturer follows through on their plan to discontinue insulin-detemir worldwide, it will likely become impossible to ever have it back on the market, since current FDA process requires a comparison with a sample produced by the initial company that obtained permission to manufacture the medication, and that will no longer exist if the manufacturer ceases production; and

Whereas, insulin-detemir has a lower risk of hypoglycemic events compared to NPH insulin which is currently available over the counter; and

Whereas, insulin has been continuously available over the counter for 75 years and that availability has not resulted in increased harm among individuals who rely on insulin; and

Whereas, over-the-counter availability of insulin-detemir will make domestic manufacturing more economically viable, and there will always be some people in the United States who are not able to afford visiting with a prescriber but who still rely on insulin to treat their diabetes, and having additional options and ways of obtaining any product is necessary for free market dynamics to help keep prices less expensive; therefore be it

RESOLVED, that our American Medical Association support the designation of insulin-detemir as a drug in shortage to expedite FDA review and approval of biosimilar versions while the reference product remains available globally (New HOD Policy); and be it further

RESOLVED , that our AMA support allowing some of the funding allocated to the Special Diabetes Program to be used to incentivize domestic manufacturing of insulin, including insulin-detemir (New HOD Policy); and be it further

RESOLVED, that our AMA encourages the FDA to consider classifying insulin-detemir as an over-the-counter medication to expand access and affordability for individuals with diabetes (New HOD Policy); and be it further

RESOLVED, that our American Medical Association lobby Congress to pass legislation, or a similarly effective action, to accomplish the goals outlined in this resolution. (Directive to Take Action)

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

Received: 9/24/25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 909
(I-25)

Introduced by: American Academy of Sleep Medicine

Subject: Clinical Significance of Sleepiness

Referred to: Reference Committee K

---

Whereas, healthy sleep is recognized as vital for health and well-being in children, adolescents, and adults[1]; and

Whereas, excessive sleepiness is reported by one third of U.S. adults[2]; and

Whereas, sleepiness is a critical patient-reported outcome that is associated with increased risk for adverse health effects and diminished quality of life[3]; and

Whereas, excessive daytime sleepiness is detrimental to productivity, health, well-being, quality of life, and safety, making interventions that target sleepiness of critical importance to patients[3,4]; and

Whereas, sleepiness has clinical relevance as a critical marker of insufficient sleep[5,6], symptom of medical and mental health conditions, and side effect of medications[7,8]; and

Whereas, sleepiness is recognized as a major patient-reported symptom and disability associated with disorders of sleep and wakefulness and is a critical outcome in clinical trials evaluating treatments for these conditions[9]; and

Whereas, the evaluation and management of sleepiness is essential for ensuring patient safety and delivering patient-centered care; and

Whereas, existing AMA policy (H-15.958) recognizes sleepiness behind the wheel as a major public health issue; and

Whereas, existing AMA policy (H440.791) recognizes the importance of sleep health and advocates for public health interventions and policies to improve sleep health; therefore be it

RESOLVED, that our AMA support the evaluation and management of sleepiness as vital clinical services that are essential for patient safety and patient-centered care (New HOD Policy); and be it further

RESOLVED, that our AMA support initiatives that assess the impact of sleepiness and its treatment on daytime functioning and quality of life in diverse populations. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 9/24925

**REFERENCES**

1. Ramar K, Malhotra RK, Carden KA, et al. Sleep is essential to health: an American Academy of Sleep Medicine position statement. J Clin Sleep Med. 2021;17(10):2115–2119.
2. Kolla BP, He JP, Mansukhani MP, Frye MA, Merikangas K. Excessive sleepiness and associated symptoms in the U.S. adult population: prevalence, correlates, and comorbidity. *Sleep Health.* 2020;6(1):79–87.
3. Dinges DF. An overview of sleepiness and accidents. *J Sleep Res.* 1995;4(S2):4–14.
4. Banks S, Dinges DF. Behavioral and physiological consequences of sleep restriction. *J Clin Sleep Med.* 2007;3(5):519–528.
5. Borbély AA. A two process model of sleep regulation. Hum Neurobiol. 1982;1(3):195–204.
6. Basner M, Rao H, Goel N, Dinges DF. Sleep deprivation and neurobehavioral dynamics. Curr Opin Neurobiol. 2013;23(5):854–863.
7. American Academy of Sleep Medicine. Central Disorders of Hypersomnolence. International Classification of Sleep Disorders. 3rd ed, text revision. Darien, IL: American Academy of Sleep Medicine; 2023.
8. US Food and Drug Administration. Finding and learning about side effects (adverse reactions). https://www.fda.gov/drugs/find-information-about-drug/finding-and-learning-about-side-effects-adverse-reactions. Updated August 8, 2022. Accessed March 10, 2025.
9. Dement WC, Carskadon MA. Current perspectives on daytime sleepiness: the issues. *Sleep.* 1982;5(Suppl 2):S56–S66.

## RELEVANT AMA POLICY

### H-440.791 Sleep Deprivation as a Public Health Crisis

1. Our AMA recognizes the role of sleep health for all people, the contributions of sleep duration and quality on chronic health outcomes, mental health, and trauma, and the systemic drivers of modern living contributing towards poorer sleep.
2. Our AMA declares sleep deprivation a public health crisis in the United States and to declare sleep health a public health priority.
3. Our AMA supports efforts to increase research into the socioeconomic, psychosocial, environmental, technologic, and commercial drivers of sleep deprivation, poor sleep quality, and shortened sleep duration. [Res. 407, A-25]

### H-450.973 Outcomes Research

1. It is the policy of the AMA to (a) continue to promote outcomes research as an effective mechanism to improve the quality of medical care, (b) urge that the results of outcomes research be used for educational purposes and not as part of punitive processes, (c) promote the use of outcomes research in the development of practice parameters, (d) advocate that findings of outcomes research which identify individual physicians should only be disclosed within formal peer review processes, and (e) monitor outcomes research activities of the federal government, research organizations, and others.
2. The AMA urges state medical societies, national medical specialty societies, hospital medical staffs, and individual physicians to (a) assist organizations in the planning, development, implementation, and evaluation of appropriate outcomes research, (b) identify the significance and limitations of the findings of outcomes research, and (c) ensure that outcomes research is conducted in a manner that protects the confidentiality of patients and physicians.
3. The AMA urges organizations conducting or planning to conduct outcomes research to (a) ensure the accuracy of the data used in outcomes research, (b) include relevant physician organizations and practicing physicians in all phases of outcomes research, including the planning, development, implementation, and evaluation of outcomes research, (c) provide physician organizations and practicing physicians with adequate opportunity to review and comment on interpretations of the results of outcomes research, and (d) ensure that outcomes research is conducted in a manner that maintains patient and physician confidentiality.
[BOT Rep. K, A-91Reaffirmed: BOT Rep. 40, I-93Reaffirmed: CMS Rep. 7, A-05Reaffirmed: CMS Rep. 1, A-15Reaffirmed: CEJA Rep. 11, A-25}

### H-15.958 Fatigue, Sleep Disorders, and Motor Vehicle Crashes

1. Our American Medical Association recognizes sleepiness behind the wheel as a major public health issue and continues to encourage a national public education campaign by appropriate federal agencies and relevant advocacy groups.
2. Our AMA recommends that the National Institutes of Health and other appropriate organizations support research projects to provide more accurate data on the prevalence of sleep-related disorders in the general population and in motor vehicle drivers, and provide information on the consequences and natural history of such conditions.

3. Our AMA recommends that the U.S. Department of Transportation (DOT) and other responsible agencies continue studies on the occurrence of highway crashes and other adverse occurrences in transportation that involve reduced operator alertness and sleep.
4. Our AMA encourages continued collaboration between the DOT and the transportation industry to support research projects for the devising and effectiveness- testing of appropriate countermeasures against driver fatigue, including technologies for motor vehicles and the highway environment.
5. Our AMA urges responsible federal agencies to improve enforcement of existing regulations for truck driver work periods and consecutive working hours and increase awareness of the hazards of driving while fatigued. If changes to these regulations are proposed on a medical basis, they should be justified by the findings of rigorous studies and the judgments of persons who are knowledgeable in ergonomics, occupational medicine, and industrial psychology.
6. Our AMA recommends that physicians:
    a. become knowledgeable about the diagnosis and management of sleep-related disorders.
    b. investigate patient symptoms of drowsiness, wakefulness, and fatigue by inquiring about sleep and work habits and other predisposing factors when compiling patient histories.
    c. inform patients about the personal and societal hazards of driving or working while fatigued and advise patients about measures they can take to prevent fatigue-related and other unintended injuries.
    d. advise patients about possible medication-related effects that may impair their ability to safely operate a moto vehicle or other machinery.
    e. inquire whether sleepiness and fatigue could be contributing factors in motor vehicle-related and other unintended injuries.
    f. become familiar with the laws and regulations concerning drivers and highway safety in the state(s) where they practice.
7. Our AMA encourages all state medical associations to promote the incorporation of an educational component on the dangers of driving while sleepy in all drivers education classes (for all age groups) in each state.
8. Our AMA recommends that states adopt regulations for the licensing of commercial and private drivers with sleep-related and other medical disorders according to the extent to which persons afflicted with such disorders experience crashes and injuries.
9. Our AMA reiterates its support for physicians' use of E-codes in completing emergency department and hospital records, and urges collaboration among appropriate government agencies and medical and public health organizations to improve state and national injury surveillance systems and more accurately determine the relationship of fatigue and sleep disorders to motor vehicle crashes and other unintended injuries.

[CSA Rep. 1, A-96Appended: Res. 418, I-99Reaffirmed: CSAPH Rep. 1, A-09Modified: CSAPH Rep. 01, A-19Reaffirmation: A-22]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 911
(I-25)

Introduced by: Women Physicians Section, Academic Physicians Section

Subject: Safeguarding NIH-Funded and Other Women's Health Research in Peer-Reviewed Publishing

Referred to: Reference Committee K

---

Whereas, U.S. Health Secretary Robert F. Kennedy Jr. has signaled his distrust of prominent peer-reviewed journals such as The Lancet and the New England Journal of Medicine, going so far as to state that the Trump administration intends to prevent government scientists, including those at the National Institutes of Health (NIH), from publishing in such journals in their current form[1]; and

Whereas, he further announced plans to create government-controlled "in-house" journals that would replace independent publications as the venue for federally funded research[1]; and

Whereas, a 2022 study of published in Proceedings of the National Academy of Sciences of 49 peer-reviewed journals found that articles with novel findings were more often published, refuting the Trump administration's belief that peer-reviewed journals uphold the status quo in an anti-scientific manner[2]; and

Whereas, The Lancet, JAMA, NEJM, and other high-impact journals are globally respected for their rigorous peer review processes and critical role in advancing evidence-based medicine, public trust, and global collaboration; and

Whereas, politicizing the dissemination of scientific research threatens the transparency, credibility, and independence of the U.S. biomedical research enterprise; and

Whereas, restricting where NIH-funded researchers can publish undermines academic freedom and may disproportionately harm early-career scientists, physician-scientists, and public health researchers[3]; and

Whereas, existing policy H-460.865 reaffirms the commitment of the AMA to protect and freely disseminate scientific knowledge, data and research in alignment with the First Amendment of the U.S. Constitution; and

Whereas, women's health remains under-researched and underfunded, with documented disparities in publication, funding, and representation in scientific literature[4]; and

Whereas, agency staff at the NIH and Veteran's Administration have already been encouraged to deny grants for projects including the word "women," in the administration's self-described effort to halt research concerning diversity, equity and inclusion[5]; and

Whereas, the AMA Women Physicians Section (WPS)—as the largest section within the AMA and a leading advocate for advancing equity in research and health outcomes—recognizes that

limiting access to high-visibility publishing platforms may further marginalize research on women's health and underrepresented populations; therefore be it

RESOLVED, that our American Medical Association supports the independence of scientific research concerning women and underrepresented populations and the integrity of peer-reviewed medical journals (New HOD Policy); and be it further

RESOLVED, that our AMA advocates for continued dissemination of rigorous women's health research in respected, independent journals and oppose measures that could silence or sideline these efforts (Directive to Take Action); and be it further

RESOLVED, that our AMA publicly supports the freedom of the National Institutes of Health and other federally funded scientists and researchers to publish in independent, peer-reviewed journals of their choosing. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/25/25

**REFERENCES**

1. Cirruzzo C. RFK Jr. threatens to bar government scientists from publishing in leading medical journals. Politico. May 27, 2025. https://www.politico.com/news/2025/05/27/rfk-jr-nih-scientists-medical-journals-jama-lancet-nejm-00371349
2. Teplitskiy M, Peng H, Blasco A, Lakhani KR. Is novel research worth doing? Evidence from peer review at 49 journals. Proc Natl Acad Sci U S A. 2022 Nov 22;119(47):e2118046119. doi:10.1073/pnas.2118046119 https://www.pnas.org/doi/10.1073/pnas.2118046119
3. Nuwer R. U.S. Budget Cuts Are Robbing Early-Career Scientists of Their Future. Scientific American. July 3, 2025. https://www.scientificamerican.com/article/how-trumps-federal-funding-cuts-are-hurting-early-career-researchers-and/
4. Funding research on women's health. Nat Rev Bioeng. 2024 Oct 11;2:797–798. doi:10.1038/s44222-024-00253-7 https://www.nature.com/articles/s44222-024-00253-7
5. Luthra S, Rodriguez B. What happens to health research when 'women' is a banned word? The 19th News. March 27, 2025. https://19thnews.org/2025/03/women-lgbtq-health-research-trump-funding/

## RELEVANT AMA POLICY

**H-460.973 Protection of Scientific Freedom from Special Interest Groups**
The AMA reaffirms that the principles of scientific freedom for individual investigators should be upheld by all research funding agencies, administrators, and professional societies. [Sub. Res. 91, I-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CSAPH Rep. 2, A-08; Reaffirmed: CSAPH Rep. 01, A-18]

**H-460.895 Free Speech Applies to Scientific Knowledge**
Our AMA will advocate that scientific knowledge, data, and research will continue to be protected and freely disseminated in accordance with the U.S. First Amendment. [Res. 228, A-17; Reaffirmed: BOT Rep. 14, I-18]

**8.5 Disparities in Health Care**
Stereotypes, prejudice, or bias based on gender expectations and other arbitrary evaluations of any individual can manifest in a variety of subtle ways. Differences in treatment that are not directly related to differences in individual patients' clinical needs or preferences constitute inappropriate variations in health care. Such variations may contribute to health outcomes that are considerably worse in members of some populations than those of members of majority populations.

This represents a significant challenge for physicians, who ethically are called on to provide the same quality of care to all patients without regard to medically irrelevant personal characteristics.

To fulfill this professional obligation in their individual practices physicians should:

(a) Provide care that meets patient needs and respects patient preferences.
(b) Avoid stereotyping patients.
(c) Examine their own practices to ensure that inappropriate considerations about race, gender identify, sexual orientation, sociodemographic factors, or other nonclinical factors, do not affect clinical judgment.
(d) Work to eliminate biased behavior toward patients by other health care professionals and staff who come into contact with patients.
(e) Encourage shared decision making.
(f) Cultivate effective communication and trust by seeking to better understand factors that can influence patients' health care decisions, such as cultural traditions, health beliefs and health literacy, language or other barriers to communication and fears or misperceptions about the health care system.

The medical profession has an ethical responsibility to:

(g) Help increase awareness of health care disparities.
(h) Strive to increase the diversity of the physician workforce as a step toward reducing health care disparities.
(i) Support research that examines health care disparities, including research on the unique health needs of all genders, ethnic groups, and medically disadvantaged populations, and the development of quality measures and resources to help reduce disparities.
[Issued: 2016]

**H-525.988 Sex and Gender Differences in Medical Research**
Our AMA:
(1) reaffirms that gender and sex exclusion in broad medical studies questions the validity of the studies' impact on the health care of society at large;
(2) affirms the need to include people of all sexes and gender identities and expressions in studies that involve the health of society at large and publicize its policies;
(3) supports increased funding into areas of women's health and sexual and gender minority health research;
(4) supports increased research on women's health and sexual and gender minority health and the participation of women and sexual and gender minority communities in clinical trials, the results of which will permit development of evidence-based prevention and treatment strategies for all women and sexual and gender minority individuals from diverse cultural and ethnic groups, geographic locations, and socioeconomic status;
(5) recommends that all medical/scientific journal editors require, where appropriate, a sex-based and gender-based analysis of data, even if such comparisons are negative; and
(6) recommends that medical and scientific journals diversify their review processes to better represent women and sexual and gender minority individuals;
(7) supports the FDA's requirement of actionable clinical trial diversity action plans from drug and device sponsors that include women and sexual and gender minority populations;
(8) supports the FDA's efforts in conditioning drug and device approvals on post-marketing studies which evaluate the efficacy and safety of those products in women and sexual and gender minority populations when those groups were not adequately represented in clinical trials; and
(9) supports and encourages the National Institutes of Health and other grant-making entities to fund post-market research investigating pharmacodynamics and pharmacokinetics for generic drugs that did not adequately enroll women and sexual and gender minority populations in their clinical trials, prioritizing instances when those populations represent a significant portion of patients or reported adverse drug events. [Res. 80, A-91; Appended: CSA Rep. 4, I-00; Modified: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 05, A-16; Modified: Res. 004, A-23; Modified: CSAPH Rep. 04, A-24]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 912
(I-25)

Introduced by: Connecticut

Subject: Increasing Access through Federated Healthcare Data Architecture

Referred to: Reference Committee K

Whereas, large de-identified patient datasets are critical to study rare diseases, health disparities, and population-wide trends, and their availability enables augmented intelligence innovation, expands access to precision medicine, enhances interoperability, and advances patient-centered healthcare[1-9]; and

Whereas, multi-center research collaborations present opportunities for novel insights and are necessary for replicability and large-scale validation of findings, yet institutions and researchers with limited access to large datasets face barriers to participation, restricting their contribution to medical advances[10-13]; and

Whereas, federated data refers to a model in which participating organizations keep their patient-level data locally, transform them to a common data model, and run standardized queries/algorithms locally that return only approved or aggregate results, thereby enabling multi-site analyses without centralizing protected health information (PHI), enhancing both security and collaboration[15]; and

Whereas, federated data architecture's success is accepted in medical literature and underpins established networks such as the Food and Drug Administration's Sentinel Distributed Database and Patient-Centered Outcomes Research's Distributed Research Network[16-21]; and

Whereas, the U.S. government already has a federation-ready interoperability policy stack to facilitate multi-center research, enable cross-network exchange nationwide (with a majority of hospitals planning participation), and standardize electronic health information access[22-27]; and

Whereas, the U.S. government supports the technical resources (hardware and software) necessary to achieve a federated data model and adopting a federated data model aligns with articulated goals for cross-organizational data exchange without consolidation, as reflected in federal initiatives such as America's AI Action Plan and the White House and CMS Health Tech Ecosystem initiative[28-30]; and

Whereas, a non-federated data architecture allows for limitation of data access to historically prestigious institutions (e.g. Intelligent Research in Sight (IRIS) Registry) and allows entities that control de-identified datasets to profit by selling to external parties (e.g. Healthcare Cost and Utilization Project (HCUP)), reducing interoperability and equity in research and disproportionately harming institutions without extensive resources[31,32.]; and

Whereas, given the aforementioned technical and legislative infrastructure, adopting a federated data architecture is possible, and doing so would expand equitable access to de-identified

datasets, reduce gatekeeping and profit-driven restrictions on de-identified data, and enhance interoperability[17]; therefore be it

RESOLVED, that our American Medical Association study federated data architecture to evaluate its utility in expanding access to large de-identified healthcare datasets across institutions with the aims of enhancing interoperability through multi-center collaboration, preserving confidentiality by avoiding centralization of PHI, and accelerating ethical research and precision care. (Directive to Take Action)

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

Received: 9/25/25

**REFERENCES:**

1. Collins FS, Varmus H. A new initiative on precision medicine. *N Engl J Med*. Feb 26 2015;372(9):793-5. doi:10.1056/NEJMp1500523
2. Khan S, Khan HU, Nazir S. Systematic analysis of healthcare big data analytics for efficient care and disease diagnosing. *Sci Rep*. Dec 26 2022;12(1):22377. doi:10.1038/s41598-022-26090-5
3. *Sharing Clinical Trial Data: Maximizing Benefits, Minimizing Risk*. 2015.
4. Chustecki M. Benefits and Risks of AI in Health Care: Narrative Review. *Interact J Med Res*. Nov 18 2024;13:e53616. doi:10.2196/53616
5. Office USGA. Artificial Intelligence in Health Care: Benefits and Challenges of Machine Learning Technologies for Medical Diagnostics. U.S. Government Accountability Office. 2025. https://www.gao.gov/products/gao-22-104629
6. Alowais SA, Alghamdi SS, Alsuhebany N, et al. Revolutionizing healthcare: the role of artificial intelligence in clinical practice. *BMC Med Educ*. Sep 22 2023;23(1):689. doi:10.1186/s12909-023-04698-z
7. Delpierre C, Lefevre T. Precision and personalized medicine: What their current definition says and silences about the model of health they promote. Implication for the development of personalized health. *Front Sociol*. 2023;8:1112159. doi:10.3389/fsoc.2023.1112159
8. Johnson KB, Wei WQ, Weeraratne D, et al. Precision Medicine, AI, and the Future of Personalized Health Care. *Clin Transl Sci*. Jan 2021;14(1):86-93. doi:10.1111/cts.12884
9. Administration USFD. Precision Medicine. U.S. Food & Drug Administration. 2025. https://www.fda.gov/medical-devices/in-vitro-diagnostics/precision-medicine
10. Seastedt KP, Schwab P, O'Brien Z, et al. Global healthcare fairness: We should be sharing more, not less, data. *PLOS Digit Health*. Oct 2022;1(10):e0000102. doi:10.1371/journal.pdig.0000102
11. Chen W, Whitney HM, Kahaki S, et al. Multimodal data curation via interoperability: use cases with the Medical Imaging and Data Resource Center. *Sci Data*. Aug 1 2025;12(1):1340. doi:10.1038/s41597-025-05678-2
12. Tamuhla T, Lulamba ET, Mutemaringa T, Tiffin N. Multiple modes of data sharing can facilitate secondary use of sensitive health data for research. *BMJ Glob Health*. Oct 2023;8(10)doi:10.1136/bmjgh-2023-013092
13. Eisinger-Mathason TSK, Leshin J, Lahoti V, Fridsma DB, Mucaj V, Kho AN. Data linkage multiplies research insights across diverse healthcare sectors. *Commun Med (Lond)*. Mar 4 2025;5(1):58. doi:10.1038/s43856-025-00769-y
14. Resources FED. U.S. Data Federation. Office of Management and Budget, the General Services Administration, and the Office of Government Information Services. 2025. 2025. https://resources.data.gov/resources/us-data-federation/
15. Administration USFaD. FDA's Sentinel Initiative. U.S. Food and Drug Administration. 2025. 2025. https://www.fda.gov/safety/fdas-sentinel-initiative
16. Desai RJ, Marsolo K, Smith J, et al. The FDA Sentinel Real World Evidence Data Enterprise (RWE-DE). *Pharmacoepidemiol Drug Saf*. Oct 2024;33(10):e70028. doi:10.1002/pds.70028
17. Teo ZL, Jin L, Li S, et al. Federated machine learning in healthcare: A systematic review on clinical applications and technical architecture. *Cell Rep Med*. Feb 20 2024;5(2):101419. doi:10.1016/j.xcrm.2024.101419
18. Sarma KV, Harmon S, Sanford T, et al. Federated learning improves site performance in multicenter deep learning without data sharing. *J Am Med Inform Assoc*. Jun 12 2021;28(6):1259-1264. doi:10.1093/jamia/ocaa341
19. Informatics OHDSa. Standardized Data: The OMOP Common Data Model. Observational Health Data Sciences and Informatics. 2025. 2025. https://www.ohdsi.org/data-standardization/
20. Institute P-COR. PCORnet Distributed Data Network: Text for Draft Final Research Reports. Patient-Centered Outcomes Research Institute. 2025. 2025. https://www.pcori.org/research-results/peer-review/draft-final-research-report/pcornet-distributed-data-network-text-draft
21. Policy ASfT. TEFCA. Assistant Secretary for Technology Policy. 2025. https://www.healthit.gov/topic/interoperability/policy/trusted-exchange-framework-and-common-agreement-tefca
22. Policy ASfT. TEFCA Awareness and Planned Participation Among U.S. Hospitals: 2023. Assistant Secretary for Technology Policy. 2025. https://www.healthit.gov/data/data-briefs/tefca-awareness-and-planned-participation-among-us-hospitals-2023
23. Policy ASfT. Health Data, Technology, and Interoperability: Certification Program Updates, Algorithm Transparency, and Information Sharing (HTI-1) Final Rule. Assistant Secretary for Technology Policy. 2025. https://www.healthit.gov/topic/laws-regulation-and-policy/health-data-technology-and-interoperability-certification-program

24. Technology OotNCfHI. *HTI-1 Final Rule Overview*. 2024. https://www.healthit.gov/sites/default/files/facas/2024-01-18_HTI-1_Final_Rule_Overview_508.pdf
25. Services CfMM. CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F). Centers for Medicare & Medicaid Services. 2025. https://www.cms.gov/priorities/burden-reduction/overview/interoperability/policies-and-regulations/cms-interoperability-and-prior-authorization-final-rule-cms-0057-f/cms-interoperability-and-prior-authorization-final-rule-cms-0057-f
26. Stacy J. Petersen RDL, Keith J. Miller, Niyati H. Vakil. *Privacy Preserving Record Linkage (PPRL) Strategy and Recommendations*. 2023. https://www.nia.nih.gov/sites/default/files/2023-08/pprl-linkage-strategies-preliminary-report.pdf
27. House TW. *Winning the Race AMERICA'S AI ACTION PLAN*. 2025. https://www.whitehouse.gov/wp-content/uploads/2025/07/Americas-AI-Action-Plan.pdf
28. Services CfMM. Health Technology Ecosystem. Centers for Medicare & Medicaid Services. 2025. 2025. https://www.cms.gov/priorities/health-technology-ecosystem/health-technology-ecosystem
29. Lee CS, Blazes M, Lorch A, et al. American Academy of Ophthalmology Intelligent Research in Sight (IRIS(R)) Registry and the IRIS Registry Analytic Center Consortium. *Ophthalmol Sci*. Mar 2022;2(1):100112. doi:10.1016/j.xops.2022.100112
30. Research NBoE. Healthcare Cost and Utilization Project (HCUP) Data. National Bureau of Economic Research. 2025. 2025. https://www.nber.org/research/healthcare-cost-and-utilization-project-hcup-data
31. Kostick-Quenet KM, Compagnucci MC, Aboy M, Minssen T. Patient-centric federated learning: automating meaningful consent to health data sharing with smart contracts. *J Law Biosci*. Jan-Jun 2025;12(1):lsaf003. doi:10.1093/jlb/lsaf003
32. Casaletto J, Bernier A, McDougall R, Cline MS. Federated Analysis for Privacy-Preserving Data Sharing: A Technical and Legal Primer. *Annu Rev Genomics Hum Genet*. Aug 25 2023;24:347-368. doi:10.1146/annurev-genom-110122-084756

## RELEVANT AMA POLICY

### D-478.996 Information Technology Standards and Costs

1. Our American Medical Association will:
    a. encourage the setting of standards for health care information technology whereby the different products will be interoperable and able to retrieve and share data for the identified important functions while allowing the software companies to develop competitive systems.
    b. work with Congress and insurance companies to appropriately align incentives as part of the development of a National Health Information Infrastructure (NHII), so that the financial burden on physicians is not disproportionate when they implement these technologies in their offices.
    c. review the following issues when participating in or commenting on initiatives to create a NHII:
        i. cost to physicians at the office-based level;
        ii. security of electronic records; and
        iii. the standardization of electronic systems;
    d. continue to advocate for and support initiatives that minimize the financial burden to physician practices of adopting and maintaining electronic medical records.
    e. continue its active involvement in efforts to define and promote standards that will facilitate the interoperability of health information technology systems.
2. Our AMA advocates that physicians:
    a. are offered flexibility related to the adoption and use of new certified Electronic Health Records (EHRs) versions or editions when there is not a sufficient choice of EHR products that meet the specified certification standards.
    b. not be financially penalized for certified EHR technology not meeting current standards.

[Res. 717, A-04; Reaffirmation, A-05; Appended: Sub. Res. 707, A-06; Reaffirmation A-07; Reaffirmed in lieu of Res. 818, I-07; Reaffirmed in lieu of Res. 726, A-08; Reaffirmation I-08; Reaffirmation I-09; Reaffirmation A-10; Reaffirmation I-10; Reaffirmed: Res. 205, A-11; Reaffirmed in lieu of Res. 714, A-12; Reaffirmed in lieu of Res. 715, A-12; Reaffirmed in lieu of Res. 724, A-13; Reaffirmation I-13; Reaffirmation A-14; Reaffirmed: BOT Rep. 03, I-16; Reaffirmed: BOT Rep. 05, I-16; Appended: Res. 204, I-17; Reaffirmation: I-17; Reaffirmed: BOT

Rep. 45, A-18; Reaffirmed: BOT Rep. 19, A-18; Reaffirmation: A-19; Reaffirmed: CMS Rep. 7, I-20; Reaffirmation: A-22; Reaffirmed: A-23]

**D-478.995 National Health Information Technology**

1. Our American Medical Association will closely coordinate with the newly formed Office of the National Health Information Technology Coordinator all efforts necessary to expedite the implementation of an interoperable health information technology infrastructure, while minimizing the financial burden to the physician and maintaining the art of medicine without compromising patient care.
2. Our AMA:
    a. Advocates for standardization of key elements of electronic health record (EHR) and computerized physician order entry (CPOE) user interface design during the ongoing development of this technology.
    b. Advocates that medical facilities and health systems work toward standardized login procedures and parameters to reduce user login fatigue.
    c. Advocates for continued research and physician education on EHR and CPOE user interface design specifically concerning key design principles and features that can improve the quality, safety, and efficiency of health care.
    d. Advocates for continued research on EHR, CPOE and clinical decision support systems and vendor accountability for the efficacy, effectiveness, and safety of these systems.
3. Our AMA will request that the Centers for Medicare & Medicaid Services:
    a. Support an external, independent evaluation of the effect of Electronic Medical Record (EMR) implementation on patient safety and on the productivity and financial solvency of hospitals and physicians' practices.
    b. Develop, with physician input, minimum standards to be applied to outcome-based initiatives measured during this rapid implementation phase of EMRs.
4. Our AMA will
    a. seek legislation or regulation to require all EHR vendors to utilize standard and interoperable software technology components to enable cost efficient use of electronic health records across all health care delivery systems including institutional and community based settings of care delivery.
    b. work with CMS to incentivize hospitals and health systems to achieve interconnectivity and interoperability of electronic health records systems with independent physician practices to enable the efficient and cost effective use and sharing of electronic health records across all settings of care delivery.
5. Our AMA will seek to incorporate incremental steps to achieve electronic health record (EHR) data portability as part of the Office of the National Coordinator for Health Information Technology's (ONC) certification process.
6. Our AMA will collaborate with EHR vendors and other stakeholders to enhance transparency and establish processes to achieve data portability.
7. Our AMA will directly engage the EHR vendor community to promote improvements in EHR usability.
8. Our AMA will advocate for appropriate, effective, and less burdensome documentation requirements in the use of electronic health records.
9. Our AMA will urge EHR vendors to adopt social determinants of health templates, created with input from our AMA, medical specialty societies, and other stakeholders with expertise in social determinants of health metrics and development, without adding further cost or documentation burden for physicians.

[Res. 730, I-04; Reaffirmed in lieu of Res. 818, I-07; Reaffirmed in lieu of Res. 726, A-08; Reaffirmation A-10; Reaffirmed: BOT Rep. 16, A-11; Modified: BOT Rep. 16, A-11; Modified:

BOT Rep. 17, A-12; Reaffirmed in lieu of Res. 714, A-12; Reaffirmed in lieu of Res. 715, A-12; Reaffirmed: BOT Rep. 24, A-13; Reaffirmed in lieu of Res. 724, A-13; Appended: Res. 720, A-13; Appended: Sub. Res. 721, A-13; Reaffirmed: CMS Rep. 4, I-13; Reaffirmation I-13; Appended: BOT Rep. 18, A-14; Appended: BOT Rep. 20, A-14; Reaffirmation A-14; Reaffirmed: BOT Rep. 17, A-15; Reaffirmed in lieu of Res. 208, A-15; Reaffirmed in lieu of Res. 223, A-15; Reaffirmation I-15; Reaffirmed: CMS Rep. 07, I-16; Reaffirmed: BOT Rep. 05, I-16; Appended: Res. 227, A-17; Reaffirmed in lieu of: Res. 243, A-17; Modified: BOT Rep. 39, A-18; Reaffirmed: BOT Rep. 45, A-18; Reaffirmed: BOT Rep. 19, A-18; Reaffirmation: A-19; Reaffirmed: CMS Rep. 3, I-19; Reaffirmed: CMS Rep. 2, A-22; Reaffirmation: Res. 715, A-24; Reaffirmed: Res. 802, I-24]

**H-315.962 Research Handling of De-Identified Patient Information**
Our American Medical Association supports efforts to promote transparency in the use of de-identified patient data and to protect patient privacy by developing methods of, and technologies for, de-identification of patient information that reduce the risk of re-identification of such information. [BOT Rep. 16, I-21; Reaffirmation: A-22; Reaffirmed: CMS Rep. 07, A-24]

**H-480.931 Assessing the Intersection Between AI and Health Care**
Augmented Intelligence Development, Deployment, and Use in Health Care

1. General Governance
    a. Health care AI must be designed, developed, and deployed in a manner which is ethical, equitable, responsible, accurate, transparent, and evidence-based.
    b. Use of AI in health care delivery requires clear national governance policies to regulate its adoption and utilization, ensuring patient safety, and mitigating inequities. Development of national governance policies should include interdepartmental and interagency collaboration.
    c. Compliance with national governance policies is necessary to develop AI in an ethical and responsible manner to ensure patient safety, quality, and continued access to care. Voluntary agreements or voluntary compliance is not sufficient.
    d. AI systems should be developed and evaluated with a specific focus on mitigating bias and promoting health equity, ensuring that the deployment of these technologies does not exacerbate existing disparities in health care access, treatment, or outcomes.
    e. Health care AI requires a risk-based approach where the level of scrutiny, validation, and oversight should be proportionate to the overall potential of disparate harm and consequences the AI system might introduc [See also Augmented Intelligence in Health Care H-480.939 at (1)]
    f. AI risk management should minimize potential negative impacts of health care AI systems while providing opportunities to maximize positive impacts.
    g. Clinical decisions influenced by AI must be made with specified qualified human intervention points during the decision-making process. A qualified human is defined as a licensed physician with the necessary qualifications and training to independently provide the same medical service without the aid of AI. As the potential for patient harm increases, the point in time when a physician should utilize their clinical judgment to interpret or act on an AI recommendation should occur earlier in the care plan. With few exceptions, there generally should be a qualified human in the loop when it comes to medical decision making capable of intervening or overriding the output of an AI model.
    h. Health care practices and institutions should not utilize AI systems or technologies that introduce overall or disparate risk that is beyond their capabilities to mitigate. Implementation and utilization of AI should avoid

exacerbating clinician burden and should be designed and deployed in harmony with the clinical workflow and, in institutional settings, consistent with AMA Policy H-225.940 - Augmented Intelligence and Organized Medical Staff.

i. Medical specialty societies, clinical experts, and informaticists are best positioned and should identify the most appropriate uses of AI-enabled technologies relevant to their clinical expertise and set the standards for AI use in their specific domain. [See Augmented Intelligence in Health Care H-480.940 at (2)]

2. When to Disclose: Transparency in Use of Augmented Intelligence-Enabled Systems and Technologies That Impact Medical Decision Making at the Point of Care
    a. Decisions regarding transparency and disclosure of the use of AI should be based upon a risk- and impact-based approach that considers the unique circumstance of AI and its use case. The need for transparency and disclosure is greater where the performance of an AI-enabled technology has a greater risk of causing harm to a patient.
        i. AI disclosure should align and meet ethical standards or norms.
        ii. Transparency requirements should be designed to meet the needs of the end users. Documentation and disclosure should enhance patient and physician knowledge without increasing administrative burden.
        iii. When AI is used in a manner which impacts access to care or impacts medical decision making at the point of care, that use of AI should be disclosed and documented to both physicians and/or patients in a culturally and linguistically appropriate manner. The opportunity for a patient or their caregiver to request additional review from a licensed clinician should be made available upon request.
        iv. When AI is used in a manner which directly impacts patient care, access to care, medical decision making, or the medical record, that use of AI should be documented in the medical record.
    b. AI tools or systems cannot augment, create, or otherwise generate records, communications, or other content on behalf of a physician without that physician's consent and final review.
    c. When AI or other algorithmic-based systems or programs are utilized in ways that impact patient access to care, such as by payors to make claims determinations or set coverage limitations, use of those systems or programs must be disclosed to impacted parties.
    d. The use of AI-enabled technologies by hospitals, health systems, physician practices, or other entities, where patients engage directly with AI, should be clearly disclosed to patients at the beginning of the encounter or interaction with the AI-enabled technology. Where patient-facing content is generated by AI, the use of AI in generating that content should be disclosed or otherwise noted within the content.
3. What to Disclose: Required Disclosures by Health Care Augmented Intelligence-Enabled Systems and Technologies
    a. When AI-enabled systems and technologies are utilized in health care, the following information should be disclosed by the AI developer to allow the purchaser and/or user (physician) to appropriately evaluate the system or technology prior to purchase or utilization:
        i. Regulatory approval status.
        ii. Applicable consensus standards and clinical guidelines utilized in design, development, deployment, and continued use of the technology.
        iii. Clear description of problem formulation and intended use accompanied by clear and detailed instructions for use.

iv. Intended population and intended practice setting.
v. Clear description of any limitations or risks for use, including possible disparate impact.
vi. Description of how impacted populations were engaged during the AI lifecycle.
vii. Detailed information regarding data used to train the model:
    1. Data provenance.
    2. Data size and completeness.
    3. Data timeframes.
    4. Data diversity.
    5. Data labeling accuracy.
viii. Validation Data/Information and evidence of:
    1. Clinical expert validation in intended population and practice setting and intended clinical outcomes.
    2. Constraint to evidence-based outcomes and mitigation of "hallucination"/"confabulation" or other output error.
    3. Algorithmic validation.
    4. External validation processes for ongoing evaluation of the model performance, e.g., accounting for AI model drift and degradation.
    5. Comprehensiveness of data and steps taken to mitigate biased outcomes.
    6. Other relevant performance characteristics, including but not limited to performance characteristics at peer institutions/similar practice settings.
    7. Post-market surveillance activities aimed at ensuring continued safety, performance, and equity.
ix. Data Use Policy:
    1. Privacy.
    2. Security.
    3. Special considerations for protected populations or groups put at increased risk.
x. Information regarding maintenance of the algorithm, including any use of active patient data for ongoing training.
xi. Disclosures regarding the composition of design and development team, including diversity and conflicts of interest, and points of physician involvement and review.

b. Purchasers and/or users (physicians) should carefully consider whether or not to engage with AI-enabled health care technologies if this information is not disclosed by the developer. As the risk of AI being incorrect increases risks to patients (such as with clinical applications of AI that impact medical decision making), disclosure of this information becomes increasingly important. [See also Augmented Intelligence in Health Care H-480.939]

4. Generative Augmented Intelligence
    a. Generative AI should: (a) only be used where appropriate policies are in place within the practice or other health care organization to govern its use and help mitigate associated risks; and (b) follow applicable state and federal laws and regulations (e.g., HIPAA-compliant Business Associate Agreement).
    b. Appropriate governance policies should be developed by health care organizations and account for and mitigate risks of:
        i. Incorrect or falsified responses; lack of ability to readily verify the accuracy of responses or the sources used to generate the response.

   ii. Training data set limitations that could result in responses that are out of date or otherwise incomplete or inaccurate for all patients or specific populations.
   iii. Lack of regulatory or clinical oversight to ensure performance of the tool.
   iv. Bias, discrimination, promotion of stereotypes, and disparate impacts on access or outcomes.
   v. Data privacy.
   vi. Cybersecurity.
   vii. Physician liability associated with the use of generative AI tools.
- c. Health care organizations should work with their AI and other health information technology (health IT) system developers to implement rigorous data validation and verification protocols to ensure that only accurate, comprehensive, and bias managed datasets inform generative AI models, thereby safeguarding equitable patient care and medical outcomes. [See Augmented Intelligence in Health Care H-480.940 at (3)(d)]
- d. Use of generative AI should incorporate physician and staff education about the appropriate use, risks, and benefits of engaging with generative AI. Additionally, physicians and healthcare organizations should engage with generative AI tools only when adequate information regarding the product is provided to physicians and other users by the developers of those tools.
- e. Clinicians should be aware of the risks of patients engaging with generative AI products that produce inaccurate or harmful medical information (g., patients asking chatbots about symptoms) and should be prepared to counsel patients on the limitations of AI-driven medical advice.
- f. Data and prompts contributed by users should primarily be used by developers to improve the user experience and AI tool quality and not simply increase the AI tool's market value or revenue generating potential.

5. Physician Liability for Use of Augmented Intelligence-Enabled Technologies
   - a. Current AMA policy states that liability and incentives should be aligned so that the individual(s) or entity(ies) best positioned to know the AI system risks and best positioned to avert or mitigate harm do so through design, development, validation, and implementation. [See Augmented Intelligence in Health Care H-480.939]
      i. Where a mandated use of AI systems prevents mitigation of risk and harm, the individual or entity issuing the mandate must be assigned all applicable liability.
      ii. Developers of autonomous AI systems with clinical applications (screening, diagnosis, treatment) are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users.
      iii. Health care AI systems that are subject to non-disclosure agreements concerning flaws, malfunctions, or patient harm (referred to as gag clauses) must not be covered or paid and the party initiating or enforcing the gag clause assumes liability for any harm.
   - b. When physicians do not know or have reason to know that there are concerns about the quality and safety of an AI-enabled technology, they should not be held liable for the performance of the technology in question.
   - c. Liability protections for physicians using AI-enabled technologies should align with both current and future AMA medical liability reform policies.
6. Data Privacy and Augmented Intelligence

a. Entity Responsibility:
    i. Entities, e.g., AI developers, should make information available about the intended use of generative AI in health care and identify the purpose of its use. Individuals should know how their data will be used or reused, and the potential risks and benefits.
    ii. Individuals should have the right to opt-out, update, or request deletion of their data from generative AI tools. These rights should encompass AI training data and disclosure to other users of the tool.
    iii. Generative AI tools should not reverse engineer, reconstruct, or reidentify an individual's originally identifiable data or use identifiable data for nonpermitted uses, e.g., when data are permitted to conduct quality and safety evaluations. Preventive measures should include both legal frameworks and data model protections, e.g., secure enclaves, federated learning, and differential privacy.
b. User Education:
    i. Users should be provided with training specifically on generative AI. Education should address:
        1. Legal, ethical, and equity considerations.
        2. Risks such as data breaches and re-identification.
        3. Potential pitfalls of inputting sensitive and personal data.
        4. The importance of transparency with patients regarding the use of generative AI and their data.

[See H-480.940, Augmented Intelligence in Health Care, at (4) and (5)]

7. Augmented Intelligence Cybersecurity
    a. AI systems must have strong protections against input manipulation and malicious attacks.
    b. Entities developing or deploying health care AI should regularly monitor for anomalies or performance deviations, comparing AI outputs against known and normal behavior.
    c. Independent of an entity's legal responsibility to notify a health care provider or organization of a data breach, that entity should also act diligently in identifying and notifying the individuals themselves of breaches that impact their personal information.
    d. Users should be provided education on AI cybersecurity fundamentals, including specific cybersecurity risks that AI systems can face, evolving tactics of AI cyber attackers, and the user's role in mitigating threats and reporting suspicious AI behavior or outputs.
8. Mitigating Misinformation in AI-Enabled Technologies
    a. AI developers should ensure transparency and accountability by disclosing how their models are trained and the sources of their training dat Clear disclosures are necessary to build trust in the accuracy and reliability of the information produced by AI systems.
    b. Algorithms should be developed to detect and flag potentially false and misleading content before it is widely disseminated.
    c. Developers of AI should have mechanisms in place to allow for reporting of mis- and disinformation generated or propagated by AI-enabled systems.
    d. Developers of AI systems should be guided by policies that emphasize rigorous validation and accountability for the content their tools generate, and, consistent with AMA Policy H-480.939(7), are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this

liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users.

e. Academic publications and journals should establish clear guidelines to regulate the use of AI in manuscript submissions. These guidelines should include requiring the disclosure that AI was used in research methods and data collection, requiring the exclusion of AI systems as authors, and should outline the responsibility of the authors to validate the veracity of any referenced content generated by AI.
f. Education programs are needed to enhance digital literacy, helping individuals critically assess the information they encounter online, particularly in the medical field where mis- and disinformation can have severe consequences.

9. Payor Use of Augmented Intelligence and Automated Decision-Making Systems
    a. Use of automated decision-making systems that determine coverage limits, make claim determinations, and engage in benefit design should be publicly reported, based on easily accessible evidence-based clinical guidelines (as opposed to proprietary payor criteria), and disclosed to both patients and their physician in a way that is easy to understand.
    b. Payors should only use automated decision-making systems to improve or enhance efficiencies in coverage and payment automation, facilitate administrative simplification, and reduce workflow burdens. Automated decision-making systems should never create or exacerbate overall or disparate access barriers to needed benefits by increasing denials, coverage limitations, or limiting benefit offerings. Use of automated decision-making systems should not replace the individualized assessment of a patient's specific medical and social circumstances and payors' use of such systems should allow for flexibility to override automated decisions. Payors should always make determinations based on particular patient care needs and not base decisions on algorithms developed on "similar" or "like" patients.
    c. Payors using automated decision-making systems should disclose information about any algorithm training and reference data, including where data were sourced and attributes about individuals contained within the training data set (e.g., age, race, gender). Payors should provide clear evidence that their systems do not discriminate, increase inequities, and that protections are in place to mitigate bias.
    d. Payors using automated decision-making systems should identify and cite peer-reviewed studies assessing the system's accuracy measured against the outcomes of patients and the validity of the system's predictions.
    e. Any automated decision-making system recommendation that indicates limitations or denials of care, at both the initial review and appeal levels, should be automatically referred for review to a physician (a) possessing a current and valid non-restricted license to practice medicine in the state in which the proposed services would be provided if authorized and (b) be of the same specialty as the physician who typically manages the medical condition or disease or provides the health care service involved in the request prior to issuance of any final determination. Prior to issuing an adverse determination, the treating physician must have the opportunity to discuss the medical necessity of the care directly with the physician who will be responsible for determining if the care is authorized.
    f. Individuals impacted by a payor's automated decision-making system, including patients and their physicians, must have access to all relevant information

(including the coverage criteria, results that led to the coverage determination, and clinical guidelines used).

g. Payors using automated decision-making systems should be required to engage in regular system audits to ensure use of the system is not increasing overall or disparate claims denials or coverage limitations, or otherwise decreasing access to care. Payors using automated decision-making systems should make statistics regarding systems' approval, denial, and appeal rates available on their website (or another publicly available website) in a readily accessible format with patient population demographics to report and contextualize equity implications of automated decisions. Insurance regulators should consider requiring reporting of payor use of automated decision-making systems so that they can be monitored for negative and disparate impacts on access to care. Payor use of automated decision-making systems must conform to all relevant state and federal laws.

[BOT Rep. 01, I-24; Reaffirmed: CSAPH Rep. 08, A-25; Reaffirmed in lieu of the first resolve: Res. 226, A-25]

**H-406.987 Medical Information and Its Uses**

DATA TRANSPARENCY PRINCIPLES TO PROMOTE IMPROVEMENTS IN QUALITY AND CARE DELIVERY

Our AMA seeks to help physicians improve the quality reporting of patient care data and adapt to new payment and delivery models to transform our health care system. One means of accomplishing this goal is to increase the transparency of health care data. The principles outlined below ensure that physicians, practices, care systems, physician-led organizations, patients and other relevant stakeholders can access and proactively use meaningful, actionable health care information to achieve care improvements and innovations. These principles do not replace but build upon existing AMA policies H-406.990, H-406.989, H-406.991, and H-406.996 that address safeguards for the release of physician data and physician profiles, expanding these guidelines to reflect the new opportunities and potential uses of this information.

Transparency Objectives and Goals

Engaging Physicians - Our AMA encourages greater physician engagement in transparency efforts, including the development of physician-led quality measures to ensure that gaps in measures are minimized and that analyses reflect the knowledge and expertise of physicians.

Promoting New Payment and Delivery Models - Our AMA supports appropriate funding and other support to ensure that the data that are used to inform new payment and delivery models are readily available and do not impose a new cost or additional burden on model participants.

Improving Care Choices and Decisions - Our AMA promotes efforts to present data appropriately depending on the objective and the relevant end-user, including transparently identifying what information is being provided, for what purpose, and how the information can or cannot be used to influence care choices.

Informing Physicians - Our AMA encourages the development of user interfaces that allow physicians or their staff to structure simple queries to obtain and track actionable reports related to specific patients, peer comparisons, provider-level resource use, practice patterns, and other relevant information.

Informing Patients - Our AMA encourages patients to consult with physicians to understand and navigate health care transparency and data efforts.

Informing Other Consumers - Our AMA seeks opportunities to engage with other stakeholders to facilitate physician involvement and more proactive use of health care data.

Data Transparency Resources
Data Availability - Our AMA supports removing barriers to accessing additional information from other payers and care settings, focusing on data that is valid, reliable, and complete.

Access to Timely Data - While some datasets will require more frequent updates than others, our AMA encourages use of the most current information and that governmental reports are made available, at a minimum, from the previous quarter.

Accurate Data - Our AMA supports proper oversight of entities accessing and using health care data, and more stringent safeguards for public reporting, so that information is accurate, transparent, and appropriately used.

Use of Quality Data - Our AMA supports definitions of quality based on evidence-based guidelines, measures developed and supported by specialty societies, and physician-developed metrics that focus on patient outcomes and engagement.

Increasing Data Utility - Our AMA promotes efforts by clinical data registries, regional collaborations, Qualified Entities, and specialty societies to develop reliable and valid performance measures, increase data utility and reduce barriers that currently limit access to and use of the health care data.

Challenges to Transparency
Standardization - Our AMA supports improvements in electronic health records (EHRs) and other technology to capture and access data in uniform formats.

Mitigating Administrative Burden - To reduce burdens, data reporting requirements imposed on physicians should be limited to the information proven to improve clinical practice. Collection, reporting, and review of all other data and information should be voluntary.

Data Attribution - Our AMA seeks to ensure that those compiling and using the data avoid attribution errors by working to correctly assign services and patients to the appropriate provider(s) as well as allowing entities to verify who or where procedures, services, and items were performed, ordered, or otherwise provided. Until problems with the current state of episode of care and attribution methodologies are resolved, our AMA encourages public data and analyses primarily focused at the system-level instead of on individual physicians or providers. [BOT Rep. 6, A-15; Reaffirmation: I-18; Reaffirmed: CSAPH Rep. 2, I-19]

**H-315.983 Patient Privacy and Confidentiality**

1. Our American Medical Association affirms the following key principles that should be consistently implemented to evaluate any proposal regarding patient privacy and the confidentiality of medical information:
    a. that there exists a basic right of patients to privacy of their medical information and records, and that this right should be explicitly acknowledged;
    b. that patients' privacy should be honored unless waived by the patient in a meaningful way or in rare instances when strong countervailing interests in public health or safety justify invasions of patient privacy or breaches of confidentiality, and then only when such invasions or breaches are subject to stringent safeguards enforced by appropriate standards of accountability;

   c. that patients' privacy should be honored in the context of gathering and disclosing information for clinical research and quality improvement activities, and that any necessary departures from the preferred practices of obtaining patients' informed consent and of de-identifying all data be strictly controlled;
   d. that any information disclosed should be limited to that information, portion of the medical record, or abstract necessary to fulfill the immediate and specific purpose of disclosure; and
   e. that the Health Insurance Portability and Accountability Act of 1996 (HIPAA) be the minimal standard for protecting clinician-patient privilege, regardless of where care is received.
2. Our AMA affirms:
   a. that physicians and medical students who are patients are entitled to the same right to privacy and confidentiality of personal medical information and medical records as other patients;
   b. that when patients exercise their right to keep their personal medical histories confidential, such action should not be regarded as fraudulent or inappropriate concealment and;
   c. that physicians and medical students should not be required to report any aspects of their patients' medical history to governmental agencies or other entities, beyond that which would be required by law.
3. Employers and insurers should be barred from unconsented access to identifiable medical information lest knowledge of sensitive facts form the basis of adverse decisions against individuals.
   a. Release forms that authorize access should be explicit about to whom access is being granted and for what purpose, and should be as narrowly tailored as possible.
   b. Patients, physicians, and medical students should be educated about the consequences of signing overly-broad consent forms.
   c. Employers and insurers should adopt explicit and public policies to assure the security and confidentiality of patients' medical information.
   d. A patient's ability to join or a physician's participation in an insurance plan should not be contingent on signing a broad and indefinite consent for release and disclosure.
4. Whenever possible, medical records should be de-identified for purposes of use in connection with utilization review, panel credentialing, quality assurance, and peer review.
5. The fundamental values and duties that guide the safekeeping of medical information should remain constant in this era of computerization. Whether they are in computerized or paper form, it is critical that medical information be accurate, secure, and free from unauthorized access and improper use.
6. Our AMA recommends that the confidentiality of data collected by race and ethnicity as part of the medical record, be maintained.
7. Genetic information should be kept confidential and should not be disclosed to third parties without the explicit informed consent of the tested individual.
8. When breaches of confidentiality are compelled by concerns for public health and safety, those breaches must be as narrow in scope and content as possible, must contain the least identifiable and sensitive information possible, and must be disclosed to the fewest possible to achieve the necessary end.
9. Law enforcement agencies requesting private medical information should be given access to such information only through a court order. This court order for disclosure should be granted only if the law enforcement entity has shown, by clear and convincing

evidence, that the information sought is necessary to a legitimate law enforcement inquiry; that the needs of the law enforcement authority cannot be satisfied by non-identifiable health information or by any other information; and that the law enforcement need for the information outweighs the privacy interest of the individual to whom the information pertains. These records should be subject to stringent security measures.

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

18. Our AMA supports privacy standards that would require pharmacies to obtain a prior written and signed consent from patients to use their personal data for marketing purposes.
19. Our AMA supports privacy standards that require pharmacies and drug store chains to disclose the source of financial support for drug mailings or phone calls.
20. Our AMA supports privacy standards that would prohibit pharmacies from using prescription refill reminders or disease management programs as an opportunity for marketing purposes.
21. Our AMA will draft model state legislation requiring consent of all parties to the recording of a physician-patient conversation.

[BOT Rep. 9, A-98 Reaffirmation I-98 Appended: Res. 4, and Reaffirmed: BOT Rep. 36, A-99 Appended: BOT Rep. 16 and Reaffirmed: CSA Rep. 13, I-99 Reaffirmation A-00 Reaffirmed: Res. 246 and 504 and Appended Res. 504 and 509, A-01 Reaffirmed: BOT Rep. 19, I-01 Appended: Res. 524, A-02 Reaffirmed: Sub. Res. 206, A-04 Reaffirmed: BOT Rep. 24, I-04 Reaffirmed: BOT Rep. 19, I-06 Reaffirmation A-07 Reaffirmed: BOT Rep. 19, A-07 Reaffirmed: CEJA Rep. 6, A-11 Reaffirmed in lieu of Res. 705, A-12 Reaffirmed: BOT Rep. 17, A-13 Modified: Res. 2, I-14 Reaffirmation: A-17 Modified: BOT Rep. 16, A-18 Appended: Res. 232, A-18 Reaffirmation: I-18 Reaffirmed: Res. 219, A-21 Reaffirmed: Res. 229, A-21 Reaffirmed: BOT Rep. 12, I-21 Reaffirmed: BOT Rep. 22, A-22 Reaffirmation: A-23 Reaffirmed: CSAPH Rep. 08, A-24]

**H-450.933 Clinical Data Registries**

1. Our AMA encourages multi-stakeholder efforts to develop and fund clinical data registries for the purpose of facilitating quality improvements and research that result in better health care, improved population health, and lower costs.
2. Our AMA encourages national medical specialty societies, state medical associations, and other physician groups to join the National Quality Registry Network and to participate in efforts to advance the development and use of clinical data registries.
3. Our AMA supports flexibility in the development and implementation of clinical data registries. The following guidelines can help maximize opportunities for clinical data registries to enhance the quality of care provided to patients:

a. Practicing physicians must be actively involved in decisions related to the development, maintenance and use of clinical data registries and registry data.
b. Data elements, risk-adjustment models and measures used in the registry should be fully transparent.
c. Registries should provide timely, actionable feedback reports to individual physicians or entities reporting at the organizational level.
d. Registries and electronic health records should be interoperable, and should be capable of sharing and integrating information across registries and with other data sources in a HIPAA-compliant and confidential manner.
e. Registry stewards should establish a formal process to facilitate the modification, expansion, or dissolution of the registry in order to accommodate advances in technology and changing clinical data needs to ensure continued utility of their registry.

4. Our AMA encourages physicians to participate in clinical data registries, and will encourage efforts that help physicians identify existing registries suitable for and of benefit to their patient populations and their practices.
5. Our AMA will continue to advocate for and support initiatives that minimize the costs and maximize the benefits of physician practice participation in clinical data registries.
6. Our AMA supports that, with the consent of the participating physician, physician-specific clinical registry data may be used to meet third-party quality reporting requirements, in accordance with the following principles:

a. Data should be used to improve the quality of patient care and the efficient use of resources in the delivery of health care services.
b. Data related to resource use and cost of care must be evaluated and reported in conjunction with quality of care information.
c. Effective safeguards must be established to protect against the dissemination of inconsistent, incomplete, invalid or inaccurate physician-specific medical practice data.
d. Case-matched, risk-adjusted quality measure and resource use data are provided to physicians to assist them in determining their relative utilization of resources in providing care to their patients.
e. When data are collected and analyzed for the purpose of meeting quality reporting requirements, the methodologies used to create the profiles and report the results are developed in conjunction with relevant physician organizations and practicing physicians, and are disclosed in sufficient detail to allow each physician or medical group to re-analyze the validity of the reported results prior to more general disclosure.
[CMS Rep. 8, A-14; Reaffirmed: CMS Rep. 05, I-16; Reaffirmed: CMS Rep. 10, A-17; Reaffirmed: CMS Rep. 06, A-18; Reaffirmed: CSAPH Rep. 2, I-19]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 917
(I-25)

Introduced by: New Jersey

Subject: Urging Comprehensive Research and Safety Testing of Industry-Engineered Food Additives (IEFAs), Including High Fructose Corn Syrup

Referred to: Reference Committee K

---

Whereas, food consumption data from the U.S. Department of Agriculture show that the use of high fructose corn syrup (HFCS) increased by more than 1,000% between 1970 and 1990, far exceeding changes in intake of any other food or food group; and

Whereas, HFCS now represents more than 40% of the caloric sweeteners added to foods and beverages and is the predominant caloric sweetener in soft drinks in the United States; and

Whereas, recent scientific studies have identified potential adverse health effects from certain industry-engineered food additives (IEFAs), including artificial obesogens, such as increased risk of obesity, metabolic disorders, and other chronic diseases; and

Whereas, one such study found that high sugar and sugar-sweetened beverage intake during adolescence was positively associated with increased risk of colorectal adenomas, with each 5% increase in calories from total fructose intake associated with a 17% higher risk of total adenomas and a 30% higher risk of high-risk adenomas (Gastroenterology, 2021); and

Whereas, the development and use of many IEFAs, including HFCS, have often proceeded without comprehensive, long-term safety testing; and

Whereas, rigorous research protocols and pre-market safety evaluations are essential to protect public health and prevent unintended health consequences; therefore be it

RESOLVED, that our American Medical Association supports stronger safety protocols and regulatory oversight of food additives, to protect the health and well-being of the American public (New HOD Policy); and be it further

RESOLVED, that our AMA advocate federal policies requiring comprehensive scientific research and safety testing of industry-engineered food additives, including HFCS and other similar substances, prior to their approval by federal regulators for use in the food supply. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/26/25

**REFERENCES**

1. Mazzoli A, Spagnuolo MS, Nazzaro M, Gatto C, Iossa S, Cigliano L. Fructose Removal from the Diet Reverses Inflammation, Mitochondrial Dysfunction, and Oxidative Stress in Hippocampus. Antioxidants (Basel). 2021 Mar 20;10(3):487. doi: 10.3390/antiox10030487. PMID: 33804637; PMCID: PMC8003595.
2.McCall, Kelly D et al. “Chapter 4 Linking Obesity and Pancreatic Cancer.” (2019).
3.Gilbert, Candace A. and Joyce M. Slingerland. “Cytokines, obesity, and cancer: new insights on mechanisms linking obesity to cancer risk and progression.” Annual review of medicine 64 (2013): 45-57 .
4. Hattori, Hidemi et al. “Excessive Intake of High-Fructose Corn Syrup Drinks Induces Impaired Glucose Tolerance.” Biomedicines 9 (2021): n. pag.
5. Hofseth, Lorne J. et al. “Early-onset colorectal cancer: initial clues and current views.” Nature Reviews Gastroenterology & Hepatology 17 (2020): 352-364.
6. Mai BH, Yan LJ. The negative and detrimental effects of high fructose on the liver, with special reference to metabolic disorders. Diabetes Metab Syndr Obes. 2019 May 27;12:821-826. doi: 10.2147/DMSO.S198968. PMID: 31213868; PMCID: PMC6549781.
7. Meyers AM, Mourra D, Beeler JA. High fructose corn syrup induces metabolic dysregulation and altered dopamine signaling in the absence of obesity. PLoS One. 2017 Dec 29;12(12):e0190206. doi: 10.1371/journal.pone.0190206. PMID: 29287121; PMCID: PMC5747444.
8. Marcus D. Goncalves et al. High-fructose corn syrup enhances intestinal tumor growth in mice.Science363,1345-1349(2019).DOI:10.1126/science.aat8515 [doi.org]
9. Wang, Z., Lipshutz, A., Martínez de la Torre, C. et al. Early life high fructose impairs microglial phagocytosis and neurodevelopment. Nature 644, 759–768 (2025). https://doi.org/10.1038/s41586-025-09098-5
10. Qing Zhao, Wen-Lian Chen, Gerry Melino, Wei Jia, Targeting fructose metabolism for cancer therapy, Cancer Letters, 631, (217914), (2025).https://doi.org/10.1016/j.canlet.2025.217914 [doi.org]
11. Xinyi Zhou, Yujia Song, Zhen Wang, Li Fu, Lin Xu, Xuping Feng, Zheng Zhang, Kefei Yuan, Dietary sugar intervention: A promising approach for cancer therapy, Biochimica et Biophysica Acta (BBA) - Reviews on Cancer, 1880, 5, (189402), (2025).
12. Yan Zhao, Wen-Wan Chen, Yan Xue, Meng-Jie Wu, High-Fructose Diet Aggravates Temporomandibular Joint Cartilage Degeneration, Journal of Craniofacial Surgery Open, 3, 3, (2025).
13. Mengxi Du, David A. Drew, Marcus D. Goncalves, Yin Cao, Andrew T. Chan, Early-onset colorectal cancer as an emerging disease of metabolic dysregulation, Nature Reviews Endocrinology, (2025).
14. Zhijie Gao, Yunqing Liu, Yujie Cui, Yiling Han, Ke Cao, Qi Wu, The advent of precision nutrigeroscience in cancer: from clinic towards molecular biology, Journal of Advanced Research, (2025).
15.Norman J. Galbraith, Michael G. White, Microbiome of Young and Later-Onset Colorectal Cancer, Surgical Clinics of North America, (2025).
16. Wenquan Hu, Xiang Wang, Zhi Fang, Jing Zhang, Munichandra Babu Tirumalasetty, Qing Robert Miao, High fructose promotes MYCN-amplified neuroblastoma progression through NgBR-ACSS2-mediated biosynthesis of acetyl-CoA, Cell Reports, 44, 7, (115947), (2025).
18.Xueying Wang, Zeyao Wang, Zihan Liu, Fanxuan Huang, Zhaoyu Pan, Zhiren Zhang, Tong Liu, Nutritional strategies in oncology: The role of dietary patterns in modulating tumor progression and treatment response, Biochimica et Biophysica Acta (BBA) - Reviews on Cancer, 1880, 3, (189322), (2025).
19. Zhenhong Li, Xinzou Fan, Fan Gao, Shengguang Pan, Xiao Ma, Hao Cheng, Hiroko Nakatsukasa, Wei Zhang, Dunfang Zhang, Fructose metabolism and its roles in metabolic diseases, inflammatory diseases, and cancer, Molecular Biomedicine, 6, 1, (2025).
20. Zhaoquan Wang, Allie Lipshutz, Celia Martínez de la Torre, Alissa J. Trzeciak, Zong-Lin Liu, Isabella C. Miranda, Tomi Lazarov, Ana C. Codo, Jesús E. Romero-Pichardo, Achuth Nair, Tanya Schild, Waleska Saitz Rojas, Pedro H. V. Saavedra, Ann K. Baako, Kelvin Fadojutimi, Michael S. Downey, Frederic Geissmann, Giuseppe Faraco, Li Gan, Jon Iker Etchegaray, Christopher D. Lucas, Marina Tanasova, Christopher N. Parkhurst, Melody Y. Zeng, Kayvan R. Keshari, Justin S. A. Perry, Early life high fructose impairs microglial phagocytosis and neurodevelopment, Nature, 644, 8077, (759-768), (2025).
21.. Bray GA, Nielsen SJ, Popkin BM. Consumption of high-fructose corn syrup in beverages may play a role in the epidemic of obesity. Am J Clin Nutr. 2004 Apr;79(4):537-43. doi: 10.1093/ajcn/79.4.537. Erratum in: Am J Clin Nutr. 2004 Oct;80(4):1090. PMID: 15051594.
22. Goodwin, Pamela J. and Vuk Stambolic. “Impact of the obesity epidemic on cancer.” Annual review of medicine 66 (2015): 281-96 .
23. Febbraio MA, Karin M. "Sweet death": Fructose as a metabolic toxin that targets the gut-liver axis. Cell Metab. 2021 Dec 7;33(12):2316-2328. doi: 10.1016/j.cmet.2021.09.004. Epub 2021 Oct 6. PMID: 34619076; PMCID: PMC8665123.
22. Joh, H. K., Lee, D. H., Hur, J., Nimptsch, K., Chang, Y., Joung, H., Zhang, X., Rezende, L. F. M., Lee, J. E., Ng, K., Yuan, C., Tabung, F. K., Meyerhardt, J. A., Chan, A. T., Pischon, T., Song, M., Fuchs, C. S., Willett, W. C., Cao, Y., Ogino, S., Giovannucci, E., & Wu, K. (2021). *Simple sugar and sugar-sweetened beverage intake during adolescence and risk of colorectal cancer precursors*. *Gastroenterology, 161*(1), 128-142.e20. https://doi.org/10.1053/j.gastro.2021.03.028 WashU Research Profiles+2PubMed+2
23. Hur, J., Otegbeye, E., Joh, H. K., Nimptsch, K., Ng, K., Ogino, S., Meyerhardt, J. A., Chan, A. T., Willett, W. C., Wu, K., Giovannucci, E., & Cao, Y. (2021). *Sugar-sweetened beverage intake in adulthood and adolescence and risk of early-onset colorectal cancer among women*. *Gut, 70*(12), 2330-2336. https://doi.org/10.1136/gutjnl-2020-323450 PubMed+2WashU Research Profiles+2
24.Feng, L., et al. (2023). *Association of sugar-sweetened beverages with the risk and mortality of colorectal cancer: A meta-analysis*. *European Journal of Clinical Nutrition*. [Accepted March 2023; 17 observational studies; RR ≈ 1.17 for incidence, ≈1.13 for mortality]. https://doi.org/10.1038/s41430-023-01234-?) PubMed
*(Note: exact authorship beyond L. Feng unavailable from the sources I accessed; you may want the full list.)*
25. Yuan, C., Joh, H. K., Wang, Q. L., Zhang, Y., Smith-Warner, S. A., Wang, M., Song, M., Cao, Y., Zhang, X., Zoltick, E. S., Hur, J., Chan, A. T., Meyerhardt, J. A., Ogino, S., Ng, K., Giovannucci, E. L., & Wu, K. (2022). *Sugar-sweetened beverage and sugar consumption and colorectal cancer incidence and mortality according to anatomic subsite*. *American Journal of Clinical Nutrition, 115*(6), 1481-1489. https://doi.org/10.1093/ajcn/nqac040 American Journal of Clinical Nutrition+1
26.Llaha, F., Gil-Lespinard, M., Unal, P., de Villasante, I., Castañeda, J., & Zamora-Ros, R. (2021). *Consumption of sweet beverages and cancer risk: A systematic review & meta-analysis of observational studies*. *Nutrients, 13*(2), 516. https://doi.org/10.3390/nu13020516 MDPI

27. Eshaghian, N., et al. (2023). *Sugar-sweetened Beverages, Natural Fruit Juices, and Cancer Risk*. *Frontiers in Nutrition*. https://doi.org/10.3389/fnut.2023.1301335 Frontiers
28. Hauan, M., et al. (2025). *Sweet Beverages and the Risk of Colorectal Cancer: Systematic Review & Meta-Analysis. BMC Cancer*. (in press / latest issue). doi:10.1186/s12885-025-13835-4 BioMed Central

**RELEVANT AMA POLICY**

1. Policy H-150.919 H-15
   The Health Effects of High Fructose Syrup H-150.919
   1. Our American Medical Association recognizes that at the present time, insufficient evidence exists to specifically restrict use of high fructose corn syrup (HFCS) or other fructose-containing sweeteners in the food supply or to require the use of warning labels on products containing HFCS.
   2. Our AMA encourages independent research (including epidemiological studies) on the health effects of HFCS and other added sugars, and evaluation of the mechanism of action and relationship between fructose dose and response.
   3. Our AMA in concert with the Dietary Guidelines for Americans, recommends that consumers limit the amount of added sugars in their diet.

   Citation: CSAPH Rep. 8, A-23;
2. H-150.998 Food Additives

Our American Medical Association supports the passage of legislation that would amend the Food Additive Act to require evidence based upon scientifically reproducible studies of the association of food additives with an increased incidence of cancer in animals or humans at dosage levels related to the amounts calculated as normal daily consumption for humans before removal of an additive from the market.
Citation: Sub. Res. 4, A-77; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Modified: BOT Rep. 6, A-10; Reaffirmed: BOT Rep. 7, A-21;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 918
(I-25)

Introduced by: New York

Subject: Remove Outdated Barriers to Genetic Testing

Referred to: Reference Committee K

---

Whereas, genetic testing for inherited and acquired mutations or variations of the genome is the basis for modern healthcare and is widely used in the management of infertility in men and women in the treatment of a variety of conditions, including many cancers; and

Whereas, Federal law, The Genetic Information Nondiscrimination Act (GINA) of 2008 protects people from genetic discrimination in health insurance and employment. GINA prohibits the use of genetic information for making decisions about health coverage or employment. Federal Law supersedes state laws making state laws fairly meaningless in terms of patient protection; and

Whereas, NYS has outdated anachronistic requirements for written consent that has to be provided to the lab to process testing for genomic abnormalities, including karyotype, testing for specific genetic abnormalities such as Y-chromosome microdeletions, and cancer gene mutation testing for cancer patients; and

Whereas, NYS is only one of 6 states that still have outdated requirements for consent for genetic testing; and

Whereas, physicians are overburdened with useless paperwork, written consent requirements delay critical care, written consent does not provide any more protection to patients than does verbal consent, and patients are protected from discrimination by both the federal law and the NYS law irrespective of the requirement for written consent; and

Whereas, many genetic abnormalities can be derived based on other characteristics with a high degree of certainty, and imposing barriers on genetic testing serves little purpose; and

Whereas, NYS has a history of making intelligent decisions, such as getting rid of the HIV consent that was widely acknowledged to impair treatment just as the genetic testing consent does. Similar laws that prohibit discrimination on the basis of HIV positivity protect patients with gene mutations; therefore be it

RESOLVED, that our American Medical Association advocate for federal and state legislation to remove requirements for separate written consent for genetic or genomic testing, and to eliminate unnecessary restrictions on sharing test result records with the treating team of providers, while preserving essential patient protections, including safeguards against discrimination by insurance companies (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for changes to laws nationwide in the states that continue to impose barriers to genetic or genomic testing in the form of written consent requirements in Massachusetts, Michigan, Nebraska, New York, South Dakota, and that our AMA report on the status of this resolution at the 2026 Annual Meeting. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/26/25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 919
(I-25)

Introduced by: American Association of Public Health Physicians

Subject: Strengthening Trust through AMA-Based Leadership for Evidence-Based Vaccines (STABLE Vaccines)

Referred to: Reference Committee K

---

Whereas, our American Medical Association (AMA) has a long-standing mission to promote the art and science of medicine and the betterment of public health[1]; and

Whereas, science-based vaccine recommendations are essential to safeguarding individual and population health[2], especially in the face of vaccine misinformation, disinformation, and politicization; and

Whereas, the current public health landscape is marked by fragmented and sometimes conflicting vaccine guidance from various institutions, which can create confusion and erode public trust[3]; and

Whereas, our AMA is uniquely positioned as a trusted and authoritative voice in medicine[4], and can serve as a convening body to bring together clinicians, scientists, public health officials, and other key stakeholders to develop, promote, and disseminate evidence-based vaccine recommendations; and

Whereas, there is a pressing need for a centralized, science-driven source that the public and clinicians can rely on for accurate, up-to-date vaccine information[5], and our AMA has the infrastructure, credibility, and reach to fulfill this role as both a central repository and a public-facing megaphone; and

Whereas, no single organization possesses all the expert guidance and sustainable funding necessary to replicate the historical functions of ACIP[6], it is therefore essential to establish a coordinating body to unify and lead these efforts; therefore be it

RESOLVED, that our American Medical Association will serve as a convener of key stakeholders to advance science-based vaccine recommendations (Directive to Take Action); and be it further

RESOLVED, that our AMA will establish itself as a trusted, centralized source and public-facing megaphone for science-based vaccine guidance (Directive to Take Action); and be it further

RESOLVED, that our AMA will contribute expertise and funding, as appropriate, to advance the mission of coordinating and promoting scientifically grounded and reliable vaccine guidance. (Directive to Take Action)

Fiscal Note: $3.1 million annually – Research and develop public facing materials.

Received: 9/26/25

**REFERENCES**

1. American Medical Association. “AMA Mission.” https://www.ama-assn.org/about, accessed 26 September 2025.
2. Asturias EJ et al, “Advisory Committee on Immunization Practices at a Crossroads.” JAMA. 2025;334 (8): 667-668. (doi:10.1001/jama.2025.10776) https://jamanetwork.com/journals/jama/fullarticle/2835626. Accessed 26 September 2025.
3. Pierson B, “Insurers, Providers face newly fragmented vaccine landscape.” Law.com. https://www.law.com/corpcounsel/2025/09/24/insurers-providers-face-newly-fragmented-vaccine-landscape, accessed 26 September 2025.
4. American Medical Association. “About the AMA.” https://www.ama-assn.org/about, accessed 26 September 2025.
5. Chu H et al, “The Path Forward for Vaccine Policy in the United States.” New England Journal of Medicine. 2025; 393: 817-822 (DOI: 10.1056/NEJMsb2509134) https://www.nejm.org/doi/pdf/10.1056/NEJMsb2509134, accessed 26 September 2025.
6. Chu, “The Path Forward”.

## RELEVANT AMA POLICY

**H-440.875 Assuring Access to ACIP/ AAFP/AAP recommended vaccines**
**H-440.860 Financing of Adult Vaccines: Recommendations for Action**
**H-440.887 Distribution and Administration of Vaccines**
**H-460.894 Value of Preventive Services**
**H-425.997 Preventive Services**
**G-625.012 Betterment of Public Health**
**D-440.922 Full Commitment by our AMA to the Betterment and Strengthening of Public Health Systems**

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 920
(I-25)

Introduced by: Senior Physicians Section

Subject: Alcohol and Aging: Educating Physicians and Advocating for Safer Warnings

Referred to: Reference Committee K

---

Whereas, alcohol use remains common among individuals aged 65 and older, with studies showing that approximately 62% of this population consume alcohol and 6% meet standard definitions of being heavy users, at more than two drinks per day[1]; and

Whereas, older adults experience increased physiological sensitivity to alcohol[2]; and

Whereas, older adults are at increased susceptibility for alcohol-medication interactions[3]; and

Whereas, recent studies demonstrate that in seniors, even moderate alcohol consumption may increase mortality risk, including cancer and chronic diseases, compared to occasional drinking[4,5]; and

Whereas, alcohol abuse and dependence are under-recognized in older adults by healthcare personnel, who may not identify or recognize atypical geriatric symptoms associated with alcohol use, thereby possibly missing opportunities for intervention and therapy[6]; and

Whereas, the AMA as of July 2025 has adopted public health policy in support of “alcohol product labeling to create awareness of health risks,” signaling a willingness to advocate for more explicit warnings[7,8]; and

Whereas, the National Institute on Alcohol Abuse and Alcoholism and the Dietary Guidelines for Americans recommends restricting or limiting alcohol intake[9]; therefore be it

RESOLVED, that our American Medical Association advocate for the inclusion of clear, evidence-based warnings concerning the health risks of alcohol use in seniors on all alcoholic beverage containers, and work with regulatory bodies to develop standards for such warning labels in alignment with AMA policy. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/26/25

**REFERENCES**


1. Rigler, S. K. (2000). Alcoholism in the elderly. *American Family Physician*, *61*(6), 1710-1716.
2. Spencer, R. L., & Hutchison, K. E. (1999). Alcohol, aging, and the stress response. *Alcohol Research & Health*, *23*(4), 272.
3. Moore, A. A., Whiteman, E. J., & Ward, K. T. (2007). Risks of combined alcohol/medication use in older adults. *The American journal of geriatric pharmacotherapy*, *5*(1), 64-74.
4. Thun, M. J., Peto, R., Lopez, A. D., Monaco, J. H., Henley, S. J., Heath Jr, C. W., & Doll, R. (1997). Alcohol consumption and mortality among middle-aged and elderly US adults. *New England Journal of Medicine*, *337*(24), 1705-1714.
5. Centers for Disease Control and Prevention. (2025, January 14). *About moderate alcohol use*. Retrieved from https://www.cdc.gov/alcohol/about-alcohol-use/moderate-alcohol-use.html

6. DiBartolo, M. C., & Jarosinski, J. M. (2017). Alcohol use disorder in older adults: challenges in assessment and treatment. *Issues in mental health nursing*, *38*(1), 25-32.
7. American Medical Association. (2025, July). *AMA adopts new public health policies to improve health of nation* [Press release]. Retrieved from https://www.ama-assn.org/press-center/ama-press-releases/ama-adopts-new-public-health-policies-improve-health-nation-11
8. American Medical Association. (2025, January) *AMA applauds Surgeon General Advisory on alcohol, cancer-causing risk*. Available from: https://www.ama-assn.org/press-center/ama-press-releases/ama-applauds-surgeon-general-advisory-alcohol-cancer-causing-risk
9. National Institute on Alcohol Abuse and Alcoholism. (2025). *The basics: Defining how much alcohol is too much*. Retrieved from https://www.niaaa.nih.gov/health-professionals-communities/core-resource-on-alcohol/basics-defining-how-much-alcohol-too-much

## RELEVANT AMA POLICY

### Alcohol Consumption and Health H-30.934

1. Our AMA recognizes that alcohol consumption at any level, not just heavy alcohol use or addictive alcohol use, is a modifiable risk factor for cancer.
2. Our AMA will work with relevant parties to:
    a. Promote public education about the risks between alcohol use and cancer, especially breast cancer; and
    b. Educate clinicians regarding the influence of alcohol use and breast cancer as well as other cancer risks and treatment complications.
3. Our AMA supports evidence-based efforts to minimize alcohol use, including eliminating the use of “pinkwashing” to market alcohol products and supporting warning labels on the ingredients and products.

Citation: Res. 516, A-19; Appended: Res. 431, A-25

### Supporting Labeling and Dietary Guideline Clarity for Alcoholic Beverages H-30.940

1. Our AMA:
    a. supports accurate and appropriate labeling disclosing the alcohol content of all beverages, including so-called "nonalcoholic" beer and other substances as well, including over-the-counter and prescription medications, with removal of "nonalcoholic" from the label of any substance containing any alcohol.
    b. supports efforts to educate the public and consumers about the alcohol content of so-called "nonalcoholic" beverages and other substances, including medications, especially as related to consumption by minors.
    c. urges the Bureau of Alcohol, Tobacco, Firearms and Explosives (ATF) and other appropriate federal regulatory agencies to continue to reject proposals by the alcoholic beverage industry for authorization to place beneficial health claims for its products on container labels.
    d. urges the development of federal legislation to require nutritional labels on alcoholic beverages in accordance with the Nutritional Labeling and Education Act.
2. Our AMA:
    a. expresses its strong disapproval of any consumption of "nonalcoholic beer" by persons under 21 years of age, which creates an image of drinking alcoholic beverages and thereby may encourage the illegal underaged use of alcohol.
    b. recommends that health education labels be used on all alcoholic beverage containers and in all alcoholic beverage advertising (with the messages focusing on the hazards of alcohol consumption by specific population groups especially at risk, such as pregnant people, as well as the dangers of irresponsible use to all sectors of the populace).
    c. recommends that the alcohol beverage industry be encouraged to accurately label all product containers as to ingredients, preservatives, and ethanol content (by percent, rather than by proof).
3. Our AMA actively supports and will work for a total statutory prohibition of advertising of all alcoholic beverages except for inside retail or wholesale outlets. Pursuant to that goal, our AMA
    a. supports federal and/or state oversight for all forms of alcohol advertising.

b. supports continued research, educational, and promotional activities dealing with issues of alcohol advertising and health education to provide more definitive evidence on whether, and in what manner, advertising contributes to alcohol abuse.
c. opposes any form of advertising which links alcoholic products to agents of socialization in order to promote drinking.
d. will work with state and local medical societies to support the elimination of advertising of alcoholic beverages from all mass transit systems.
e. urges college and university authorities to bar alcoholic beverage companies from sponsoring athletic events, music concerts, cultural events, and parties on school campuses, and from advertising their products or their logo in school publications.
f. urges its constituent state associations to support state legislation to bar the promotion of alcoholic beverage consumption on school campuses and in advertising in school publications.

4. Our AMA:
    a. urges producers and distributors of alcoholic beverages to discontinue all advertising directed toward youth, including promotions on high school and college campuses.
    b. urges advertisers and broadcasters to cooperate in eliminating television program content that depicts the irresponsible use of alcohol without showing its adverse consequences (examples of such use include driving after drinking, drinking while pregnant, or drinking to enhance performance or win social acceptance).
    c. supports continued warnings against the irresponsible use of alcohol and challenges the liquor, beer, and wine trade groups to include in their advertising specific warnings against driving after drinking.
    d. commends those automobile and alcoholic beverage companies that have advertised against driving while under the influence of alcohol.
5. Our AMA supports federal and state legislation and regulations requiring standardized, front-of-package labeling on all alcoholic beverages that discloses:
    a. the number of standard drinks per container and aligns with current guidelines on alcohol consumption; and
    b. the best available science, including appropriate acknowledgment of alcohol's causal link to cancer and the evidence that the risk of harm increases with greater alcohol consumption.
6. Our AMA supports legislation and regulations ensuring:
    a. alcohol labeling is presented with sufficient prominence, legibility, and design features, such as minimum font size, and color contrast, and optional pictorial elements, to enhance readability and support informed decision-making across populations; and
    b. clear, evidence-based point-of-sale warning signage in physical and digital retail environments where alcohol is sold.
7. Our AMA supports extending alcohol labeling requirements to "non-alcoholic" or "zero proof" beverages that are manufactured, packaged, or marketed in a manner similar to alcoholic beverages, to ensure consistent transparency regarding alcohol content.
8. Our AMA continues to strongly urge the Dietary Guidelines Advisory Committee to explicitly warn about the risks of alcohol consumption and its relationship to certain cancers and other diseases and affirm that there is no safe threshold for alcohol consumption.
9. Our AMA will submit a public comment in response to the Alcohol and Tobacco Tax and Trade Bureau's proposed rule on Alcohol Facts Statements, calling for labeling standards that include standard drink information, health risk disclosures, consumer-centric design, and harmonization with federal dietary guidance and emerging public health evidence.
10. Our AMA supports research and evaluation initiatives to determine the impact of alcohol warning labels and signage on consumer knowledge and behavior, health outcomes, and alcohol sales patterns, with ongoing assessment to ensure future labeling interventions are evidence-informed and population-appropriate.

Citation: CSA Rep. 1, A-04; Reaffirmation A-08; Reaffirmed CSAPH Rep. 01, A-18; Modified Res. 427, A-22; Modified: Res. 918, I-22; Modified: Speakers Rep. 02, I-24; Modified: Res. 405, A-25

**Alcohol Use Disorder in Older Adults H-30.950**

1. Our AMA encourages medical educators to expand instructional material on alcohol and aging at all levels of medical education, particularly in residency and/or postgraduate training.
2. Our AMA will cooperate with other groups, such as the American Association of Retired Persons and appropriate government agencies, in public education programs for older adults concerning alcohol-related problems.

Citation: CSA Rep. 1, I-93; Reaffirmed: CSA Rep. 8, A-05; Modified: CSAPH Rep.1, A-25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 921
(I-25)

Introduced by: Senior Physicians Section

Subject: Prioritizing Deprescribing in Seniors

Referred to: Reference Committee K

---

Whereas, despite American Medical Association policy on polypharmacy D-120.928, the prevalence of polypharmacy has tripled over the last twenty years[1]; and

Whereas, 4 out of 10 people older than 65 take five or more medications, putting them at risk of adverse drug toxicity, falls, delirium, cognitive impairment and decreased quality of life[1]; and

Whereas, the demographic surge of people older than 65 will only make the problem more prevalent; and

Whereas, deprescribing, the proactive and systematic identification and discontinuation of medications with potential risk greater than potential benefits, offers a significant opportunity to improve patient safety and quality of care; and

Whereas, the Agency for Healthcare Research and Quality (AHRQ) has designated deprescribing as a patient safety priority[2]; therefore be it

RESOLVED, that our American Medical Association declare that deprescribing, the proactive and systematic identification and discontinuation of medications with potential risk greater than potential benefits, is a medical priority in the management of senior patients and advocate for the integration of deprescribing as a standard component of high-quality prescribing practices (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for the development of educational initiatives and clinical decision support tools to facilitate safe and effective deprescribing in electronic health records (Directive to Take Action); and be it further

RESOLVED, that our AMA call for research and policy efforts to address barriers for implementation of deprescribing in routine medical care (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for all insurers to reimburse deprescribing activities (Directive to Take Action); and be it further

RESOLVED, that our AMA shall report back on the status of deprescribing to the House of Delegates at A-26 and yearly thereafter, with appropriate metrics to address potential barriers and to guide further advocacy, until it has become implemented as a mainstream component of health care. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/26/25

**REFERENCES**

1. Lown Institute. (n.d.). *Medication overload and older Americans: How the drive to prescribe is harming older Americans.* Retrieved September 2, 2025, from https://lowninstitute.org/projects/medication-overload-how-the-drive-to-prescribe-is-harming-older-americans/
2. Linsky AM, Motala A, Lawson E, et al. Deprescribing To Reduce Medication Harms in Older Adults: Rapid Response. 2024 Feb. In: Making Healthcare Safer IV: A Continuous Updating of Patient Safety Harms and Practices [Internet]. Rockville (MD): Agency for Healthcare Research and Quality (US); 2023 Jul-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK600387/

## RELEVANT AMA POLICY

**Safe and Efficient E-Prescribing H-120.921**
Our AMA encourages health care stakeholders to improve electronic prescribing practices in meaningful ways that will result in increased patient safety, reduced medication error, improved care quality, and reduced administrative burden associated with e-prescribing processes and requirements. Specifically, the AMA encourages:
A. E-prescribing system implementation teams to conduct an annual audit to evaluate the number, frequency and user acknowledgment/dismissal patterns of e-prescribing system alerts and provide an audit report to the software vendors for their consideration in future releases.
B. Health care organizations and implementation teams to improve prescriber end-user training and on-going education.
C. Implementation teams to prioritize the adoption of features like structured and codified Sig formats that can help address quality issues, allowing for free text when necessary.
D. Implementation teams to enable functionality of pharmacy directories and preferred pharmacy options.
E. Organizational leadership to encourage the practice of inputting a patient's preferred pharmacy at registration, and re-confirming it upon check-in at all subsequent visits.
F. Implementation teams to establish interoperability between the e-prescribing system and the EHR to allow prescribers to easily confirm continued need for e-prescription refills and to allow for ready access to pharmacy choice and selection during the refill process.
G. Implementation teams to enhance EHR and e-prescribing system functions to require residents assign an authorizing attending physician when required by state law.
H. Organizational leadership to implement e-prescribing systems that feature more robust clinical decision support, and ensure prescriber preferences are tested and seriously considered in implementation decisions.
i. Organizational leadership to designate e-prescribing as the default prescription method.
J. The DEA to allow for lower-cost, high-performing biometric devices (e.g., fingerprint readers on laptop computers and mobile phones) to be leveraged in two-factor authentication.
K. States to allow integration of PDMP data into EHR systems.
L. Health insurers, pharmacies and e-prescribing software vendors to enable real-time benefit check applications that enable more up to date prescription coverage information and allow notification when a patient changes health plans or a health insurer has changed a pharmacy's network status.
M. Functionality supporting the electronic transfer and cancellation of prescriptions.
Citation: BOT Rep. 20, A-19

**Reducing Polypharmacy as a Significant Contributor to Senior Morbidity D-120.928**

1. Our American Medical Association will work with other organizations e.g., AARP, other medical specialty societies, PhRMA, and pharmacists to educate patients about the significant effects of all medications and most supplements, and to encourage physicians to teach patients to bring all medications and supplements or accurate, updated lists including current dosage to each encounter.
2. Our AMA along with other appropriate organizations encourages physicians and ancillary staff if available to initiate discussions with patients on improving their medical care through the use of only the minimal number of medications (including prescribed or over-the-counter, including vitamins and supplements) needed to optimize their health.
3. Our AMA will work with other stakeholders and EHR vendors to address the continuing problem of inaccuracies in medication reconciliation and propagation of such inaccuracies in electronic health records.
4. Our AMA will work with other stakeholders and EHR vendors to include non-prescription medicines and supplements in medication lists and compatibility screens

Citation: Res. 515, A-22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 922
(I-25)

Introduced by: Medical Student Section, Underrepresented in Medicine Advocacy Section

Subject: Addressing Health Impacts of Indian Boarding Schools

Referred to: HOD Reference Committee K

---

Whereas, Indian boarding schools in the United States were established and perpetuated under federal policies such as the Indian Civilization Act of 1819, which funded missionary-run schools to forcibly "civilize" Native American children by erasing their cultural identities and replacing them with Anglo-American practices[1-2]; and

Whereas, it is documented that in over 417 institutions operated across 37 states, Native American children faced physical abuse, malnutrition, overcrowded conditions, and punishment for speaking their languages or practicing cultural traditions, with over 973 documented deaths and many more unmarked graves[3]; and

Whereas, boarding school attendees were exposed to DDT, which was directly applied to their bodies as a 'delousing' measure, significantly increasing their risk of developing breast cancer, liver cancer, and hematologic malignancies compared to non-attendees[3-4]; and

Whereas, Indian boarding schools created conditions that led to alarmingly high rates of infectious diseases, including tuberculosis, which was up to four times more prevalent among attendees, with mortality rates as high as 40-60%[4-6]; and

Whereas, former boarding school attendees suffer from significantly elevated rates of chronic health conditions, including diabetes, arthritis, hyperlipidemia, and anemia, as well as post-traumatic stress disorder, alcohol and opioid use disorders, and suicidality[5-6]; and

Whereas, survivors of Indian boarding schools and their descendants face ongoing barriers to healing, including limited access to healthcare, pervasive poverty, intergenerational trauma, loss of cultural identity, disrupted family structures, high rates of violence, and educational inequities, all of which contribute to persistent health disparities and hinder recovery[7]; and

Whereas, Tribal Nations have implemented initiatives to promote healing and recovery from the intergenerational trauma caused by Indian boarding schools, yet these efforts are often undermined by insufficient funding, inadequate resources, and lack of structural support from federal and state governments[7]; and

Whereas, the following federal legislation has been reintroduced in the 119th Congress: the Truth and Healing Commission on Indian Boarding School Policies Act S. 671 (formerly H.R. 7227/S. 1723), which aims to investigate human rights violations, document unmarked burial sites, and provide recommendations for reparative justice[8-9]; therefore be it

RESOLVED, that our American Medical Association support efforts to address the historical injustices and ongoing health impacts of Indian boarding schools. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Date Received: 09/29/25

**REFERENCES**

1. Fixico, Donald Lee. *The urban Indian experience in America.* UNM Press, 2000. https://www.researchgate.net/publication/268044911_The_Urban_Indian_Experience_in_America
2. Pember, Mary Annette. "Death by civilization." *The Atlantic* 8 2019. https://jakupmichaelsen.github.io/eksamensopgaver/mkj84zq2dq/files/193759_assignment_4b.pdf
3. Newland, Bryan Todd. *Federal Indian Boarding School Initiative Investigative Report: Vol. II.* United States Department of the Interior, Office of the Secretary, 2024. https://www.bia.gov/sites/default/files/media_document/doi_federal_indian_boarding_school_initiative_investigative_report_vii_final_508_compliant.pdf
4. Bigheart, Juanita. *"Historical trauma and the boarding school experience: The lived experience of Seneca Indian school attendees."* PhD diss., California Lutheran University, 2021. https://www.proquest.com/openview/be08564660e71ce6678f7efba67542ab/1?pq-origsite=gscholar&cbl=18750&diss=y
5. Sebwenna-Painter, Kaitlyn. *"Psychological impacts of historic loss and current events surrounding American Indian boarding schools."* American Indian and Alaska Native Mental Health Research (Online) 30, no. 2 (2023): 1-21. https://coloradosph.cuanschutz.edu/docs/librariesprovider205/journal_files/vol30/30_2_2023_1_sebwenna-painter.pdf
6. Running Bear, Ursula, Janette Beals, Carol E. Kaufman, and Spero M. Manson. "Boarding school attendance and physical health status of Northern Plains tribes." *Applied research in quality of life* 13, no. 3 (2018): 633-645. https://pmc.ncbi.nlm.nih.gov/articles/PMC6110289/
7. Tsosie, Rebecca. *"Accountability for the Harms of Indigenous Boarding Schools: The Challenge of "Healing the Persisting Wounds" of "Historic Injustice."* Sw. L. Rev. 52 (2023): 20. https://heinonline.org/HOL/LandingPage?handle=hein.journals/swulr52&div=6&id=&page=
8. "S.1723 - Truth and Healing Commission on Indian Boarding School Policies Act of 2024," 118th Congress (2023-2024), Congress.gov, accessed March 9, 2025, https://www.congress.gov/bill/118th-congress/senate-bill/1723
9. "*S.761 - Truth and Healing Commission on Indian Boarding School Policies Act of 2025,*" 119th Congress (2025-2026), Congress.gov, accessed March 9, 2025, https://www.congress.gov/bill/119th-congress/senate-bill/761/text

**RELEVANT AMA POLICY**

**H-350.976 Improving Health Care of American Indians and Alaska Natives**
(1) Our American Medical Association recommends that all individuals, special interest groups, and levels of government recognize the American Indian and Alaska Native people as full citizens of the US, entitled to the same equal rights and privileges as other US citizens. (2) Our AMA recommends that the federal government provide sufficient funds to support needed health services for American Indians and Alaska Natives. (3) Our AMA recommends that state and local governments give special attention to the health and health-related needs of nonreservation American Indians and Alaska Natives in an effort to improve their quality of life. (4) Our AMA recommends that American Indian and Alaska Native religious and cultural beliefs be recognized and respected by those responsible for planning and providing services in Indian health programs. (5) Our AMA recognizes practitioners of Indigenous medicine as an integral and culturally necessary individual in delivering health care to American Indians and Alaska Natives. (6) Our AMA monitors Medicaid Section 1115 waivers that recognize the value of traditional American Indian and Alaska Native healing services as a mechanism for improving patient-centered care and health equity among American Indian and Alaska Native populations when coordinated with physician-led care. (7) Our AMA supports consultation with Tribes to facilitate the development of best practices, including but not limited to culturally sensitive data collection, safety monitoring, the development of payment methodologies, healer credentialing, and tracking of traditional healing services utilization at Indian Health Service, Tribal, and Urban Indian Health Programs. (8) Our AMA recommends strong emphasis be given to mental health programs for American Indians and Alaska Natives in an effort to reduce the high incidence of alcoholism, homicide, suicide, and accidents. (9) Our AMA recommends a team approach drawing from traditional health providers supplemented by psychiatric social workers, health aides, visiting nurses, and health educators be utilized in solving these problems. (10) Our AMA will continue its liaison with the Indian Health Service and the National Indian Health Board and establish a liaison with the Association of American Indian Physicians. (11) Our AMA recommends that state and county medical associations establish liaisons with intertribal health councils in those states where American Indians and Alaska Natives reside. (12) Our AMA supports and encourages further development and use of

innovative delivery systems and staffing configurations to meet American Indian and Alaska Native health needs but opposes overemphasis on research for the sake of research, particularly if needed federal funds are diverted from direct services for American Indians and Alaska Natives. (13) Our AMA strongly supports those bills before Congressional committees that aim to improve the health of and health-related services provided to American Indians and Alaska Natives and further recommends that members of appropriate AMA councils and committees provide testimony in favor of effective legislation and proposed regulations. [CLRPD Rep. 3, I-98; Reaffirmed: Res. 221, A-07; Reaffirmation A-12; Reaffirmed: Res. 233, A-13; Reaffirmed: BOT Rep. 09, A-23; Modified: CMS Rep. 03, A-24; Reaffirmed: Res. 244, A-24]

**H-350.977 Indian Health Service**
The policy of the American Medical Association is to support efforts in Congress to enable the Indian Health Service to meet its obligation to bring American Indian health up to the general population level. Our AMA specifically recommends:

1. Indian Population:
    a. In current education programs, and in the expansion of educational activities suggested below, special consideration be given to involving the American Indian and Alaska native population in training for the various health professions, in the expectation that such professionals, if provided with adequate professional resources, facilities, and income, will be more likely to serve the tribal areas permanently;
    b. Exploration with American Indian leaders of the possibility of increased numbers of nonfederal American Indian health centers, under tribal sponsorship, to expand the American Indian role in its own health care;
    c. Increased involvement of private practitioners and facilities in American Indian care, through such mechanisms as agreements with tribal leaders or Indian Health Service contracts, as well as normal private practice relationships; and
    d. Improvement in transportation to make access to existing private care easier for the American Indian population.
2. Federal Facilities: Based on the distribution of the eligible population, transportation facilities and roads, and the availability of alternative nonfederal resources, the AMA recommends that those Indian Health Service facilities currently necessary for American Indian care be identified and that an immediate construction and modernization program be initiated to bring these facilities up to current standards of practice and accreditation.
3. Personnel:
    a. Compensation scales for Indian Health Service physicians be increased to a level competitive with other Federal agencies and nongovernmental service;
    b. Consideration should be given to increased compensation for specialty and primary care service in remote areas;
    c. In conjunction with improvement of Service facilities, efforts should be made to establish closer ties with teaching centers and other federal health agencies, thus increasing both the available staffing and the level of professional expertise available for consultation;
    d. Allied health professional staffing of Service facilities should be maintained at a level appropriate to the special needs of the population served without detracting from physician compensation;
    e. Continuing education opportunities should be provided for those health professionals serving these communities, and especially those in remote areas, and, increased peer contact, both to maintain the quality of care and to avert professional isolation and burnout; and
    f. Consideration should be given to a federal statement of policy supporting continuation of the Public Health Service to reduce the great uncertainty now felt by many career officers of the corps.
4. Medical Societies: In those states where Indian Health Service facilities are located, and in counties containing or adjacent to Service facilities, that the appropriate medical societies should explore the possibility of increased formal liaison with local Indian Health Service physicians. Increased support from organized medicine for improvement of health care provided under their

direction, including professional consultation and involvement in society activities should be pursued.

5. Our AMA also supports the removal of any requirement for competitive bidding in the Indian Health Service that compromises proper care for the American Indian population.
6. Our AMA will advocate that the Indian Health Service (IHS) establish an Office of Academic Affiliations responsible for coordinating partnerships with LCME- and COCA-accredited medical schools and ACGME-accredited residency programs.
7. Our AMA will encourage the development of funding streams to promote rotations and learning opportunities at Indian Health Service, Tribal, and Urban Indian Health Programs.
8. Our AMA will call for an immediate change in the Public Service Loan Forgiveness Program to allow physicians to receive immediate, but incremental, loan forgiveness when they practice in an Indian Health Service, Tribal, or Urban Indian Health Program.
9. Our AMA supports reform of the Indian Health Service (IHS) Loan Repayment Program eligibility for repayment with either a part-time or full-time employment commitment to IHS and Tribal Health Programs.[CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmation A-12; Reaffirmed: Res. 233, A-13; Appended: Res. 305, A-23; Reaffirmed: BOT Rep. 09, A-23; Reaffirmed: CMS Rep. 03, A-24; Reaffirmed: Res. 244, A-24; Reaffirmed: BOT Rep. 31, A-24; Modified: CMS Res. 305, A-24]

**D-350.977 Addressing the Longitudinal Healthcare Needs of American Indian Children in Foster Care**

(1) Our American Medical Association recognizes the Indian Child Welfare Act of 1978 as a model in American Indian and Alaska Native child welfare legislation. (2) Our AMA supports federal legislation preventing the removal of American Indian and Alaska Native children from their homes by public and private agencies without cause. (3) Our AMA will work with local and state medical societies and other relevant stakeholders to support legislation preventing the removal of American Indian and Alaska Native children from their homes by public and private agencies without cause. (4) Our AMA supports state and federal funding opportunities for American Indian and Alaska Native child welfare systems. (5) Our AMA will support the construction of health information systems to enhance information exchange between both tribal and non-tribal child welfare agencies and health care professionals. (6) Our AMA will advocate for the designation of medical teams, and/or committees to longitudinally follow children in foster care, including to ensure the provision of continuity of care for children who are at the age of transition out of foster care. (7) Our AMA will advocate for oversight of local, tribal, and state child welfare systems by physicians with expertise in pediatrics and child psychiatry. (8) Our AMA will promote existing medical homes which provide continuity of care to children in foster care when feasible. (9) Our AMA will support the appointment of a licensed pediatrician or family medicine physician (with substantial pediatric experience) in each state with experience in child welfare to the position of medical director of child welfare and a psychiatrist with substantial child and adolescent psychiatric experience to the position of psychiatric medical director of child welfare for each Title IV-E agency. [Res. 443, A-22; Appended: Res. 930, I-22]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 923
(I-25)

Introduced by: Medical Student Section, Oregon, Washington

Subject: Enhancing Disaster Preparedness Mechanisms for People with Disabilities

Referred to: HOD Reference Committee K

---

Whereas, people with disabilities face disproportionately higher risks during disasters due to systemic gaps in emergency preparedness, including inaccessible evacuation routes, inadequate emergency communication, and insufficient medical resources in shelters[1-3]; and

Whereas, 26% of U.S. adults live with a disability, yet emergency preparedness plans frequently fail to account for their specific needs—contributing to the fact that individuals with disabilities are two to four times more likely to be injured or die during disasters[4-6]; and

Whereas, the National Association of the Deaf and other advocacy groups have documented failures in emergency alert systems, including the lack of visual, auditory, and tactile notifications necessary for individuals with sensory impairments, leading to increased risk for injury and fatality[18-20]; and

Whereas, individuals with developmental disabilities (DD) are more than four times more likely to be injured during a disaster compared to their peers, yet disaster preparedness training for individuals with DD remains inadequate[21]; and

Whereas, disability-specific disaster preparedness measures—such as assistive technologies, durable medical equipment, and mobility devices—have been shown to improve emergency response outcomes for individuals with disabilities[27]; and

Whereas, studies indicate that tailored preparedness training significantly enhances disaster readiness among wheelchair users, and the World Health Organization recommends incorporating assistive technologies into humanitarian response efforts to reduce barriers to essential services during crises[27]; and

Whereas, funding for both disability-related research and emergency preparedness programs inclusive of people with disabilities has experienced periods of decline over the past decade; federal support for disability research, such as through the National Institute on Disability, Independent Living, and Rehabilitation Research (NIDILRR), remained largely flat in real terms from 2012 to 2019, while philanthropic investment in disability issues accounted for only about 2% of U.S. grantmaking and declined by 14% globally between 2017 and 2018[29,30]; and

Whereas, the Americans with Disabilities Act (ADA) and the Rehabilitation Act of 1973 mandate accessibility in public spaces, but compliance gaps in emergency planning persist, with a 2019 National Council on Disability report highlighting that federal and local disaster preparedness policies often overlook disability-specific accommodations[11-12,16]; and

Whereas, major disasters—including the Maui (Lāhainā) wildfires (2023), the Southern California wildfires (2025), and Hurricane Helene (2024)—have revealed severe failures in emergency response for people with disabilities, as evidenced by higher mortality rates due to inaccessible evacuation routes, inadequate emergency assistance, and individuals with disabilities being left behind due to a lack of accessible transportation, sign language interpreters, and emergency medical resources for those with mobility impairments[7-10]; therefore be it

RESOLVED, that our American Medical Association, in coordination with relevant stakeholders, advocate for greater integration of inclusive emergency alert systems (e.g., visual, auditory, and haptic notifications) in emergency preparedness planning to ensure disaster response accessibility for people with disabilities (Directive to Take Action); and be it further

RESOLVED, that our AMA support increased federal and state funding for disability-specific disaster preparedness measures such as assistive technologies, durable medical equipment, mobility devices, and education programs in collaboration with relevant stakeholders. (New HOD Policy)

Fiscal Note: Modest – between $1,000 - $5,000

Date Received: 09/29/25

**REFERENCES**

1. Kailes JI, Enders A. Moving beyond "special needs": a function-based framework for emergency management and planning. *J Disabil Policy Stud.* 2007;17(4):230-237.
2. Rooney C, White GW. Consumer perspective: narrative analysis of a disaster preparedness and emergency response survey from persons with mobility impairments. *J Disabil Policy Stud.* 2007;17(4):206-215.
3. Fox MH, White GW, Rooney C, Cahill A. The psychosocial impact of disaster on persons with disabilities. *Am J Public Health.* 2010;100(7):S78-S84.
4. Virginia Board for People with Disabilities. 2024 Assessment of Inclusive Emergency Preparedness, Response and Recovery in Virginia. First Edition. Richmond, VA: Virginia Board for People with Disabilities; August 8, 2024.
5. Smith DL, Notaro SJ. Personal emergency preparedness for people with disabilities from the 2006–2007 Behavioral Risk Factor Surveillance System. *Disabil Health J.* 2009;2(2):86-94.
6. National Council on Disability. The Impacts of Extreme Weather Events on People with Disabilities. May 4, 2023. https://www.ncd.gov/assets/uploads/reports/2023/ncd-extreme-weather-2023.pdf.
7. Ervin C. People with disabilities were left behind during the Los Angeles fires. *Progressive*. February 3, 2025. Available at: https://progressive.org/latest/people-with-disabilities-were-left-behind-during-the-los-angeles-fires-ervin-20250203/. Accessed February 29, 2025.
8. *Disabled disaster relief for the Maui fires*. Partnership for Inclusive Disaster Strategies. 2023. Available at: https://disasterstrategies.org/disabled-disaster-relief-for-the-maui-fires/.
9. U.S. Census Bureau. *Hurricane Helene and people with disabilities: preparedness disparities*. 2024. Available at: https://www.census.gov/library/stories/2024/10/hurricane-helene.html.
10. National Council on Disability. The Impact of Hurricanes Katrina and Rita on People with Disabilities: A Look Back and Remaining Challenges. Washington, DC: National Council on Disability; August 3, 2006.
11. National Council on Disability. *Preserving Our Freedom: Ending Institutionalization of People with Disabilities During and After Disasters.* Washington, DC: National Council on Disability; May 24, 2019. https://www.ncd.gov/assets/uploads/reports/2019/ncd_preserving_our_freedom_508.pdf
12. Federal Emergency Management Agency. FEMA further advances Americans with Disabilities Act anniversary with programs that improve assistance for people with disabilities. FEMA website. Published July 26, 2024. https://www.fema.gov/press-release/20240726/fema-further-advances-americans-disabilities-act-anniversary-programs-improve
13. National Institutes of Health (NIH). *NIH designates people with disabilities as a population with health disparities*. 2023. Available at: https://www.nih.gov/news-events/news-releases/nih-designates-people-disabilities-population-health-disparities. Accessed February 29, 2025.
14. Novack V. Disabled people are completely excluded from FEMA's 2019 disaster preparedness report [press release]. Center for American Progress. October 3, 2019. Accessed April 4, 2025. https://www.americanprogress.org/article/statement-disabled-people-completely-excluded-femas-2019-disaster-preparedness-report/
15. U.S. Department of Justice, Civil Rights Division. *ADA Best Practices Tool Kit for State and Local Governments*. Available at: https://www.ada.gov/pcatoolkit/toolkitmain.htm. Accessed February 29, 2025.

16. Rehabilitation Act of 1973, 29 U.S.C. § 701.
17. U.S. Geological Survey. Implementation and administration of Section 508 of the Rehabilitation Act. *Survey Manual Chapter 600.6.* Updated April 5, 2019. https://www.usgs.gov/about/organization/science-support/office-enterprise-information/survey-manual-6006-section-508
18. FEMA Ready Campaign. *Disability and Disaster Preparedness*. Available at: https://www.ready.gov/disability.
19. National Fire Protection Association. *Emergency Evacuation Planning Guide for People with Disabilities*. Available at: https://www.nfpa.org/public-education.
20. CareHawk. The importance of visual alerts and audio notifications during emergencies. CareHawk website. https://www.carehawk.com/articles/importance-visual-alerts-audio-notification-emergency/. Published 2023.
21. National Association of the Deaf. *Emergency Preparedness and Communication Access*. Available at: https://www.nad.org/emergency-preparedness. Accessed February 29, 2025.
22. How FEMA struggles to help people with disabilities during disasters. *Federal Times.* Published July 31, 2019. https://www.federaltimes.com/management/2019/07/31/how-fema-struggles-to-help-people-with-disabilities-during-disasters/
23. Life Safety Express. ADA compliance and safety planning. Life Safety Express website. https://lifesafetyexpress.com/life-safety/life-safety-regulations-and-standards/ada-compliance-safety-planning/. Published 2022.
24. Health Facilities Management. Reducing the risks in ADA compliance. Health Facilities Management website. https://www.hfmmagazine.com/articles/4863-reducing-the-risks-in-ada-compliance. Published May 5, 2022.
25. U.S. General Services Administration. *Universal Design and Section 508 Compliance*. Available at: https://www.section508.gov/develop/universal-design/.
26. Zhuo Y, Luo X, Yi T. The effectiveness of a disaster preparedness educational intervention for wheelchair users: a pilot study. *Int J Disaster Risk Reduct.* 2024;95:104812. doi:10.1016/j.ijdrr.2024.104812.
27. World Health Organization. Assistive technology in emergencies. WHO website. https://www.who.int/teams/health-product-policy-and-standards/assistive-and-medical-technology/assistive-technology/at-humanitarian-work.
28. Consortium for Citizens with Disabilities. Emergency management letter of concern to DHS and FEMA. July 27, 2018. National Low Income Housing Coalition website. https://nlihc.org/sites/default/files/CCD_Emergency_Management_Letter_of_Concern_to_DHS-FEMA-July_2018.pdf
29. Disability & Disaster Recovery Coalition. *DRRC Year in Review and Proposed Agenda for 2020.* Disability & Disaster Recovery Coalition; December 2020. Accessed April 5, 2025. https://drrc-coalition.org/wp-content/uploads/2020/12/drrc-year-in-review-and-proposed-agenda-for-2020-d0871834.pdf
30. Human Rights Funders Network. *Reversing the Trend: The Time is Now to Fund Disability Rights.* Human Rights Funders Network; 2020. https://www.hrfn.org/resources/reversing-the-trend-the-time-is-now-to-fund-disability-rights/

## RELEVANT AMA POLICY

**H-130.942 Development of a Federal Public Health Disaster Intervention Team**
Our AMA: … (2) through its Center for Public Health Preparedness and Disaster Response, will work with the DHHS, PHSCC, DHS, and other relevant government agencies to provide comprehensive disaster education and training for all federal medical and public health employees and volunteers through the National Disaster Life Support and other appropriate programs. Such training should address the medical and mental health needs of all populations, including children, the elderly, and other vulnerable groups. [BOT Rep. 3, A-07; Reaffirmed in lieu of Res. 218, I-15]

**D-130.966 Domestic Disaster Relief Funding**
Our AMA: …(2) will lobby actively for the recommendations outlined in the AMA/APHA Linkages Leadership Summit including: a) appropriate funding and protection of public health and health care systems as critical infrastructures for responding to day-to-day emergencies and mass causality events; b) full integration and interoperable public health and health care disaster preparedness and response systems at all government levels; d) incorporation of disaster preparedness and response competency-based education and training in undergraduate, graduate, post-graduate, and continuing education programs. [Res. 421, A-11; Reaffirmation: A-15]

**H-295.868 Education in Disaster Medicine and Public Health Preparedness During Medical School and Residency Training**
(1) Our American Medical Association recommends that formal education and training in disaster medicine and public health preparedness be incorporated into the curriculum at all medical schools and residency programs. (2) Our AMA encourages medical schools and residency programs to utilize multiple methods, including simulation, disaster drills, interprofessional team-based learning, and other interactive formats for teaching disaster medicine and public health preparedness. (3) Our AMA encourages public and private funders to support the development and implementation of education and training opportunities in disaster medicine and public health preparedness for medical students and resident

physicians. (4) Our AMA encourages medical schools and residency programs to use community-based disaster training and drills as appropriate to the region and community they serve as opportunities for medical students and residents to develop team skills outside the usual venues of teaching hospitals, ambulatory clinics, and physician offices. (5) Our AMA will make medical students and residents aware of the context (including relevant legal issues) in which they could serve with appropriate training, credentialing, and supervision during a national disaster or emergency, e.g., non-governmental organizations, American Red Cross, Medical Reserve Corps, and other entities that could provide requisite supervision. (6) Our AMA will work with the Federation of State Medical Boards to encourage state licensing authorities to include medical students and residents who are properly trained and credentialed to be able to participate under appropriate supervision in a national disaster or emergency. (7) Our AMA encourages physicians, residents, and medical students to participate in disaster response activities through organized groups, such as the Medical Response Corps and American Red Cross, and not as spontaneous volunteers. (8) Our AMA encourages teaching hospitals to develop and maintain a relocation plan to ensure that educational activities for faculty, medical students, and residents can be continued in times of national disaster and emergency. [CME Rep. 15, A-09; Reaffirmed: CME Rep. 7, A-10; Appended: CME Rep. 7, A-10; Reaffirmed and Appended: CME Rep. 1, I-11; Modified: CME Rep. 1, A-21]

**H-90.968 Medical Care of Persons with Disabilities**
Our AMA: … (1g) cooperation among physicians, health & human services professionals, and a wide variety of adults with disabilities to implement priorities and quality improvements for the care of persons with disabilities; and (4) will collaborate with appropriate stakeholders to create a model general curriculum/objective that… b) includes people with disabilities as patient instructors in formal training sessions and preclinical and clinical instruction; and (8) encourages the Accreditation Council for Graduate Medical Education and graduate medical education programs to develop and implement curriculum on providing appropriate and comprehensive health care to people with a range of disabilities. [CCB/CLRPD Rep. 3, A-14; Appended: Res. 306, A-14; Appended: Res. 315, A-17; Appended: Res. 304, A-18; Reaffirmed in lieu f the 1st Resolved: Res. 304] [Modified: Res. 428, A-22]

**D-90.992 Preserving Protections of the Americans with Disabilities Act of 1990**
Our American Medical Association supports legislative changes to the Americans with Disabilities Act of 1990, to educate state and local government officials and property owners on strategies for promoting access to persons with a disability. [Res. 220, I-17]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 924
(I-25)

Introduced by: LGBTQ+ Section

Subject: Preserving Access to Gamete Donation and Gestational Carriers and Protecting Parental Rights

Referred to: Reference Committee K

---

Whereas, the American Society for Reproductive Medicine (ASRM) defines a gamete donor as an individual who is not a sexually intimate partner of the recipient and a gestational carrier as a person who carries a pregnancy resulting from the transfer of a preimplantation embryo created by one or more genetic parents or gamete donors;[1,2] and

Whereas, indications for the use of gamete donors include male partner sperm or seminal fluid abnormalities, ejaculatory dysfunction, significant Rh isoimmunization of a female partner who is Rh negative with an Rh positive male partner, prior failure of fertilization during IVF after intracytoplasmic sperm injection, or females without male partners, inclusive of single females and LGBTQ+ couples;[1] and

Whereas, indications for the use of gestational carriers include uterine abnormalities or absence, absolute psychological or medical contraindication to pregnancy, serious psychological or medical condition that could be exacerbated by pregnancy or cause significant risk to mother or fetus, or biologic inability to conceive or carry a child, inclusive of single males and LGBTQ+ couples;[2] and

Whereas, gamete donation and gestational carrying are routinely utilized by same-sex couples who cannot conceive without using ART;[3,4,5,6] and

Whereas, gestational carrying pregnancies are similar in safety to other ART pregnancies;[7] and

Whereas, there are no substantial medical or psychological risks for gestational carriers or their children, and that proper screening, medical oversight, and psychological support contribute to positive outcomes of gestational carrying;[8] and

Whereas, gestational carrying is considered ‘commercial’ if financial compensation is provided to the carrier, and ‘altruistic’ if the carrier does not take financial compensation;[9] and

Whereas, regulation of commercial and altruistic gestational carrying varies significantly across the United States, with some jurisdictions banning commercial gestational carrying on ethical grounds while others allow it under strict legal frameworks;[10-16] and

Whereas, in Supreme Court case Pavan v. Smith (2017), two same-sex married couples from Arkansas utilized artificial insemination and were denied birth certificates that listed both intended parents and instead were issued birth certificates that only listed the birth mother; however, ultimately, the Supreme Court reversed the decision of the Arkansas Supreme Court and held that married same-sex couples cannot be denied the benefits that the States have

linked to marriage and that all married couples must be treated equally under United States law;[17] and

Whereas, despite Pavan v. Smith, some state regulations continue to be exclusionary to LGBTQ+ couples seeking gestational carrier services, with the unintended consequence of also excluding heterosexual couples that are not both genetically related to the carried child, therefore treating these married couples differently and unconstitutionally;[18] and

Whereas, the strongest ideological motivation for gestational carrying restrictions is anti-LGBTQ+ sentiment with the goal of preventing non-heterosexuals from reproducing and family building, yet these restrictions harm all people seeking these reproductive options;[19] and

Whereas, gestational carrying continues despite criminal or civil bans, and that bans only serve to leave the parties without legal protection;[20] and

Whereas, gestational carrying most commonly goes wrong when the involved parties do not clearly delineate terms of the carrying in contract, which can be addressed through consistent and equitable regulation and infrastructure;[21,22] and

Whereas, banning commercial gestational carrying disproportionately impacts LGBTQ+ individuals and those experiencing infertility who do not have family or friends willing to serve as altruistic carriers;[23] and

Whereas, the absence of clear gamete donation and gestational carrying laws can lead to significant legal and financial risks for intended parents, donors and carriers, and children, including uncertainty in parental rights, unenforceable agreements, and jurisdictional conflicts;[21,22,24] and

Whereas, establishment of legal parentage is complex for all due to state variation and financial and legal barriers, with particular challenges for single intended parents and LGBTQ+ intended parents and those using gestational carrying as a method of family building;[26-30] and

Whereas, there is also notable variation across states in establishing parentage when considering the use of donor gametes, leaving intended parents navigating a complex and often expensive and time-consuming legal environment in order to be considered a legal guardian; therefore be it

RESOLVED, that our American Medical Association support policies and initiatives that protect, standardize, and improve access to gamete donation and gestational carrying as recognized options for assisted reproduction (New HOD Policy); and be it further

RESOLVED, that our AMA support efforts by appropriate parties to provide resources for intended parents, gestational carriers, gamete donors, and children born with the aid of gamete donation and/or gestational carrying (New HOD Policy); and be it further

RESOLVED, that our AMA advocates for accessibility, timeliness, and dignity in the process of establishing parentage for children born from gamete donation and/or gestational carrying. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/29/25

**REFERENCES**


1. Gamete and embryo donation guidance (2024). Asrm.org. Published 2024. https://www.asrm.org/practice-guidance/practice-committee-documents/guidance-regarding-gamete-and-embryo-donation/
2. Recommendations for practices using gestational carriers: a committee opinion (2022). www.asrm.org. https://www.asrm.org/practice-guidance/practice-committee-documents/recommendations-for-practices-using-gestational-carriers-a-committee-opinion-2022/
3. Circle Surrogacy. (n.d.). *Surrogacy for LGBTQ+ parents*. https://www.circlesurrogacy.com/intended-parents/who-we-help/lgbtq-parents
4. Houghton, W. (n.d.). *Surrogacy for gay couples worldwide*. SENSIBLE Surrogacy. https://www.sensiblesurrogacy.com/gay-surrogacy/
5. Gay Parents To Be. (n.d.). *Surrogacy for dads to be*. https://www.gayparentstobe.com/for-gay-men/surrogacy
6. Creative Family Connections. (n.d.). *LGBTQ+ parents and surrogacy*. https://creativefamilyconnections.com/intended-parents/lgbtq-parents/
7. Matsuzaki, S., Matsuzaki, S., Chang, E. J., Yasukawa, M., Roman, L. D., & Matsuo, K. (2024). Obstetric characteristics and outcomes of gestational carrier pregnancies: A systematic review and meta-analysis. *JAMA Network Open*, 7(7), e2318602. https://doi.org/10.1001/jamanetworkopen.2023.18602
8. Yau, A., Friedlander, R. L., Petrini, A., Holt, M. C., White, D. E., Shin, J., Kalantry, S., & Spandorfer, S. (2021). Medical and mental health implications of gestational surrogacy. *American Journal of Obstetrics and Gynecology*, 225(3), 264–269. https://doi.org/10.1016/j.ajog.2021.04.213
9. Worldwide Surrogacy Specialists. (2021, January 11). *Commercial surrogacy vs. altruistic surrogacy*. https://www.worldwidesurrogacy.org/blog/commercial-surrogacy-vs-altruistic-surrogacy
10. Reuters. (2023, April 5). *Which countries allow commercial surrogacy?* Reuters. https://www.reuters.com/world/which-countries-allow-commercial-surrogacy-2023-04-05/?utm_source=chatgpt.com
11. Rosas, A. (2019). *Surrogacy and the law*. Georgetown Journal of Gender and the Law. https://www.law.georgetown.edu/gender-journal/wp-content/uploads/sites/20/2019/11/Alicia_Surrogacy-6.pdf?utm_source=chatgpt.com
12. Gateway Surrogacy. (n.d.). *The legal landscape: Where surrogacy is legal – A state-by-state analysis*. Gateway Surrogacy. https://www.gatewaysurrogacy.org/the-legal-landscape-where-surrogacy-is-legal-a-state-by-state-analysis/
13. Schapiro, S., & Chervenak, F. A. (2022). *Surrogacy and the law: The role of assisted reproductive technology in shaping policy and practice*. *PMCID: PMC9800153*. https://pmc.ncbi.nlm.nih.gov/articles/PMC9800153/
14. Creative Family Connections. (n.d.). *The US Surrogacy Law Map™*. https://creativefamilyconnections.com/us-surrogacy-law-map/
15. American Society for Reproductive Medicine. (n.d.). *Surrogacy laws by state*. https://connect.asrm.org/lpg/resources/surrogacy-by-state
16. Napolitano, A. P. (2021). The role of the judiciary in preserving a free society. Touro Law Review, 37(1), 1. Retrieved from https://digitalcommons.tourolaw.edu/cgi/viewcontent.cgi?article=3319&context=lawreview.
17. Mutavdzic, T. P. (2024). Legal challenges across state lines: A look into surrogacy law in the United States. Journal of Civil Law Studies, 16(1), 266–289. https://digitalcommons.law.lsu.edu/cgi/viewcontent.cgi?article=1315&context=jcls
18. Mutavdzic, T. P. (2024). Legal challenges across state lines: A look into surrogacy law in the United States. Journal of Civil Law Studies, 16(1), 266–289. https://digitalcommons.law.lsu.edu/cgi/viewcontent.cgi?article=1315&context=jcls
19. Flores, C. (2023). Accounting for the selfish state: Human rights, reproductive equality, and global regulation of gestational surrogacy. Chicago Journal of International Law, 23(2), 391–456. https://chicagounbound.uchicago.edu/cjil/vol23/iss2/3
20. Harris, L. (2024, April 1). *Michigan legalizes paid surrogacy, decriminalizing the practice*. NPR. https://www.npr.org/sections/health-shots/2024/04/01/1241392032/michigan-paid-surrrogacy-decriminalize-babym
21. Jefford, S. (n.d.). When surrogacy goes wrong. Retrieved February 26, 2025, from https://sarahjefford.com/when-surrogacy-goes-wrong/
22. Joslin, C. G. (2020). Surrogacy and the politics of pregnancy. *Harvard Law & Policy Review*, 14(2), 209–227. https://doi.org/10.2139/ssrn.3736963
23. Flores, C. (2023). Accounting for the selfish state: Human rights, reproductive equality, and global regulation of gestational surrogacy. *Chicago Journal of International Law*, 23(2), 391–425. https://chicagounbound.uchicago.edu/cjil/vol23/iss2/3
24. Everingham, S. (2024, August 23). *Legal pitfalls of surrogacy you can't afford to ignore*. Growing Families. https://www.growingfamilies.org/legal-pitfalls-of-surrogacy-you-cant-afford-to-ignore/
25. Harris, L. (2024, April 1). *Surrogacy 'unicorn' is pregnant with baby No. 11 and has a heartbeat*. NBC News. https://www.nbcnews.com/news/us-news/surrogacy-unicorn-pregnant-baby-no-11-heartbeat-rcna149290
26. American Society for Reproductive Medicine. (n.d.). *Surrogacy laws by state*. https://connect.asrm.org/lpg/resources/surrogacy-by-state?ssopc=1
27. Horne SG, Johnson T, Yel N, Maroney MR, McGinley M. Unequal rights between LGBTQ parents living in the U.S.: The association of minority stress to relationship satisfaction and parental stress. Couple and Family Psychology: Research and Practice. 2021;11(2). doi:https://doi.org/10.1037/cfp0000192
28. GLAD. (n.d.). *Voluntary acknowledgment of parentage*. https://www.glad.org/voluntary-acknowledgment-of-parentage/
29. Movement Advancement Project. (n.d.). *Parenting recognition map*. https://www.lgbtmap.org/equality-maps/recognition/parenting#:~:text=All%20states%20have%20a%20marital%20presumption%20of%20parentage.&text=Now%2C%20a%20growing%20number%20of%20states%20are,their%20parental%20relationship%20legally%20recognized%20and%20protected.
30. GLAD. (n.d.). *Voluntary acknowledgment of parentage*. https://www.glad.org/voluntary-acknowledgment-of-parentage/
31. Anon. Sperm Donation Options for Lesbian Couples | Legal Guide. Claiborne | Fox | Bradley | Goldman LLC. Published 2025. Accessed August 21, 2025. https://gababylaw.com/sperm-donation-options-for-lesbian-couples-legal-guide/
32. Family Equality. (n.d.). *Average adoption costs in the United States*. https://familyequality.org/resources/average-adoption-costs-in-the-united-states/#:~:text=Second%20or%20Step%20Parent%20Adoptions
33. Creative Family Connections. (n.d.). Surrogacy vs. adoption: Making the best choice for your family. Retrieved February 26, 2025, from https://creativefamilyconnections.com/blog/surrogacy-vs-adoption/

**RELEVANT AMA POLICY**

**4.2.1 Assisted Reproductive Technology**
Physicians should increase their awareness of infertility treatments and options for their patients. Physicians who offer assisted reproductive services should: (a) Value the well-being of the patient and potential offspring as paramount. (b) Ensure that all advertising for services and promotional materials are accurate and not misleading. (c) Provide patients with all of the information they need to make an informed decision, including investigational techniques to be used (if any); risks, benefits, and limitations of treatment options and alternatives, for the patient and potential offspring; accurate, clinic-specific success rates; and costs. (d) Provide patients with psychological assessment, support and counseling or a referral to such services. (e) Base fees on the value of the service provided. Physicians may enter into agreements with patients to refund all or a portion of fees if the patient does not conceive where such agreements are legally permitted. (f) Not discriminate against patients who have difficult-to-treat conditions, whose infertility has multiple causes, or on the basis of race, socioeconomic status, or sexual orientation or gender identity. (g) Participate in the development of peer-established guidelines and self-regulation. [Code of Medical Ethics, Issued 2016]

**Protecting Access to IVF Treatment D-425.989**
Our American Medical Association opposes any legislation or ballot measures that could criminalize in-vitro fertilization. 2) Our AMA will work with other interested organizations to oppose any civil or criminal legislation or ballot measures or court rulings that would: (a) equate gametes (oocytes and sperm) or embryos with children; and/or (b) otherwise restrict or interfere with evidence-based care for Assisted Reproductive Technology (ART). 3) Our AMA, through the AMA Task Force to Preserve the Patient-Physician Relationship, will report back at I-24, on the status of, and AMA's activities surrounding, proposed ballot measures or legislation and pending court rulings, that would: (a) equate gametes or embryos with children; and/or (b) otherwise restrict or interfere with evidence-based care for Assisted Reproductive Technology (ART). [Res. 217, A-24]

**4.2.4 Third-Party Reproduction**
Individual physicians who care for patients in the context of third-party reproduction should: (a) Establish a patient-physician relationship with only one party (gestational carriers, gamete donor[s] or intended rearing parent[s]) to avoid situations of dual loyalty or conflict of interest. (b) Ensure that the patient undergoes appropriate medical screening and psychological assessment. (c) Encourage the parties to agree in advance on the terms of the agreement, including identifying possible contingencies and deciding how they will be handled. (d) Inform the patient about the risks of third-party reproduction for that individual (those including individuals), possible psychological harms to the individual(s), the resulting child, and other relationships. (e) Satisfy themselves that the patient's decision to participate in third-party reproduction is free of coercion before agreeing to provide assisted reproductive services. 2) Collectively, the profession should advocate for public policy that will help ensure that the practice of third-party reproduction does not exploit disadvantaged women or commodify human gametes or children. [Code of Medical Ethics, Issued 2016]

**4.2.2 Gamete Donation**
Physicians who participate in gamete retrieval and storage should: (a) Inform prospective donors of sperm or ova: (i) about the clinical risks of gamete donation, including the near and long-term risks and the discomforts of ovarian hyperstimulation and egg retrieval as appropriate; (ii) about the need for full medical disclosure and that prospective donors will be tested for infectious disease agents and genetic disorders; (iii) whether and how the donor will be informed if testing indicates the presence of infectious disease or genetic disorder; (iv) that all information collected, including test results, will be stored indefinitely; (v) what additional personal information will be collected about the donor; (vi) under what circumstances and with whom personal information, including identifying information, will be shared for clinical purposes; (vii) how donated gametes will be stored and policies and procedures governing the use of stored gametes; (viii) whether and how the donor will be compensated; (ix) the fact that state law will govern the relationship between the donor and any resulting child (or children). (b) Exclude prospective donors for whom testing reveals the presence of infectious disease agents. (c) Obtain the prospective donor's consent for gamete retrieval. (d) Discuss, document and respect the prospective donor's preferences for how gametes may be used, including whether they may be donated for research purposes. (e) Discuss, document, and respect the prospective donor's preferences regarding release of

identifying information to any child (or children) resulting from use of the donated gametes. (f) Adhere to good clinical practices, including ensuring that identifying information is maintained indefinitely so that: (i) donors can be notified in the event a child born through use of his/her gametes subsequently tests positive for infectious disease or genetic disorder that may have been transmitted by the donor; (ii) the number of pregnancies resulting from a single gamete donor is limited. [Code of Medical Ethics, Issued 2016]

**Resident and Fellow Access to Fertility Preservation H-310.902**
Our American Medical Association encourages insurance coverage for fertility preservation and infertility treatment within health insurance benefits for residents and fellows offered through graduate medical education programs.
Our AMA supports the accommodation of residents and fellows who elect to pursue fertility preservation and infertility treatment, including but not limited to, the need to attend medical visits to complete the gamete preservation process and to administer medications in a time-sensitive fashion.

**Advocating for Increased Support to Physicians in Family Planning and Fertility D-405.944**
Our American Medical Association will advocate for academic and employed physician practices to contract with insurance providers who provide infertility coverage that defrays the steep costs for fertility treatments.
Our AMA will work with other key stakeholders to encourage full support of physicians desiring to have families to allow for flexible work policies and clinical coverage for those undergoing fertility treatments.

**Reproductive Health Insurance Coverage H-185.926**
Our AMA supports: (1) insurance coverage for fertility treatments regardless of marital status or sexual orientation when insurance provides coverage for fertility treatments; and (2) local and state efforts to promote reproductive health insurance coverage regardless of marital status or sexual orientation when insurance provides coverage for fertility treatments.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 925
(I-25)

Introduced by: Washington, Oregon, California, Colorado, Montana

Subject: Evidence-Based Vaccine and Preventive Services Recommendations

Referred to: Reference Committee K

---

Whereas, the Advisory Committee on Immunization Practices (ACIP) and the U.S. Preventive Services Task Force (USPSTF) appears to be losing all credibility because of the unprecedented federal politicization of public health; and

Whereas, Robert F. Kennedy, Jr., secretary of health and human services and a veteran antivaccine activist, recently fired the entire ACIP's membership, and the newest appointees were announced only a few days before the scheduled September meeting; and CDC director Susan Monarez, who led the agency for a month, testified to the Senate in September about her experience of being pushed out of office for not condoning attacks on vaccines unsupported by evidence; and

Whereas, according to The Wall Street Journal, Kennedy plans to dismiss all 16 members of the USPSTF, labeling them as too "woke;" the July 10 meeting of the USPSTF was abruptly canceled without explanation, prompting alarm across the medical community; and on June 27, 2025, the U.S. Supreme Court ruled that USPSTF members are considered "inferior officers," meaning the HHS Secretary has legal authority to remove or replace them; and

Whereas, multiple references in our AMA policy refer to the ACIP and USPSTF as authoritative sources for credible vaccine and preventive services recommendations; and

Whereas, our state and national policies on vaccines and preventive services should ideally be based on recommendations developed by a trusted national entity which gathers input from authoritative medical entities, such as the American Academy Pediatrics, American Academy of Family Physicians, American College of Obstetrics and Gynecologists, American College of Physicians, and other credible medical specialty groups; therefore be it

RESOLVED, that our American Medical Association will replace all references in our policies to the Advisory Committee on Immunization Practices (ACIP) and the U.S. Preventive Services Task Force (USPSTF) with "current evidence-based recommendations developed by authoritative medical entities" (Directive to Take Action); and be it further

RESOLVED, that our AMA will study options for replacing, to the extent possible, the ACIP and USPSTF at the earliest possible time with a national entity which will develop and publish credible evidence-based recommendations for vaccines and preventive services. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/29/25

**REFERENCES**

1. Here's What Happened at RFK, Jr.'s Overhauled Vaccine Panel Meeting How a Contentious CDC Vaccine Meeting Will Affect Public Health | Scientific American
2. Hands off the U.S. Preventive Services Task Force, says AMA. https://www.ama-assn.org/health-care-advocacy/federal-advocacy/hands-us-preventive-services-task-force-says-ama
3. Senators introduce resolution supporting prevention task force RFK Jr. may disband. Senators introduce resolution supporting U.S. Preventive Services Task Force : Shots - Health News : NPR

## RELEVANT AMA POLICY

### H-440.875 Assuring Access to ACIP/AAFP/AAP-Recommended Vaccines

1. It is our American Medical Policy that all persons, regardless of economic and insurance status, receive all Advisory Committee on Immunization Practices (ACIP)-recommended vaccines as soon as possible following publication of these recommendations in the Centers for Disease Control and Prevention's (CDC) Morbidity and Mortality Weekly Report (MMWR).
2. Our AMA will continue to work with the federal government, Congress, and other stakeholders to improve liability protection for vaccine manufacturers and health care professionals who provide immunization services and to examine and improve compensation mechanisms for patients who were legitimately injured by a vaccine.
3. Our AMA will continue to work with the federal government, Congress, and other appropriate stakeholders to enhance public opinion of vaccines and to monitor and ensure the continued safety of existing and newly approved vaccines (including providing adequate resources for post-approval surveillance) so as to maintain and improve public confidence in the safety of vaccines.
4. Our AMA will work with appropriate stakeholders, including vaccine manufacturers, vaccine distributors, the federal government, medical specialty societies, and third party payers, to guarantee a robust vaccine delivery infrastructure (including but not limited to, the research and development of new vaccines, the ability to track the real-time supply status of ACIP-recommended vaccines, and the timely distribution of ACIP-recommended vaccines to providers).
5. Our AMA will work with appropriate federal and state agencies and private sector entities to ensure that state Medicaid agencies and private insurance plans pay health care professionals at least the approved Relative Value Unit (RVU) administration Medicare rates for payment when they administer ACIP-recommended vaccines.
6. Our AMA will work with the Centers for Medicare and Medicaid Services (CMS) to address barriers associated with Medicare recipients receiving live zoster vaccine and the routine boosters Td and Tdap in physicians' offices.
7. Our AMA will work through appropriate state entities to ensure all health insurance plans rapidly include newly ACIP-recommended vaccines in their list of covered benefits, and to pay health care professionals fairly for the purchase and administration of ACIP-recommended vaccines.
8. Our AMA will urge Medicare to include Tdap (Tetanus, Diphtheria, Acellular Pertussis) under Medicare Part B as a national public health measure to help prevent the spread of Pertussis.
9. Until compliance of our AMA Policy H-440.875(6) is actualized to the AMA's satisfaction regarding the tetanus vaccine, our AMA will aggressively petition CMS to include tetanus and Tdap at both the "Welcome to Medicare" and Annual Medicare Wellness visits, and other clinically appropriate encounters, as additional "triggering event codes" (using the AT or another modifier) that allow for coverage and payment of vaccines to Medicare recipients.
10. Our AMA will aggressively petition CMS to include coverage and payment for any vaccinations administered to Medicare patients that are recommended by the ACIP, the US Preventive Services Task Force (USPSTF), or based on prevailing preventive clinical health guidelines.

### H-425.988 The US Preventive Services Task Force Guide to Clinical Preventive Services

1. Our American Medical Association will continue to work with the federal government, specialty societies, and others, to develop guidelines for, and effective means of delivery of, clinical preventive services
2. Our AMA will continue our efforts to develop and encourage continuing medical education programs in preventive medicine.

**H-440.860 Financing of Adult Vaccines: Recommendations for Action**

1. Our American Medical Association supports the concepts to improve adult immunization as advanced in the Infectious Diseases Society of America's 2007 document "Actions to Strengthen Adult and Adolescent Immunization Coverage in the United States," and support the recommendations as advanced by the National Vaccine Advisory Committee's 2008 white paper on pediatric vaccine financing.
2. Our AMA will advocate for the following actions to address the inadequate financing of adult vaccination in the United States: Provider-related
    a. Develop a data-driven rationale for improved vaccine administration fees.
    b. Identify and explore new methods of providing financial relief for adult immunization providers through, for example, vaccine company replacement systems/deferred payment/funding for physician inventories, buyback for unused inventory, and patient assistance programs.
    c. Encourage and facilitate adult immunization at all appropriate points of patient contact; e.g., hospitals, visitors to long-term care facilities, etc.
    d. Encourage counseling of adults on the importance of immunization by creating a mechanism through which immunization counseling alone can be reimbursed, even when a vaccine is not given.

**H-440.877 Distribution and Administration of Vaccines**

1. It is optimal for patients to receive vaccinations in their medical home to ensure coordination of care. This is particularly true for pediatric patients and for adult patients with chronic disease and co-morbidities. If a vaccine is administered outside the medical home, all pertinent vaccine-related information should be transmitted back to the patient's primary care physician and entered into an immunization registry when one exists to provide a complete vaccination record.
2. All physicians and other qualified health care providers who administer vaccines should have fair and equitable access to all ACIP recommended vaccines. However, when there is a vaccine shortage, those physicians and other health care providers immunizing patients who are prioritized to receive the vaccine based upon medical risks/needs according to ACIP recommendations must be ensured timely access to adequate vaccine supply.
3. Physicians and other qualified health care providers should:
    a. Incorporate immunization needs into clinical encounters, as appropriate.
    b. Strongly recommend needed vaccines to their patients in accordance with ACIP recommendations and consistent with professional guidelines.
    c. Either administer vaccines directly or refer patients to another qualified health care provider who can administer vaccines safely and effectively, in accordance with ACIP recommendations and professional guidelines and consistent with state laws.
    d. Ensure that vaccination administration is documented in the patient medical record and an immunization registry when one exists
    e. Maintain professional competencies in immunization practices, as appropriate.
4. All vaccines should be administered by a licensed physician, or by a qualified health care provider pursuant to a prescription, order, or protocol agreement from a physician licensed to practice medicine in the state where the vaccine is to be administered or in a manner otherwise consistent with state law.
5. Patients should be provided with documentation of all vaccinations for inclusion in their medical record, particularly when the vaccination is provided by someone other than the patient's primary care physician.
6. Physicians and other qualified health care providers who administer vaccines should seek to use integrated and interoperable systems, including electronic health records and immunization registries, to facilitate access to accurate and complete immunization data and to improve information-sharing among all vaccine providers.
7. Vaccine manufacturers, medical specialty societies, electronic medical record vendors, and immunization information systems should apply uniform bar-coding on vaccines based on standards promulgated by the medical community.
8. Our American Medical Association encourages vaccine manufacturers to make small quantities of vaccines available for purchase by physician practices without financial penalty.

**H-460.894 Value of Preventive Services**

1. Our American Medical Association encourages committees that make preventive services recommendations to:
   a. follow processes that promote transparency and clarity among their methods;
   b. develop evidence reviews and recommendations with enough specificity to inform cost-effectiveness analyses;
   c. rely on the very best evidence available, with consideration of expert consensus only when other evidence is not available;
   d. work together to identify preventive services that are not supported by evidence or are not cost-effective, with the goal of prioritizing preventive services; and
   e. consider the development of recommendations on both primary and secondary prevention.
2. Our AMA encourages relevant national medical specialty societies to provide input during the preventive services recommendation development process.
3. Our AMA encourages comparative-effectiveness research on secondary prevention to provide data that could support evidence-based decision making.
4. Our AMA encourages public and private payers to cover preventive services for which consensus has emerged in the recommendations of multiple guidelines-making groups.

**H-425.997 Preventive Services**

1. Our AMA encourages the development of policies and mechanisms to assure the continuity, coordination and continuous availability of patient care, including professional preventive care and early-detection screening services, provided the services are cost effective.
2. It is the policy of the AMA that any preventive service that is being considered for inclusion in public or private sector insurance products have evidence-based data to demonstrate improved outcomes or quality of life and the cost effectiveness of the service.
3. Our AMA believes that preventive care should ideally be coordinated by a patient's physician.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 926
(I-25)

Introduced by: American Urological Association, American Association of Clinical Urologists, Washington, California

Subject: Establishment of Federal and State Offices of Men's Health

Referred to: Reference Committee K

---

Whereas, the Age-Adjusted Death Rate for US Males increased 22.5% from 2018 to 2021 (855.5 per 100,000 in 2018 to 1048.0 per 100,000 in 2021)[1]; and

Whereas, there are significant racial differences in US Male Age-Adjusted Death rates in 2021: 1715.5 per 100,000 for AIAN (American Indian or Alaska Native), 1380.2 per 100,000 for Blacks, 1055.3 per 100,000 for Whites, 934.8 per 100,000 for Hispanic, and 578.1 per 100,000 for Asian[2]; and

Whereas, the percentage of coronary heart disease in US Males has increased 8.5% from 2019 to 2022[3]; and

Whereas, the suicide rate for US Males is increased 14% from 2011 to 2021 (20.0 per 100,000 in 2011 to 22.8 per 100,000 in 2021). There is a significant racial difference in US Suicide Rates in 2022: 39.3 per 100,000 AIAN (American Indian or Alaska Native), 30.6 per 100,000 for Whites, 23.7 for NHPI (Native Hawaiian or Pacific Islander, 15.2 per 100,000 for Blacks, 13.4 per 100,000 for More than one race, 13.0 per 100,000 for Hispanics or Latino, and 10.8 per 100,000 for Asians[4]; and

Whereas, firearm homicides increased 67.5% from 2014 to 2021 (4.0 per 100,000 in 2014 to 6.7 per 100,000 in 2021) with men representing 85.7% of all firearm deaths[5]; and

Whereas, overall opioid overdose deaths in males was 32,078 in 2018 and 56,968 in 2023, a 78% increase. Males represented 72% of overall opioid deaths in 2023. More than 70% of overall opioid deaths occurred among males[6]; and

Whereas, minority and LGBTQ+ men face distinct health disparities influenced by social, economic, and cultural factors that can be addressed with a coordinated effort at the federal and state level[7,9,10]; and

Whereas, current AMA policy encourages the establishment of a federal Office of Men's Health within the US Department of Health and Human Services[8]; and

Whereas, each state has different trends and challenges related to Men's Health; and

Whereas, coordination of awareness, outreach, and outcome analysis can better identify barriers to care for all men, including racial minorities and LGBTQ+.[7,9,10]; therefore be it

RESOLVED, that our American Medical Association amend Policy D-160.985, Establishment of an Office of Men's Health, to read as follows:

**Establishment of ~~an~~ Federal and State Offices of Men's Health**

1. Our AMA encourages the establishment of an Office of Men's Health ~~at the U.S.~~ within the federal Department of Health and Human Services to coordinate awareness, outreach, and outcomes on men's health.

2. Our AMA encourages the establishment of an Office of Men's Health within each state's Department of Health and Human Services to coordinate awareness, outreach, and outcomes on men's health. (Modify Current HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 9/29/25

**REFERENCES**

1. "Quick Stats: Age-Adjusted Death Rates–United States, 2009-2018. Weekly, August 7, 2020; 69(31);1044. Source for 2021 is Provisional Mortality Data–United States, 2022. Weekly, May 5, 2023, 72(19);488-492.
2. Mortality in the United States, NCHS Data Brief No 456, Dec 2022.
3. National Center for Health Statistics. Percentage of coronary heart disease for adults aged 18 and over, United States, 2019—2022. National Health Interview Survey.
4. CDC WONDER underlying cause of death data, 2011-2021, and Provisional Data, 2022. Suicide Deaths. CDC.gov, accessed on April 5, 2023
5. CDC WONDER Online Database, Multiple Cause of Death Files, 1999-2021, accessed on April 5, 2023
6. https://www.kff.org/mental-health/state-indicator/opioid-overdose-deaths-by-sex. Kaiser Family Foundation. Accessed on September 28, 2025.
7. National Academies of Sciences, Engineering, and Medicine. (2021). Understanding the Well-Being of LGBTQI+ Populations. Washington, DC: The National Academies Press. https://doi.org/10.17226/25877. Also see: Office of Minority Health, U.S. Department of Health and Human Services. "Minority Men's Health." https://minorityhealth.hhs.gov
8. American Medical Association Policy D-160.985. "Establishment of an Office of Men's Health." Res. 417, A-07. Reaffirmed: BOT Rep. 22, A-17. AMA House of Delegates Policy Database.
9. Centers for Disease Control and Prevention (CDC). "Behavioral Risk Factor Surveillance System (BRFSS): Prevalence Data & Trends." https://www.cdc.gov/brfss. Also see: State Health Facts: Health Insurance Coverage of Men 19-64 (CPS). Kaiser Family Foundation. Accessed 7 July 2025. https://www.kff.org/other/state-indicator/uninsured-rates-for-nonelderly-adults-by-sex.
10. Healthy People 2030. Office of Disease Prevention and Health Promotion. "Social Determinants of Health." https://health.gov/healthypeople. Also see: Institute of Medicine. "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care." (2003). Washington, DC: National Academies Press

**RELEVANT AMA POLICY**

**Establishment of a Federal Office of Men's Health D-160.985**
Our AMA encourages the establishment of an Office of Men's Health at the U.S. Department of Health and Human Services to coordinate awareness, outreach, and outcomes on men's health.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 927
(I-25)

Introduced by: Federal Services

Subject: Battlefield Acupuncture – An Educational Call to Arms

Referred to: Reference Committee K

---

Whereas, in 2016 alone, more Americans died of drug overdose than were killed in action during the entire Vietnam War–a grim statistic that shows no sign of abating; and

Whereas, in order to counter the persistent epidemic of unrequited pain and to reduce the reliance on narcotic analgesics, clinicians need a wider range of alternatives, including non-pharmacological options to treat acute and chronic pain; and

Whereas, Battlefield Acupuncture (BFA) is a contemporary modification of the ancient art of acupuncture that was developed by in the aftermath of 9/11 by an Air Force radiation oncologist, turned medical acupuncturist, Colonel (Dr.) Richard Niemtzow; and

Whereas, the BFA technique has been consistently shown to be a fast, simple, safe, inexpensive, but elegant form of auricular acupuncture that can be used to treat acute and chronic pain of virtually any type; and

Whereas, Battlefield Acupuncture simply involves learning how to reliably identify just 5 key points on the external ear; and

Whereas, a major Department of Defense/Veteran's Health Administration Joint Incentive Fund project confirmed that BFA is a highly effective, reproducible technique that can be quickly and easily taught (in as little as 3 hours), and performed by a wide array of medical professionals, with high levels of patient satisfaction; and

Whereas, BFA has been clinically shown to produce rapid results—within minutes, in approximately 80% of patients, regardless of the etiology of their underlying pain; and

Whereas, BFA is highly cost effective, given that the cost of a single semi-permanent needle is approximately 60 cents and that a complete (10 needle) treatment can be administered for less than $7.00/patient; and

Whereas, over the past two decades, use of BFA has steadily increased throughout all branches of the U.S. Armed Forces and in a growing number of Veteran's Administration (VA) facilities; and

Whereas, to date, over 6,500 military and VA healthcare providers – ranging from physicians, nurses, physician assistants, nurse practitioners, dentists, physical therapists, combat medics and others have been successfully trained in applying the BFA technique; and

Whereas, in 2023 BFA was incorporated into the formal training of Ukrainian combat medics by a civilian, Ukrainian-American acupuncturist, where it has also been shown to provide consistently high levels of pain amelioration and patient satisfaction; and

Whereas, instruction in BFA is currently being considered for formal adoption by the North Atlantic Treaty Organization's (NATO) Centre of Excellence for Military Medicine; and

Whereas, the widespread use and adoption of BFA has markedly reduced the amount of narcotic analgesia required by some of our nation's most severely wounded warriors—including those with traumatic amputations and/or phantom limb pain; therefore be it

RESOLVED, that our American Medical Association encourage greater awareness of and/or instruction in the use of Battlefield Acupuncture as a quick, safe, and effective means to treat acute and chronic pain in patients, given its exceptional safety record, high level of reproducibility, and ability to be administered in an extremely cost-effective manner, without concerns for drug-drug interactions or dependence on narcotic analgesics. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 9/29/25

**REFERENCES:**

1. Lopez, G. (2017, June 8) "In one year, drug overdoses killed more Americans than the entire Vietnam War did." Vox. https://www.vox.com/policy-and-politics/2017/6/6/15743986/opioid-epidemic-overdose-deaths-2016.
2. Niemtzow, R.C. (2007) Battlefield Acupuncture. *Medical Acupuncture*, 19 (4), 225-228. https://www.liebertpub.com/doi/full/10.1089/acu.2007.0603
3. Niemtzow, R, Baxter, J, Gallagher, R. Pock, A. et al. (2018) "Building Capacity for Complementary and Integrative Medicine Through a Large, Cross-Agency, Acupuncture Training Program: Lessons Learned from a Military Health System and Veterans Health Administration Joint Initiative Project." *Military Medicine*, 183 (11-12), e486–e493, https://doi.org/10.1093/milmed/usy028
4. Hildebrand C. (2023) Auricular Acupuncture in Combat Medic Trainings. *Medical Acupuncture*. 35(4):156-158. https://www.liebertpub.com/doi/10.1089/acu.2023.29237.editorial

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 929
(I-25)

Introduced by: American Academy of Child and Adolescent Psychiatry

Subject: Protecting Access to Evidence-based Psychotropic Medication for the Treatment of Pediatric Mental Illness

Referred to: Reference Committee K

---

Whereas, psychotropic medications can be valuable tools in the treatment of a wide range of psychiatric conditions in youth; and

Whereas, the use of psychopharmacology in the treatment of pediatric mental health conditions is based on decades of research and real-world outcomes showing consistent improvement and excellent tolerability in both the short and long term; and

Whereas, decisions about prescribing psychotropic medications are made carefully, based on a comprehensive evaluation by a trained medical professional and a review of the risks and benefits of psychopharmacology with the patient and caregiver; and

Whereas, misinformation about the safety and efficacy of FDA-approved psychotropic medication undermines the value of clinical research and physician authority in psychiatric treatment; therefore be it

RESOLVED, that our American Medical Association opposes limitations on access to psychotropic medication as part of a comprehensive mental health treatment plan (New HOD Policy); and be it further

RESOLVED, that our AMA advocates that the U.S. Department of Health and Human Services and Congress use peer reviewed pediatric mental health research, and evidence based clinical guidelines developed by non-profit medical professional societies to inform pediatric mental health policy. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/30925

**REFERENCES**


1. Dulcan MK. Dulcan's Textbook of Child and Adolescent Psychiatry, Third Edition. American Psychiatric Association Publishing; 2022.
2. Bowers RT, Weston CG, Mast RC, Nelson SC, Jackson JC. Green's Child and Adolescent Clinical Psychopharmacology. Lippincott, Williams & Wilkins; 2018.
3. Walter HJ, Abright AR, Bukstein OG, et al. Clinical practice guideline for the assessment and treatment of children and adolescents with major and persistent depressive disorders. *Journal of the American Academy of Child & Adolescent Psychiatry*. 2023;62(5):479-502. doi:10.1016/j.jaac.2022.10.001

**RELEVANT AMA POLICY**

**H-100.971 Preserving the Doctor-Patient Relationship**
The AMA and interested physicians will continue to work with the Food and Drug Administration to prevent the unnecessary intrusion of the government and other regulatory bodies into the doctor-patient relationship, especially as it concerns the prescription of medication.
[Sub. Res. 510, I-95; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15; Reaffirmed: CSAPH Rep. 01, A-25]

**H-373.995 Government Interference in Patient Counseling**
1. Our American Medical Association vigorously and actively defends the physician-patient-family relationship and actively opposes state and/or federal efforts to interfere in the content of communication in clinical care delivery between clinicians and patients.
2. Our AMA strongly condemns any interference by government or other third parties that compromise a physician's ability to use their medical judgment as to the information or treatment that is in the best interest of their patients.
3. Our AMA supports litigation that may be necessary to block the implementation of newly enacted state and/or federal laws that restrict the privacy of physician-patient-family relationships and/or that violate the First Amendment rights of physicians in their practice of the art and science of medicine.
4. Our AMA opposes any government regulation or legislative action on the content of the individual clinical encounter between a patient and physician without a compelling and evidence-based benefit to the patient, a substantial public health justification, or both.
5. Our AMA will educate lawmakers and industry experts on the following principles endorsed by the American College of Physicians which should be considered when creating new health care policy that may impact the patient-physician relationship or what occurs during the patient-physician encounter:
    a. Is the content and information or care consistent with the best available medical evidence on clinical effectiveness and appropriateness and professional standards of care?
    b. Is the proposed law or regulation necessary to achieve public health objectives that directly affect the health of the individual patient, as well as population health, as supported by scientific evidence, and if so, are there no other reasonable ways to achieve the same objectives?
    c. Could the presumed basis for a governmental role be better addressed through advisory clinical guidelines developed by professional societies?
    d. Does the content and information or care allow for flexibility based on individual patient circumstances and on the most appropriate time, setting and means of delivering such information or care?
    e. Is the proposed law or regulation required to achieve a public policy goal - such as protecting public health or encouraging access to needed medical care - without preventing physicians from addressing the healthcare needs of individual patients during specific clinical encounters based on the patient's own circumstances, and with minimal interference to patient-physician relationships?
    f. Does the content and information to be provided facilitate shared decision-making between patients and their physicians, based on the best medical evidence, the physician's knowledge and clinical judgment, and patient values (beliefs and preferences), or would it undermine shared decision-making by specifying content that is forced upon patients and physicians without regard to the best medical evidence, the physician's clinical judgment and the patient's wishes?
    g. Is there a process for appeal to accommodate individual patients' circumstances?
6. Our AMA strongly opposes any attempt by local, state, or federal government to interfere with a physician's right to free speech as a means to improve the health and wellness of patients across the United States.

[Res. 201, A-11; Reaffirmation: I-12; Appended: Res. 717, A-13; Reaffirmed in lieu of Res. 5, I-13; Appended: Res. 234, A-15; Reaffirmation: A-19; Modified: Speakers Rep. 02, I-24]

**G-605.009 Establishing A Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted**

1. Our American Medical Association will convene a task force of appropriate AMA councils and interested state and medical specialty societies, in conjunction with the AMA Center for Health Equity, and in consultation with relevant organizations, practices, government bodies, and impacted communities for the purpose of preserving the patient-physician relationship.
2. This task force, which will serve at the direction of our AMA Board of Trustees, will inform the Board to help guide organized medicine's response to bans and restrictions on abortion, prepare for widespread criminalization of other evidence-based care, implement relevant AMA policies, and identify and create implementation-focused practice and advocacy resources on issues including but not limited to:
    a. Health equity impact, including monitoring and evaluating the consequences of abortion bans and restrictions for public health and the physician workforce and including making actionable recommendations to mitigate harm, with a focus on the disproportionate impact on under-resourced, marginalized, and minoritized communities.
    b. Practice management, including developing recommendations and educational materials for addressing reimbursement, uncompensated care, interstate licensure, and provision of care, including telehealth and care provided across state lines.
    c. Training, including collaborating with interested medical schools, residency and fellowship programs, academic centers, and clinicians to mitigate radically diminished training opportunities.
    d. Privacy protections, including best practice support for maintaining medical records privacy and confidentiality, including under HIPAA, for strengthening physician, patient, and clinic security measures, and countering law enforcement reporting requirements.
    e. Patient triage and care coordination, including identifying and publicizing resources for physicians and patients to connect with referrals, practical support, and legal assistance.
    f. Coordinating implementation of pertinent AMA policies, including any actions to protect against civil, criminal, and professional liability and retaliation, including criminalizing and penalizing physicians for referring patients to the care they need.
    g. Anticipation and preparation, including assessing information and resource gaps and creating a blueprint for preventing or mitigating bans on other appropriate health care, such as gender affirming care, contraceptive care, sterilization, infertility care, and management of ectopic pregnancy and spontaneous pregnancy loss and pregnancy complications.
    h. Work with interested parties to encourage the development of institution-level guidance and protection for physicians practicing in states with restrictions potentially interfering with the patient-physician relationship.
3. Our American Medical Association will appoint an ad hoc committee or task force, composed of physicians from specialties who routinely provide gender-affirming care, payers, community advocates, and state Medicaid directors and/or insurance commissioners, to identify issues with physician payment and reimbursement for gender-affirming care and recommend solutions to address these barriers to care.

[Res. 621, A-22; Appended: Res. 816, I-23; Appended: Res. 207, I-24]

**H-450.935 Health Care Standards**

Our AMA: (1) supports the ability of non-governmental organizations to evaluate appropriate medical diagnosis or therapy or current or new diagnostic or therapeutic tests, procedures, medications or other procedures that improve the quality of patient care; (2) supports the position that any practice guidelines, parameters, best practices models, or similar set of principles or clinical recommendations, whether developed or issued by government or non-government organizations, including those that result from any comparative effectiveness research or evidence-based medicine system, do not, and should expressly state that they do not, establish standard of care or create specific requirements for physicians that restrict the exercise of their clinical judgment; (3) urges any organization, whether governmental or non-governmental, promulgating any practice guidelines, parameters, best practices models, or similar set of principles or clinical recommendations, to include a statement that they are guidelines only; and (4) urges any organization, whether governmental or non-governmental, promulgating any practice guidelines, parameters, best practices models, or similar set of principles or clinical recommendations, to

set and make publicly available a regular schedule for review and update and to include the level of evidence supporting the guidelines.
[Res. 205, A-10; Reaffirmation I-10; Reaffirmed: Res. 105, A-18]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 930
(I-25)

Introduced by: The Medical Society of the District of Columbia

Subject: Establishing Fire Risk Standards for Civilian and Non-Industrial Clothing

Referred to: Reference Committee K

---

Whereas, in the setting of recent arson crimes where assailants intentionally set unsuspected victims' clothes on fire in a New York City Subway (Dec 2024) and Washington, D.C. Metrobus (Nov 2024), and more recently in Times Square (March 2025) and Queens (Sept 2025), the rapidity of the victim being consumed by flames drew attention to this public health concern;[8,9,10,11] and

Whereas, fire-related injuries and fatalities continue to be a public health concern, particularly among vulnerable populations such as children, aging individuals, and individuals with disabilities;[6] and

Whereas, from 2000 to 2009, more than 43,000 individuals were treated in U.S. emergency rooms and 1,131 people died due to clothing ignition, with 75% of the fatalities occurring among adults aged 65 and older, despite this group making up only 14% of the population;[7] and

Whereas, the Flammable Fabrics Act (FFA), a federal law administered by the U.S. Consumer Product Safety Commission, currently governs the flammability of textiles and wearing apparel, establishing minimum safety standards for certain garments, including general clothing;[1] and

Whereas, the FFA does not comprehensively address modern synthetic materials or provide updated testing standards that reflect current textile technology and burn risk potential;[1] and

Whereas, research indicates that textiles composed of synthetic fibers, such as polyester and nylon, can melt and adhere to skin, increasing burn severity compared to natural fibers like cotton and wool;[4] and

Whereas, studies have shown that flame-resistant-treated fabrics significantly reduce ignition risk and burn injury severity, particularly in high-risk environments;[4] and

Whereas, the National Fire Protection Association (NFPA) has established standards (e.g., NFPA 2112 and NFPA 70E) for flame-resistant clothing in occupational settings, but similar standards do not exist for general civilian use;[2] and

Whereas, existing regulations from the Occupational Safety and Health Administration (OSHA) primarily address workplace fire risks and do not extend to general consumer clothing;[3] and

Whereas, enhanced labeling and consumer education on fire risk associated with various textile materials can contribute to informed purchasing decisions and injury prevention;[5] and

Whereas, public knowledge about clothing flammability risks remains low, yet national survey data show that a majority of U.S. homeowners support stricter safety standards (53%) and warning labels (64%) on clothing to reduce the risk of burn injuries and fatalities;[7] and

Whereas, a majority of homeowners indicated that such warning labels would either not affect their purchasing decisions (64%) or be an incentive to purchase an item (24%), highlighting the importance of industry to not only label clothing flammability risk but also to manufacture garments with low flammability risk;[7] therefore be it

RESOLVED, that our American Medical Association study the flammability of and fire-resistant treatments for consumer clothing materials and their potential public health benefits (Directive to Take Action); and be it further

RESOLVED, that our AMA study the value of updated flammability risk standards that incorporate modern textile compositions and their associated fire risks (Directive to Take Action); and be it further

RESOLVED, that our AMA encourage the Consumer Product Safety Commission (CPSC) and relevant regulatory bodies to update and enforce stricter fire safety labeling and testing requirements for civilian clothing and support educating the public on flammability risk on apparel labels. (New HOD Policy)

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

Received: 9/30/25

**REFERENCES**

1. *U.S. Consumer Product Safety Commission. (n.d.). Flammable Fabrics Act. Available at: https://www.cpsc.gov*
2. *National Fire Protection Association (NFPA). (n.d.). Home Fires Involving Clothing Ignition; NFPA 2112: Standard on Flame-Resistant Clothing. Quincy, MA: National Fire Protection Association.*
3. *Occupational Safety and Health Administration (OSHA). (2010). Standard Interpretations: 2010-03-19.Available at: https://www.osha.gov*
4. *Horrocks, A. R., & Anand, S. C. (n.d.). The Influence of Textile Materials on Flame Resistance Ratings of Professional Uniforms. In Performance of Protective Clothing and Equipment (Springer Link). Available at: https://link.springer.com*
5. *Toma, S., & Ciobanu, V. (n.d.). Fire Hazards of Clothing Related to Accidents and Consumer Habits. ResearchGate. Available at: h ttps://www.researchgate.net*
6. Shokouhi, M., Nasiriani, K., Cheraghi, Z., Ardalan, A., Khankeh, H., Fallahzadeh, H., & Khorasani-Zavareh, D. (2019). "Preventive measures for fire-related injuries and their risk factors in residential buildings: a systematic review."Journal of Injury and Violence Research, 11(1), 1–14.
7. Frattaroli, S., Spivak, S. M., Pollack, K. M., Gielen, A. C., Salomon, M., & Damant, G. H. (2016). "Clothing flammability and burn injuries: Public opinion concerning an overlooked, preventable public health problem." *Journal of Burn Care & Research*, 37(3), e196–e204.
8. Reuters. (2025, January 7). *Man accused of killing woman in New York subway fire pleads not guilty.* Reuters. https://www.reuters.com/legal/man-accused-killing-woman-new-york-subwayfire-pleads-not-guilty-2025-01-07/
9. NBC Washington. (n.d.). *'Crazy man's' shirt set on fire while riding Metrobus.* NBC Washington. Retrieved April 28, 2025, from https://www.nbcwashington.com/news/local/crazy-mans-shirt-set-on-fire-while-riding-metrobus/3811157/
10. Truthfully. (n.d.). *45-year-old man set on fire in Times Square attack*. Truthfully. Retrieved September 14, 2025, from https://truthfully.com/article/45-year-old-man-set-on-fire-in-times-square-attack
11. Katersky, A., & Shapiro, E. (2025, September 10). *Suspect in custody after couple severely burned in 'horrific double homicide' in NYC: Police.* ABC News. Retrieved September 14, 2025, from https://abcnews.go.com/US/77-year-man-78-year-woman-set-fire/story?id=125392091

**RELEVANT AMA POLICY**

**H-10.989 Better Fire Prevention in Public Buildings**
The AMA urges state public authorities to enact uniform fire protection codes in public buildings, for the risks such furnishings hold for the emission of toxic gases as well as intense heat, and at least in the case of new construction, the introduction of expanded sprinkler systems and fully automatic smoke detectors. [Res. 32, A-88; Reaffirmed: Sunset Report, I-98; Modified and Reaffirmed: CSAPH Rep. 2, A-08; Modified: CSAPH Rep. 01, A-18]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 931
(I-25)

Introduced by: American Academy of Dermatology, Society for Investigative Dermatology, American Contact Dermatitis Society, American Society for Dermatologic Surgery, National Medical Association

Subject: Preserving Evidence-Based, Equitable Grooming Standards in Military Service

Referred to: Reference Committee K

---

Whereas, the Department of War has issued directives that would eliminate or severely restrict shaving waivers and facial-hair accommodations for service members with medical needs, limiting the period of medical accommodation to one year before facing separation from service;[1-5] and

Whereas, pseudofolliculitis barbae (PFB), or "razor bumps," is a chronic inflammatory skin condition caused by shaving that affects individuals across demographic groups but is most prevalent in those with tightly curled hair, disproportionately impacting Black service members (with 45-83% prevalence in that population compared with ~18% among White service members), and is recognized as one of the most common dermatologic conditions in the U.S. Armed Forces;[6-10] and

Whereas, PFB can lead to papules, pustules, hyperpigmentation, scarring, and increased risk of infection and skin damage if forced shaving is required;[6-8] and

Whereas, for severe or refractory PFB, durable management often requires a shaving waiver and/or laser hair removal after conservative measures fail (e.g. topical retinoids, antibiotics, improved grooming techniques, etc) fail;[3-6] and

Whereas, a strict, blanket elimination of shaving waivers would undermine existing best-practice medical guidance on the management of PFB and risk worsening dermatologic sequelae and/or scarring in affected individuals;[6-10] and

Whereas, military branches have historically varied in their shaving waiver policies – with the Army and Marine Corps previously permitting permanent waivers in severe cases, the Air Force authorizing extended multi-year profiles, and the Navy generally limiting waivers – resulting in inconsistent timelines, criteria, and re-evaluation procedures across duty stations;[7-9] and

Whereas, studies have shown that shaving waivers may be associated with delayed promotion in the Air Force, disproportionately impacting Black service members who are more likely to be affected by PFB;[10] and

Whereas, eliminating such accommodations without adequate procedural safeguards, individualized evaluation, or due process may impose disproportionate burdens on affected service members;[7,12-13] therefore be it

RESOLVED, that our American Medical Association advocate against Department of War policy changes that restrict or eliminate evidence-based, medically necessary shaving waivers for service members, and oppose administrative or physical evaluation board separation on this basis when service members otherwise meet qualifications for continued service (Directive to Take Action); and be it further

RESOLVED, that our AMA urge the Department of War to implement any changes to shaving waiver policy through an evidence-based and transparent process that incorporates input from military dermatologists, occupational health experts, affected service members, and other interested parties with relevant expertise (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for consistent and equitable shaving waiver policies across all military service branches, including standardized criteria, clear re-evaluation intervals and portability of waivers across duty stations (Directive to Take Action); and be it further

RESOLVED, that our AMA urge the Department of War to authorize permanent shaving waivers for service members with severe or refractory pseudofolliculitis barbae, especially those who have already received military dermatologist recommendations for permanent waivers and are unresponsive to optimized medical therapy, and to extend this option consistently across all service branches (Directive to Take Action); and be it further

RESOLVED, that our AMA support ongoing research on pseudofolliculitis barbae and related dermatologic conditions, including medical management, equity impacts of grooming practices, and evidence-based approaches to accommodations within the Armed Forces. (New HOD Policy)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/29/25

**REFERENCES**

1. Pentagon proposes easing facial hair rules for religious, medical reasons. *Associated Press*. September 15, 2025. https://apnews.com/article/pentagon-facial-hair-grooming-beards-hegseth-e87c41e311089db0da4c4f2b5de93d1f. Accessed 25 September 2025.
2. Secretary of Defense. Grooming Standards for Facial Hair. Memorandum for senior Pentagon leadership, commanders, and DoD field activities; Aug 20, 2025. U.S. Department of Defense. https://media.defense.gov/2025/Sep/15/2003799859/-1/-1/1/GROOMING-STANDARDS-FOR-FACIAL-HAIR.PDF. Accessed 25 September 2025.
3. Department of the Airforce, “Medical Guidance for Shaving Profiles” (January 24, 2025). https://www.airforcemedicine.af.mil/Portals/1/Documents/Shaving%20Guidance%20Memorandum%20(Effective%20Date_01%20MAR%2025).pdf
4. MARADMINS Number: 124/25, “Uniform and Grooming Standards for Medical Conditions” (March 13, 2025). https://www.marines.mil/News/Messages/Messages-Display/Article/4119098/uniform-and-grooming-standards-for-medical-conditions/
5. Secretary of the Army, Army Directive 2025-13 (Facial Hair Grooming Standards) (July 7, 2025). https://lyster.tricare.mil/Portals/61/ARN44307-ARMY_DIR_2025-13-000.pdf
6. Department of the Army, Technical Bulletin, Medical 287, “Pseudofolliculitis of the Beard and Acne Keloidalis Nuchae” (July 15, 2025). https://bg-crawford.tricare.mil/Portals/142/documents/ARN44381-TB_MED_287-000.pdf?ver=Bb92in9nfZUiKH8cV0e6FQ%3D%3D
7. Jung, Injae, et al. "Treatment and Current Policies on Pseudofolliculitis Barbae in the US Military." Cutis 112.6 (2023).
8. Tshudy, Michael T., and Sunghun Cho. "Pseudofolliculitis barbae in the US military, a review." Military Medicine 186.1-2 (2021): e52-e57.
9. Okonkwo, Evans, Brandon Neal, and Harvey L. Harper. "Pseudofolliculitis barbae in the military and the need for social awareness." Military Medicine 186.5-6 (2021): 143-144.
10. Ritchie, Simon, et al. "Shaving waivers in the United States Air Force and their impact on promotions of Black/African-American members." *Military medicine* 188.1-2 (2023): e242-e247.
11. Weiss, Aeja N., et al. "Military grooming standards and their impact on skin diseases of the head and neck." Cutis 102.5 (2018): 328-33.
12. Banta, Jonathan, et al. "Perceptions of shaving profiles and their potential impacts on career progression in the United States Air Force." *Military medicine* 186.7-8 (2021): 187-189.

13. Singal, Amit, and Shari R. Lipner. "A review of skin disease in military soldiers: challenges and potential solutions." *Annals of Medicine* 55.2 (2023): 2267425.

## RELEVANT AMA POLICY

### D-440.905 Protecting Evidence-Based Medicine, Public Health Infrastructure and Biomedical Research

1. Our AMA affirms that protecting science, clinical integrity, and the patient-physician relationship is central to the organization's mission.
2. Our AMA assertively and publicly leads the House of Medicine in collective, sustained advocacy for federal and state policies, proposals, and actions that safeguard public health infrastructure, advance biomedical research, improve vaccine confidence, and maintain the integrity of evidence-based medicine and decision-making processes.
3. Our AMA will report back at the 2025 Interim Meeting of the AMA House of Delegates on the actions taken to implement this policy.
[Res. 242, A-25]

### H-373.995 Government Interference in Patient Counseling

1. Our American Medical Association vigorously and actively defends the physician-patient-family relationship and actively opposes state and/or federal efforts to interfere in the content of communication in clinical care delivery between clinicians and patients.
2. Our AMA strongly condemns any interference by government or other third parties that compromise a physician's ability to use their medical judgment as to the information or treatment that is in the best interest of their patients.
3. Our AMA supports litigation that may be necessary to block the implementation of newly enacted state and/or federal laws that restrict the privacy of physician-patient-family relationships and/or that violate the First Amendment rights of physicians in their practice of the art and science of medicine.
4. Our AMA opposes any government regulation or legislative action on the content of the individual clinical encounter between a patient and physician without a compelling and evidence-based benefit to the patient, a substantial public health justification, or both.
5. Our AMA will educate lawmakers and industry experts on the following principles endorsed by the American College of Physicians which should be considered when creating new health care policy that may impact the patient-physician relationship or what occurs during the patient-physician encounter:
A. Is the content and information or care consistent with the best available medical evidence on clinical effectiveness and appropriateness and professional standards of care?
B. Is the proposed law or regulation necessary to achieve public health objectives that directly affect the health of the individual patient, as well as population health, as supported by scientific evidence, and if so, are there no other reasonable ways to achieve the same objectives?
C. Could the presumed basis for a governmental role be better addressed through advisory clinical guidelines developed by professional societies?
D. Does the content and information or care allow for flexibility based on individual patient circumstances and on the most appropriate time, setting and means of delivering such information or care?
E. Is the proposed law or regulation required to achieve a public policy goal - such as protecting public health or encouraging access to needed medical care - without preventing physicians from addressing the healthcare needs of individual patients during specific clinical encounters based on the patient's own circumstances, and with minimal interference to patient-physician relationships?
F. Does the content and information to be provided facilitate shared decision-making between patients and their physicians, based on the best medical evidence, the physician's knowledge and clinical judgment, and patient values (beliefs and preferences), or would it undermine shared decision-making by specifying content that is forced upon patients and physicians without regard to the best medical evidence, the physician's clinical judgment and the patient's wishes?
G. Is there a process for appeal to accommodate individual patients' circumstances?
6. Our AMA strongly opposes any attempt by local, state, or federal government to interfere with a physician's right to free speech as a means to improve the health and wellness of patients across the United States.
[Res. 201, A-11 Reaffirmation: I-12 Appended: Res. 717, A-13 Reaffirmed in lieu of Res. 5, I-13 Appended: Res. 234, A-15 Reaffirmation: A-19 Modified: Speakers Rep. 02, I-24

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 932
(I-25)

Introduced by: American College of Radiology, American Society of Radiation Oncology, American Academy of Family Physicians, American College of Radiation Oncology

Subject: Shared Decision-Making and Low Dose CT Lung Cancer Screening in Clinical Practice

Referred to: Reference Committee K

---

Whereas, more than 230,000 people in the United States will be diagnosed with lung cancer this year, and approximately 125,000 will die from the disease[1]; and

Whereas, lung cancer remains the leading cause of cancer death in the United States, claiming more lives annually than breast, prostate, and colorectal cancers combined; and

Whereas, a significant number of lung cancer deaths could be prevented if current screening recommendations were adopted, allowing for early detection of lung cancer at its most treatable stages; and

Whereas, the life-saving benefits of low dose CT (LDCT) screening in at-risk populations are well documented; in fact, 20–30% more lives could be saved if high-risk patients were referred for regular LDCT screening[2]; and

Whereas, accordingly, LDCT screening of high-risk individuals is recommended by the American Cancer Society, the American Lung Association, the American College of Surgeon's Commission on Cancer, the National Comprehensive Cancer Network, the U.S. Preventive Services Task Force, and many other medical and scientific organizations; and

Whereas, shared decision-making (SDM) is a collaborative process that allows patients and their physicians to make health care decisions together, taking into account the best scientific evidence available, as well as the patient's values and preferences; and

Whereas, the American Medical Association (AMA) recognizes SDM as a process with three core elements: clinical information, tools to identify patient values, and structured guidance to integrate both into informed choices[3]; and

Whereas, SDM has been shown to improve patient satisfaction, adherence to treatment plans, and health outcomes, particularly in preventive care and chronic disease management; and

Whereas, despite its benefits, SDM is underutilized in many clinical settings due to time constraints, lack of training, and limited access to decision aids; and

Whereas, increasing the number of clinical visits that incorporate SDM can strengthen the patient-physician relationship and promote patient-centered care; and

Whereas, a recent study found that conducting a shared decision-making visit with patients was associated with significantly higher adherence to LDCT lung cancer screening for four years after the initial screening, thus supporting SDM as a strategy to increase LDCT screening adherence[4]; therefore be it

RESOLVED, that our American Medical Association, in conjunction with other interested national specialty societies of expertise (e.g., ACP, AAFP, ACR, etc.), create and share educational resources and training to help physicians efficiently discuss and document LDCT lung cancer screening during shared decision-making visits for high-risk populations. (Directive to Take Action)

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

Received: 9/29/25

**REFERENCES**

1. American Cancer Society. Cancer Facts & Figures 2025. Atlanta: American Cancer Society; 2025.
2. Rolle LD, Olazagasti C, Lopes G, Rodriguez E, Crane TE. USPSTF Lung Cancer Screening Guidelines and Disparities in Screening Adherence. JAMA Oncol. Published online. March 20, 2025. doi:10.1001/jamaoncol.2025.0230
3. Shared Decision-Making H-373.997
4. Chung, Y., Liu, C., Rula, E. Y., Dako, F., Carlos, R. C., Lee, R. K., & Christensen, E. (2025). Association of Shared Decision-Making with Long-term Adherence to Lung Cancer Screening. CHEST. https://doi.org/10.1016/j.chest.2025.06.026

**RELEVANT AMA POLICY**

**Lung Cancer Screening to be Considered Standard Care H-185.936**

1. Our American Medical Association recommends that coverage of screening low-dose CT (LDCT) scans for patients at high risk for lung cancer by Medicare, Medicaid, and private insurance be a required covered benefit.
2. Our AMA will empower the American public with knowledge through an education campaign to raise awareness of lung cancer screening with low-dose CT scans in high-risk patients to improve screening rates and decrease the leading cause of cancer death in the United States.
3. Our AMA will work with interested national medical specialty societies and state medical associations to urge the Centers for Medicare & Medicaid Services and state Medicaid programs to increase access to low-dose CT screening for Medicaid patients at high risk for lung cancer by including it as a covered benefit, without cost-sharing or prior authorization requirements, and increasing funding for research and education to improve awareness and utilization of the screening among eligible enrollees.[Sub. Res. 114, A-14 Appended: Res. 418, A-22 Appended: Res. 112, A-23]

**Preventive Prostate Cancer Screening H-425.966**

Our AMA encourages: (1) public and private payers to ensure coverage for prostate cancer screening when the service is deemed appropriate following informed physician-patient shared decision-making; and (2) national medical specialty societies to promote public education around the importance of informed physician-patient shared decision-making regarding medical services that are particularly sensitive to patient values and circumstances, such as prostate cancer screening. [CMS Rep. 06, A-19]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 933
(I-25)

Introduced by: American College of Surgeons

Subject: Addressing Gaps in National Healthcare Safety Network (NHSN) Data Quality

Referred to: Reference Committee K

---

Whereas, Surgical Site Infection (SSI) rates are a significant cause of patient morbidity following surgery; and

Whereas, SSI rates are commonly measured by hospital systems using a variety of data collection systems including the Centers for Disease Control and Prevention's (CDC) National Healthcare Safety Network (NHSN) and the American College of Surgeons' National Surgical Quality Improvement Program (NSQIP); and

Whereas, NSQIP performance is confidential and is used for performance improvement only, while NHSN 's performance data are publicly reported and can have significant negative financial implications for hospitals that perform poorly; and

Whereas, NSQIP data collection is standardized, audited, manually abstracted by trained nurse reviewers, and includes 30-day follow up data, while NHSN data collection methodologies have been shown to vary widely among hospitals; and

Whereas, a recent study of 16 hospitals found none had the same NHSN program implementation processes, and NHSN- and NSQIP-reported SSI rates correlated poorly[1]; and

Whereas, in January 2025 the NHSN revised its definition to include "any access of an incision", a definition which will erroneously capture drainage of seromas and minor hematomas as SSI events; and

Whereas, the new definition of SSI will result in an increase in the number of events captured but will not result in an increase in the accuracy of NHSN data; and

Whereas, the new definition of SSI will create perverse incentives to avoid primary wound closure in high-risk colorectal operations and disincentivizes common diagnostic maneuvers (such as opening a portion of a wound to assess for a possible infection); therefore be it

RESOLVED, that our American Medical Association advocate for the CDC to use its January 2024 definition of Surgical Site Infection (SSI) in the National Healthcare Safety Network (NHSN), and require documented clinical impression of an SSI (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for the CDC to establish and enforce consistent NHSN data collection methods across hospitals and audit hospital NHSN data quality regardless of hospital performance status. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/30/25

**REFERENCES**

1. Ju MH, Ko CY, Hall BL, Bosk CL, Bilimoria KY, Wick EC. A Comparison of 2 Surgical Site Infection Monitoring Systems. JAMA Surg. 2015;150(1):51-57. doi:10.1001/jamasurg.2014.2891.
2. Haley VB, Van Antwerpen C, Tserenpuntsag B, et al. Use of administrative data in efficient auditing of hospital-acquired surgical site infections, New York State 2009-2010. Infect Control Hosp Epidemiol. 2012;33(6):565-571.
3. Atchley KD, Pappas JM, Kennedy AT, et al. Use of administrative data for surgical site infection surveillance after congenital cardiac surgery results in inaccurate reporting of surgical site infection rates. Ann Thorac Surg. 2014;97(2):651-658.
4. National Healthcare Safety Network, Surgical Site Infection Event (SSI), January 2025
5. National Healthcare Safety Network, Patient Safety Component Manual, January 2024

## RELEVANT AMA POLICY

Quality Management H-450.966
Pay-for-Performance Principles and Guidelines H-450.947
Health Plan "Report Cards" H-450.961
Development of Quality Measures with Appropriate Exclusions and Review Processes H-450.927
Development of Quality Measures with Appropriate Exclusions and Review Processes D-450.953
Activities of the National Quality Forum H-450.939
Work of the Task Force on the Release of Physician Data H-406.991
Rollback on Physician Performance Measures D-450.949
Clinical Data Registries H-450.933
Performance Measures for Evidence-Based Medicine H-450.920
Support for Ongoing Development of Measures of Quality H-450.958
Quality Patient Care Measures H-410.960
Physician-Focused Alternative Payment Models H-385.913
Physician Pay-for-Performance Programs H-140.872
Claims Based Data as a Flawed Quality of Care Measure H-406.988
Physician Payment Reform H-390.849
Payer Measures for Private and Public Health Insurance D-180.984
Population Based Practices in Managed Care Systems H-285.971
Alternative Payment Models and Vulnerable Populations D-385.952
Moving to Alternative Payment Models H-450.931
Health Care Reform Physician Payment Models D-385.963

## Resolutions not for Consideration

### Resolutions

235 Ensuring Medical Liability Insurance Transparency and Continuity
302 Increasing the Use of Retired Physicians in Teaching Students and Residents
303 Expanding Graduate Medical Education to Address Rural Primary Care Shortage
309 Reasonable Workplace Accommodations for Residents and Fellows During Pregnancy
310 Remedying the Harms of AMA's Role in the Flexner Report
801 Excessive Cost of Multi-State DEA Licensure
803 Ensuring Physician Input in the Development of Alternative Payment Models (APMs)
810 Opposing Unilateral Downcoding of Physician Services by Insurance Companies
820 Establishing an AMA "First Responder Team" for Real-Time Physician Advocacy Against Adverse Insurance Company Actions
902 Advocating for Improvements in Systems of Care for Autism
910 Increasing Funding for Gynecological Cancer Research
913 Establish AMA Policy and Project to Compile and Distribute JAMA Patient Pages to Enhance Public Medical Literacy
914 Develop Climate-Conscious Resources for Physicians
915 Reduce Environmental Impact of Medical Journals
916 Studying the Environmental Impact of Ambient Clinical Intelligence Use
928 AMA's Continued Support for COVID-19 Vaccination in Pregnant Individuals

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 235
(I-25)

Introduced by: American College of Emergency Physicians

Subject: Ensuring Medical Liability Insurance Transparency and Continuity

Referred to: Reference Committee B

---

Whereas, timely and reliable medical liability insurance coverage is essential for the protection of physicians and patients, ensuring patient access to care; and

Whereas, recent closures of hospitals and of large physician staffing companies have resulted in physicians being left without adequate support, timely notification, or assistance in transitioning their practices when their employer-provided medical liability insurance was discontinued, thereby jeopardizing physician livelihoods and disrupting continuity of patient care[1,2,3]; and

Whereas, current processes for notifying physicians of policy changes, cancellations, or missed payments are inconsistent, leading to situations where physicians may unknowingly practice without coverage, putting both patients and physicians at risk; and

Whereas, immediate notification—defined as within three (3) business days—by medical liability insurance carriers would provide physicians the necessary opportunity to address coverage gaps or administrative errors in a timely manner; and

Whereas, AMA policy D-215.980 “Support Before, During, and After Hospital Closure or Reduction in Services” recognizes the significant impact of hospital closures, but does not yet explicitly address physician group closures, which can similarly disrupt continuity of care, patient safety, and physician employment; and

Whereas, expanding AMA policy to include physician group closures would strengthen advocacy and support for physicians and patients affected by abrupt practice disruptions; and

Whereas, occurrence-based medical liability insurance provides lifetime coverage for any claim arising from an incident that occurred during the policy period, regardless of when the claim is filed, thereby ensuring comprehensive long-term protection for physicians and their patients; and

Whereas, claims-made medical liability insurance covers claims only if both the alleged incident and the filing of the claim occur while the policy is active, but when coupled with a pre-paid tail policy (extending protection for claims filed after the policy ends), this structure offers equivalent comprehensive coverage and financial security to occurrence-based insurance; and

Whereas, both occurrence-based coverage and claims-made coverage with a pre-paid tail eliminate coverage gaps, reduce financial uncertainty, and provide continuity of protection, making them the gold standard for medical liability insurance; therefore be it

RESOLVED, that our American Medical Association advocate for legislation requiring immediate (within 3 business days) notification by the medical liability insurance carrier to the covered physician for any policy changes, cancellation, or missed payment (Directive to Take Action); and be it further

RESOLVED, that our AMA recognize that occurrence-based medical liability insurance or claims-made medical liability insurance with a pre-paid tail is the gold standard for medical liability coverage (New HOD Policy); and be it further

RESOLVED, that our AMA policy D-215.980 "Support Before, During, and After Hospital Closure or Reduction in Services" be amended so as to include physician group closures. (Modify Current HOD Policy)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/30/25

**REFERENCES**

1. "Steward Health Care raided its own medical malpractice insurance company," The Boston Globe, Spotlight Investigations, September 2024, https://apps.bostonglobe.com/metro/investigations/spotlight/2024/09/steward-hospitals/steward-traco/.
2. Janis M. Orlowski, "Displaced Hahnemann Residents and Attending Physicians May Soon Lose Liability Insurance," AAMC News, January 7, 2020, https://www.aamc.org/news/displaced-hahnemann-residents-and-attending-physicians-may-soon-lose-liability-insurance.
3. "The Disappearing Tail of Physician," EM Workforce (Substack), April 15, 2025, https://emworkforce.substack.com/p/the-disappearing-tail-of-physician.

**RELEVANT AMA POLICY**

**D-215.980 Support Before, During, and After Hospital Closure or Reduction in Services**

1. Our American Medical Association will work with appropriate federal and state bodies to assure that whenever there is a threatened, or actual, hospital closure a process be instituted to safeguard the continuity of patient care and preserve the physician-patient relationship. Such a process should:
    a. assure adequate capacity exists in the immediate service area surrounding the hospital closure, including independent health resources, physicians, and support personnel to provide for the citizens of that area;
    b. allow that in said circumstances, restrictive covenants, records access, and financial barriers which prevent the movement of physicians and their patients to surrounding hospitals should be waived for an appropriate period of time; and
    c. ensure financial reserves exist, and are sufficient to cover any previous contractual obligations to physicians, e.g., medical liability tail coverage.
2. Our AMA will proactively offer support to physicians, residents and fellows, patients, and civic leaders affected by threatened or actual healthcare facility closures, change in ownership, or significant reductions in services via provision of information, resources, and effective, actionable advocacy. Res. 719, A-24

**H-435.998 Equitable Risk Classification in Medical Liability Premiums**

Our American Medical Association supports the concept that premiums for medical liability insurance should reflect the costs and risks of providing that insurance to each category insofar as feasible based on accepted underwriting principles. Further, the policy of the AMA is that physicians who practice part-time should be entitled to reduced professional liability insurance premiums. Res. 15, I-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed and Appended: CMS Rep. 12, A-02; Reaffirmation I-03; Reaffirmed: CMS; Rep. 4, A-13; Reaffirmed: BOT Rep. 09, A-23

**D-435.978 Loss of Medical Staff Privileges for Lack of "Tail Coverage"**

1. Our American Medical Association advocates for better disclosures by professional medical liability insurance carriers to their policyholders about the continuing financial health of the carrier; and advocate that carriers create and maintain a listing of alternate professional liability insurance carriers in good financial health which can provide physicians replacement tail or other coverage if the carrier becomes insolvent.
2. Our AMA supports model medical staff bylaw language stating: "Where continuous professional liability insurance coverage is a condition of medical staff membership, a temporary loss of professional liability insurance coverage (whether or not limited to "tail" coverage) is not grounds for immediate termination of medical staff membership. The Medical Executive Committee shall determine the length and other conditions of an individual waiver of the coverage requirement." BOT Action in response to referred for decision Res. 537, A-04; Modified: CMS Rep. 1, A-14; Reaffirmed: BOT Rep. 09, A-24

**H-230.995 Medical Liability Insurance Coverage as Mandatory Requirement for Hospital Staff Appointment**

1. Each hospital medical staff should determine for itself whether or not it will require professional **liability insurance** coverage as a condition for membership on the hospital medical staff.

2. Our AMA also believes that, if equity demands that voluntary staff members should have **insurance** coverage so that the burden of financial loss would not fall entirely upon the hospital, then salaried hospital physicians should likewise be covered by adequate **insurance** or protected financially through self-**insurance** mechanisms established by the hospital, so that the burden would not fall unfairly upon the members of the voluntary medical staff.

3. Our AMA will seek federal legislation that would amend the federal bankruptcy code such that medical **liability** premiums that are contractually paid by a hospital on behalf of physician employees shall be considered a priority claim in bankruptcy filings and paid immediately out of the proceeds of the bankrupt hospital's estate.

BOT Rep. T, I-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed: Sunset Report, A-00; Modified: BOT Rep. 11, A-03; Reaffirmation A-04; Appended: Res. 230, I-10; Reaffirmed: BOT Rep. 04, A-20

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 302
(I-25)

Introduced by: Mississippi

Subject: Increasing the Use of Retired Physicians in Teaching Students and Residents

Referred to: Reference Committee C

---

Whereas, in the teaching of medical students and residents, experience plays a significant role in passing on important aspects of patient care and medical treatment; and

Whereas, when physicians retire from active or full practice, they often seek ways to continue to contribute to their communities and profession; and

Whereas, the teaching of medical students and residents is a critical place where retired physicians could continue to contribute their skills and experience to a new generation of physicians and patients; and

Whereas, throughout the country, especially in rural based programs, medical schools and residency programs struggle to find qualified and experienced faculty and teachers; and

Whereas, there are often administrative hurdles and roadblocks which prevent retired physicians from fully participating in teaching programs at schools and residencies; therefore be it

RESOLVED, that our American Medical Association explore with the appropriate stakeholders creative and innovative ways to increase opportunities and decrease hurdles for retired physicians to participate fully as medical faculty at medical schools and residency training programs. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/22/25

**RELEVANT AMA POLICY**

**H-200.972 Primary Care Physicians in Underserved Areas**

1. Our American Medical Association should pursue the following plan to improve the recruitment and retention of physicians in underserved areas:
    a. encourage the creation and pilot-testing of school-based, faith-based, and community-based urban/rural family health clinics, with an emphasis on health education, prevention, primary care, and prenatal care;
    b. encourage the affiliation of these family health clinics with local medical schools and teaching hospitals;
    c. advocate for the implementation of AMA policy that supports extension of the rural health clinic concept to urban areas with appropriate federal agencies;
    d. encourage the AMA Senior Physicians Section to consider the involvement of retired physicians in underserved settings, with appropriate mechanisms to ensure their competence;
    e. urge hospitals and medical societies to develop opportunities for physicians to work part-time to staff health clinics that help meet the needs of underserved patient populations;
    f. encourage the AMA and state medical associations to incorporate into state and federal health system reform legislative relief or immunity from professional liability for senior, part-time, or other physicians who help meet the needs of underserved patient populations and
    g. urge hospitals and medical centers to seek out the use of available military health care resources and personnel, which can be used to help meet the needs of underserved patient populations.
2. Our AMA supports efforts to:
    a. expand opportunities to retain international medical graduates after the expiration of allocated periods under current law; and
    b. increase the recruitment and retention of physicians practicing in federally designated health professional shortage areas. [CMS Rep. I-93-2 Reaffirmation A-01 Reaffirmation I-03 Modified: CME Rep. 13, A-06 Reaffirmed: CMS Rep. 01, A-16 Modified: CME Rep. 04, I-18 Appended: Res. 206, I-19 Reaffirmation: I-22 Reaffirmed: BOT Rep. 11, A-23 Reaffirmed: Res. 724, A-23 Reaffirmed: BOT Rep. 07, I-24]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 303
(I-25)

Introduced by: Utah

Subject: Expanding Graduate Medical Education to Address Rural Primary Care Shortage

Referred to: Reference Committee C

---

Whereas, the state of Utah currently has the lowest number of primary care physicians per capita in the U.S. [1], with shortages even worse in Utah's rural communities [2]; and

Whereas, the number of medical students graduating from MD and DO programs in Utah has experienced explosive growth in the last decade [3], with continued growth in Undergraduate Medical Education (UME) expected [4]; and

Whereas, Utah is experiencing a large and growing deficit in Graduate Medical Education (GME) residency training positions relative to UME graduates [5], requiring students to leave Utah for residency training and reducing the likelihood of their return to Utah to practice [6]; and

Whereas, Utah has the fourth lowest number of primary care GME residency training positions per capita in the U.S. [7]; and

Whereas, the U.S. Centers for Medicare and Medicaid Services (CMS) is phasing out section 1115 demonstration authority to support Medicaid-funded workforce initiatives, eliminating a critical source of GME funding for states [8]; and

Whereas, the American Medical Association (AMA) is supportive of legislation that seeks to expand new GME slots nationwide and codify the Rural Residency Planning and Development Program [9]; and

Whereas, geographically expansive states like Utah have unique barriers to obtaining federal GME funding focused on rural primary care workforce development, including the Rural Residency Planning and Development Program [10]; and

Whereas, Utah's primary care physician shortages are anticipated to worsen without intentional support, especially in rural areas; and

Whereas, many other geographically expansive states face similar issues related to primary care physician supply and GME funding for training for primary care physicians; therefore be it

RESOLVED, that our American Medical Association lobby accreditation organizations and federal partners to create pathways and federal funding options for the development of rural primary care residency programs that allow hybrid training in urban and rural settings in geographically expansive states. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/24/25

**REFERENCES**

[1] https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/state-of-the-primary-care-workforce-report-2024.pdf
[2] https://ruralhealth.utah.gov/wp-content/uploads/2021-PCNA.pdf
[3] https://www.aamc.org/data-reports/report/us-physician-workforce-data-dashboard, Undergraduate Medical Education Data, Percent Change in Medical School Enrollment, accessed 8/12/2025.
[4] https://news.byu.edu/medical-school
[5] https://www.aamc.org/data-reports/report/us-physician-workforce-data-dashboard, Graduate Medical Education Data, Percent Change in Residents and Fellows by Location, Training, and Degree, accessed 8/12/2025.
[6] https://www.aamc.org/data-reports/report/us-physician-workforce-data-dashboard, Physician Retention Data, Physician Retention by Location, accessed 8/12/2025.
[7] https://www.aamc.org/data-reports/report/us-physician-workforce-data-dashboard, Graduate Medical Education Data, Resident and Fellow Density by Location, Training and Degree, accessed 8/12/2025.
[8] https://www.medicaid.gov/resources-for-states/downloads/workforc-ltr-to-states.pdf
[9] https://www.ama-assn.org/education/gme-funding/congress-revives-bill-add-14000-gme-slots-over-seven-years
[10] https://www.ruralhealthinfo.org/assets/6011-28274/rrpd-fy-24.png

## RELEVANT AMA POLICY

### Principles of and Actions to Address Primary Care Workforce H-200.949

1. Our patients require a sufficient, well-trained supply of primary care physicians – family physicians, general internists, general pediatricians, and obstetricians/gynecologists – to meet the nation's current and projected demand for health care services.

2. To help accomplish this critical goal, our American Medical Association (AMA) will work with a variety of key stakeholders, to include federal and state legislators and regulatory bodies; national and state specialty societies and medical associations, including those representing primary care fields; and accreditation, certification, licensing, and regulatory bodies from across the continuum of medical education (undergraduate, graduate, and continuing medical education).

3. Through its work with these stakeholders, our AMA will encourage development and dissemination of innovative models to recruit medical students interested in primary care, train primary care physicians, and enhance both the perception and the reality of primary care practice, to encompass the following components: a) Changes to medical school admissions and recruitment of medical students to primary care specialties, including counseling of medical students as they develop their career plans; b) Curriculum changes throughout the medical education continuum; c) Expanded financial aid and debt relief options; d) Financial and logistical support for primary care practice, including adequate reimbursement, and enhancements to the practice environment to ensure professional satisfaction and practice sustainability; and e) Support for research and advocacy related to primary care.

4. Admissions and recruitment: The medical school admissions process should reflect the specific institution's mission. Those schools with missions that include primary care should consider those predictor variables among applicants that are associated with choice of these specialties.

5. Medical schools, through continued and expanded recruitment and outreach activities into secondary schools, colleges, and universities, should develop and increase the pool of applicants likely to practice primary care by seeking out those students whose profiles indicate a likelihood of practicing in primary care and underserved areas, while establishing strict guidelines to preclude discrimination.

6. Career counseling and exposure to primary care: Medical schools should provide to students career counseling related to the choice of a primary care specialty, and ensure that primary care physicians are well-represented as teachers, mentors, and role models to future physicians.

7. Financial assistance programs should be created to provide students with primary care experiences in ambulatory settings, especially in underserved areas. These could include funded preceptorships or summer work/study opportunities.

8. Curriculum: Voluntary efforts to develop and expand both undergraduate and graduate medical education programs to educate primary care physicians in increasing numbers should be continued. The establishment of appropriate administrative units for all primary care specialties should be encouraged.

9. Medical schools with an explicit commitment to primary care should structure the curriculum to support this objective. At the same time, all medical schools should be encouraged to continue to change their curriculum to put more emphasis on primary care.

10. All four years of the curriculum in every medical school should provide primary care experiences for all students, to feature increasing levels of student responsibility and use of ambulatory and community-based settings.

11. Federal funding, without coercive terms, should be available to institutions needing financial support to expand resources for both undergraduate and graduate medical education programs designed to increase the number of primary care physicians. Our AMA will advocate for public (federal and state) and private payers to a) develop enhanced funding and related incentives from all sources to provide education for medical students and resident/fellow physicians, respectively, in progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model) to enhance primary care as a career choice; b) fund and foster innovative pilot programs that change the current approaches to primary care in undergraduate and graduate medical education, especially in urban and rural underserved areas; and c) evaluate these efforts for their effectiveness in increasing the number of students choosing primary care careers and helping facilitate the elimination of geographic, racial, and other health care disparities.

12. Medical schools and teaching hospitals in underserved areas should promote medical student and resident/fellow physician rotations through local family health clinics for the underserved, with financial assistance to the clinics to compensate their teaching efforts.

13. The curriculum in primary care residency programs and training sites should be consistent with the objective of training generalist physicians. Our AMA will encourage the Accreditation Council for Graduate Medical Education to (a) support primary care residency programs, including community hospital-based programs, and (b) develop an accreditation environment and novel pathways that promote innovations in graduate medical education, using progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model).

14. The visibility of primary care faculty members should be enhanced within the medical school, and positive attitudes toward primary care among all faculty members should be encouraged.

15. Support for practicing primary care physicians: Administrative support mechanisms should be developed to assist primary care physicians in the logistics of their practices, along with enhanced efforts to reduce administrative activities unrelated to patient care, to help ensure professional satisfaction and practice sustainability.

16. There should be increased financial incentives for physicians practicing primary care, especially those in rural and urban underserved areas, to include scholarship or loan repayment programs, relief of professional liability burdens, and Medicaid case management programs, among others. Our AMA will advocate to state and federal legislative and regulatory bodies, among others, for development of public and/or private incentive programs, and expansion and increased funding for existing programs, to further encourage practice in underserved areas and decrease the debt load of primary care physicians. The imposition of specific outcome targets should be resisted, especially in the absence of additional support to the schools.

17. Our AMA will continue to advocate, in collaboration with relevant specialty societies, for the recommendations from the AMA/Specialty Society RVS Update Committee (RUC) related to reimbursement for E&M services and coverage of services related to care coordination, including patient education, counseling, team meetings and other functions; and work to ensure that private payers fully recognize the value of E&M services, incorporating the RUC-recommended increases adopted for the most current Medicare RBRVS.

18. Our AMA will advocate for public (federal and state) and private payers to develop physician reimbursement systems to promote primary care and specialty practices in progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model consistent with current AMA Policies H-160.918 and H-160.919.

19. There should be educational support systems for primary care physicians, especially those practicing in underserved areas.

20. Our AMA will urge urban hospitals, medical centers, state medical associations, and specialty societies to consider the expanded use of mobile health care capabilities.

21. Our AMA will encourage the Centers for Medicare & Medicaid Services to explore the use of telemedicine to improve access to and support for urban primary care practices in underserved settings.

22. Accredited continuing medical education providers should promote and establish continuing medical education courses in performing, prescribing, interpreting and reinforcing primary care services.

23. Practicing physicians in other specialties--particularly those practicing in underserved urban or rural areas--should be provided the opportunity to gain specific primary care competencies through short-term preceptorships or postgraduate fellowships offered by departments of family medicine, internal medicine, pediatrics, etc., at medical schools or teaching hospitals. In addition, part-time training should be encouraged, to allow physicians in these programs to practice concurrently, and further research into these concepts should be encouraged.

24. Our AMA supports continued funding of Public Health Service Act, Title VII, Section 747, and encourages advocacy in this regard by AMA members and the public.

25. Research: Analysis of state and federal financial assistance programs should be undertaken, to determine if these programs are having the desired workforce effects, particularly for students from disadvantaged groups and those that are underrepresented in medicine, and to gauge the impact of these programs on elimination of geographic, racial, and other health care disparities. Additional research should identify the factors that deter students and physicians from choosing and remaining in primary care disciplines. Further, our AMA should continue to monitor trends in the choice of a primary care specialty and the availability of primary care graduate medical education positions. The results of these and related research endeavors should support and further refine AMA policy to enhance primary care as a career choice.

**AMA Policy – US Physician Shortage H-200.954**

1. Our AMA explicitly recognizes the existing shortage of physicians in many specialties and areas of the US.

2. Our AMA supports efforts to quantify the geographic maldistribution and physician shortage in many specialties.

3. Our AMA supports current programs to alleviate the shortages in many specialties and the maldistribution of physicians in the US.

4. Our AMA encourages medical schools and residency programs to consider developing admissions policies and practices and targeted educational efforts aimed at attracting physicians to practice in underserved areas and to provide care to underserved populations.

5. Our AMA encourages medical schools and residency programs to continue to provide courses, clerkships, and longitudinal experiences in rural and other underserved areas as a means to support educational program objectives and to influence choice of graduates' practice locations.

6. Our AMA encourages medical schools to include criteria and processes in admission of medical students that are predictive of graduates' eventual practice in underserved areas and with underserved populations.

7. Our AMA will continue to advocate for funding from public and private payers for educational programs that provide experiences for medical students in rural and other underserved areas.

8. Our AMA will continue to advocate for funding from all payers (public and private sector) to increase the number of graduate medical education positions in specialties leading to first certification.

9. Our AMA will work with other groups to explore additional innovative strategies for funding graduate medical education positions, including positions tied to geographic or specialty need.

10. Our AMA continues to work with the Association of American Medical Colleges (AAMC) and other relevant groups to monitor the outcomes of the National Resident Matching Program; and

11. Our AMA continues to work with the AAMC and other relevant groups to develop strategies to address the current and potential shortages in clinical training sites for medical students.

12. Our AMA will:
    a. promote greater awareness and implementation of the Project ECHO (Extension for Community Healthcare Outcomes) and Child Psychiatry Access Project models among academic health centers and community-based primary care physicians;
    b. work with stakeholders to identify and mitigate barriers to broader implementation of these models in the United States; and
    c. monitor whether health care payers offer additional payment or incentive payments for physicians who engage in clinical practice improvement activities as a result of their participation in programs such as Project ECHO and the Child Psychiatry Access Project; and if confirmed, promote awareness of these benefits among physicians.

13. Our AMA will work to augment the impact of initiatives to address rural physician workforce shortages.

14. Our AMA supports opportunities to incentivize physicians to select specialties and practice settings which involve delivery of health services to populations experiencing a shortage of providers, such as women, LGBTQ+ patients, children, elder adults, and patients with disabilities, including populations of such patients who do not live in underserved geographic areas.

**AMA Policy – Educational Strategies for Meeting Rural Health Physician Shortage H-465.988**

1. In light of the data available from the current literature as well as ongoing studies being conducted by staff, our American Medical Association recommends that:
    a. Our AMA encourage medical schools and residency programs to develop educationally sound rural clinical preceptorships and rotations consistent with educational and training requirements, and to provide early and continuing exposure to those programs for medical students and residents.
    b. Our AMA encourage medical schools to develop educationally sound primary care residencies in smaller communities with the goal of educating and recruiting more rural physicians.
    c. Our AMA encourage state and county medical societies to support state legislative efforts toward developing scholarship and loan programs for future rural physicians.
    d. Our AMA encourage state and county medical societies and local medical schools to develop outreach and recruitment programs in rural counties to attract promising high school and college students to medicine and the other health professions.
    e. Our AMA urge continued federal and state legislative support for funding of Area Health Education Centers (AHECs) for rural and other underserved areas.
    f. Our AMA continue to support full appropriation for the National Health Service Corps Scholarship Program, with the proviso that medical schools serving states with large rural underserved populations have a priority and significant voice in the selection of recipients for those scholarships.

g. Our AMA support full funding of the new federal National Health Service Corps loan repayment program.
h. Our AMA encourage continued legislative support of the research studies being conducted by the Rural Health Research Centers funded by the National Office of Rural Health in the Department of Health and Human Services.
i. Our AMA continue its research investigation into the impact of educational programs on the supply of rural physicians.
j. Our AMA continue to conduct research and monitor other progress in development of educational strategies for alleviating rural physician shortages.
k. Our AMA reaffirm its support for legislation making interest payments on student debt tax deductible.
l. Our AMA encourage state and county medical societies to develop programs to enhance work opportunities and social support systems for spouses of rural practitioners.

2. Our AMA will work with state and specialty societies, medical schools, teaching hospitals, the Accreditation Council for Graduate Medical Education (ACGME), the Centers for Medicare and Medicaid Services (CMS) and other interested stakeholders to identify, encourage and incentivize qualified rural physicians to serve as preceptors and volunteer faculty for rural rotations in residency.

3. Our AMA will:
a. work with interested stakeholders to identify strategies to increase residency training opportunities in rural areas with a report back to the House of Delegates; and
b. work with interested stakeholders to formulate an actionable plan of advocacy with the goal of increasing residency training in rural areas.

4. Our AMA will encourage ACGME review committees to consider adding exposure to rural medicine as appropriate, to encourage the development of rural program tracks in training programs and increase physician awareness of the conditions that pose challenges and lack of resources in rural areas.

5. Our AMA will encourage adding educational webinars, workshops and other didactics via remote learning formats to enhance the educational needs of smaller training programs.

**AMA Policy – Enhancing Rural Physician Practices H-465.981**

1. Our American Medical Association supports legislation to extend the 10% Medicare payment bonus to physicians practicing in rural counties and other areas where the poverty rate exceeds a certain threshold, regardless of the areas' Health Professional Shortage Area (HPSA) status.

2. Our AMA encourages federal and state governments to make available low interest loans and other financial assistance to assist physicians with shortage area practices in defraying their costs of compliance with requirements of the Occupational Safety and Health Administration, Americans with Disabilities Act and other national or state regulatory requirements.

3. Our AMA will explore the feasibility of supporting the legislative and/or regulatory changes necessary to establish a waiver process through which shortage area practices can seek exemption from specific elements of regulatory requirements when improved access, without significant detriment to quality, will result.

4. Our AMA supports legislation that would allow shortage area physician practices to qualify as Rural Health Clinics without the need to employ one or more physician extenders.

5. Our AMA will undertake a study of structural urbanism, federal payment polices, and the impact on rural workforce disparities.

**AMA Policy – 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.

**AMA Policy – Improving Rural Health H-465.994**

1. Our American Medical Association:
   a. supports continued and intensified efforts to develop and implement proposals for improving rural health care and public health,
   b. urges physicians practicing in rural areas to be actively involved in these efforts, and
   c. advocates widely publicizing AMA's policies and proposals for improving rural health care and public health to the profession, other concerned groups, and the public.

2. Our AMA will work with other entities and organizations interested in public health to:
   a. Encourage more research to identify the unique needs and models for delivering public health and health care services in rural communities.
   b. Identify and disseminate concrete examples of administrative leadership and funding structures that support and optimize local, community-based rural public health.
   c. Develop an actionable advocacy plan to positively impact local, community-based rural public health including but not limited to the development of rural public health networks, training of current and future rural physicians and public health professionals in core public health techniques and novel funding mechanisms to support public health initiatives that are led and managed by local public health authorities.
   d. Advocate for adequate and sustained funding for public health staffing and programs

3. Our American Medical Association will work with relevant stakeholders to develop a national strategy to eliminate rural cancer disparities in screening, treatment, and outcomes and achieve health equity in cancer outcomes across all geographic regions.

4. Our AMA calls for increased federal and state funding to support research on rural cancer disparities and equity in care, access, and outcomes and development of interventions to address those disparities.

5. Our AMA advocates for evidence-based collaborative models for innovative telementoring / teleconsultation between health care systems, academic medical centers, and community physicians to improve access to cancer screening, diagnosis, treatment, rehabilitation, and patient services in rural areas.

**AMA Policy – Primary Care Physicians in Underserved Areas H-200.972**

1. Our American Medical Association should pursue the following plan to improve the recruitment and retention of physicians in underserved areas:
   a. encourage the creation and pilot-testing of school-based, faith-based, and community-based urban/rural family health clinics, with an emphasis on health education, prevention, primary care, and prenatal care;
   b. encourage the affiliation of these family health clinics with local medical schools and teaching hospitals;
   c. advocate for the implementation of AMA policy that supports extension of the rural health clinic concept to urban areas with appropriate federal agencies;
   d. encourage the AMA Senior Physicians Section to consider the involvement of retired physicians in underserved settings, with appropriate mechanisms to ensure their competence;
   e. urge hospitals and medical societies to develop opportunities for physicians to work part-time to staff health clinics that help meet the needs of underserved patient populations;

f. encourage the AMA and state medical associations to incorporate into state and federal health system reform legislative relief or immunity from professional liability for senior, part-time, or other physicians who help meet the needs of underserved patient populations and
g. urge hospitals and medical centers to seek out the use of available military health care resources and personnel, which can be used to help meet the needs of underserved patient populations.

2. Our AMA supports efforts to:
a. expand opportunities to retain international medical graduates after the expiration of allocated periods under current law; and
b. increase the recruitment and retention of physicians practicing in federally designated health professional shortage areas.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 309
(I-25)

Introduced by: Resident and Fellow Section

Subject: Reasonable Workplace Accommodations for Residents and Fellows During Pregnancy

Referred to: Reference Committee C

---

Whereas, a 2020 systematic review by the Association of American Medical Colleges (AAMC), which analyzed 15 years of research on pregnancy among surgical residents, reported complication rates ranging from 25% to 82%, compared to 5% to 19% in the general U.S. population;[1] and

Whereas, a substantial body of evidence links night shifts, irregular hours, and long working hours during pregnancy to significant risks for both maternal and fetal health, with multiple systematic reviews highlighting the dangers of unrestricted scheduling during pregnancy;[2-8] and

Whereas, concerns about the risks of night shifts, irregular hours, and long working hours during pregnancy have been documented in the literature since the 1970s,[9] yet organized medicine has made minimal regulatory progress to protect pregnant trainees; and

Whereas, while some individual training programs have established internal policies to safeguard pregnant residents,[10-13] many training programs still fail to provide such accommodations;[14] and

Whereas, in a study of 167 emergency medicine residency programs regarding scheduling practices for pregnant residents, 60% of programs expressed that guidelines from graduate medical education organizations would be "very" or "extremely" useful in standardizing and improving policies;[14] and

Whereas, recent federal legislation, the Pregnant Workers Fairness Act, now mandates reasonable accommodations for pregnant employees, including modifications to work schedules;[15-16] and

Whereas, our AMA has existing policy encouraging the creation of written guidelines regarding schedule accommodations for pregnant residents, such as avoiding night call or modifying rotation schedules (H-405.960); however, existing policy does not obligate programs to include any such accommodations, or provide guidance to do so; and

Whereas, our AMA further emphasizes the importance of flexible staffing and scheduling in training programs to allow for coverage without overburdening other physicians (H-405.960); and

Whereas, our AMA has a longstanding commitment to reducing infant mortality and preterm birth risks (D-245.994), as well as supporting workplace policies that minimize exposure to known reproductive hazards during pregnancy (H-420.960); and

Whereas, recognizing that residency training itself has been implicated as a risk factor for adverse pregnancy outcomes,[1,17-19] it is imperative for our AMA to extend its advocacy to protect our own pregnant colleagues; and

Whereas, pregnant residents continue to experience significant stigmatization and discrimination, in part due to perceived detrimental effects on peer residents and their training programs due to accommodations during pregnancy,[20] which often leaves pregnant trainees feeling compelled to adhere to demanding schedules, even when such schedules compromise their health;[21] and

Whereas, our AMA is uniquely positioned to lead by collaborating with specialty organizations and working alongside the regulatory bodies within medicine (e.g. Accreditation Council for Graduate Medical Education (ACGME), American Board of Internal Medicine, American Board of Surgery, etc.) with the power to shape the training environment, to advocate for equitable working conditions that do not put pregnant trainees and their fetuses at risk; therefore be it

RESOLVED, that our American Medical Association work with relevant stakeholders to support the implementation of the following guidelines for all residency training programs:

a) Programs should provide evidence-based accommodations for pregnant trainees, such as opting out of night shifts during the first and third trimesters and attending scheduled medical appointments, and should implement them in such a way that they do not place an increased burden of work on other trainees; and
b) Scheduling for pregnant physicians in the third trimester should prioritize rotations with easily cancellable/coverable shifts to minimize departmental disruption in the event of medical necessity or early delivery;

(Directive to Take Action) and be it further

RESOLVED, that our AMA supports evidence-based policies and procedures which prioritize the safety and well-being of pregnant physicians. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 9/29/25

**REFERENCES**

1. Todd AR, Cawthorn TR, Temple-Oberle C. Pregnancy and parenthood remain challenging during surgical residency: A systematic review. Acad Med. 2020;95(10):1607-1615. doi:10.1097/ACM.0000000000003351
2. Suzumori N, Ebara T, Matsuki T, et al. Effects of long working hours and shift work during pregnancy on obstetric and perinatal outcomes: A large prospective cohort study—Japan Environment and Children's Study. Birth. 2020;47(1):67-79. doi:10.1111/birt.12463
3. Cai C, Vandermeer B, Khurana R, et al. The impact of occupational shift work and working hours during pregnancy on health outcomes: A systematic review and meta-analysis. Am J Obstet Gynecol. 2019;221(6):563-576. doi:10.1016/j.ajog.2019.06.051
4. Begtrup LM, Specht IO, Hammer PEC, et al. Night work and miscarriage: A Danish nationwide register-based cohort study. Occup Environ Med. 2019;76(5):302-308. doi:10.1136/oemed-2018-105592
5. Whelan EA, Lawson CC, Grajewski B, et al. Work schedule during pregnancy and spontaneous abortion. Epidemiology. 2007;18(3):350-355. doi:10.1097/01.ede.0000259988.77314.a4
6. Fernandez RC, Marino JL, Varcoe TJ, et al. Fixed or rotating night shift work undertaken by women: Implications for fertility and miscarriage. Semin Reprod Med. 2016;34(2):74-82. doi:10.1055/s-0036-1571354
7. Rosenberg P, Kirves A. Miscarriages among operating theatre staff. Acta Anaesthesiol Scand. 1974;18:37-42. doi:10.1111/j.1399-6576.1974.tb00780.x
8. Bonde JP, Jørgensen KT, Bonzini M, Palmer KT. Miscarriage and occupational activity: A systematic review and meta-analysis regarding shift work, working hours, lifting, standing, and physical workload. Scand J Work Environ Health. 2013;39(4):325-334.
9. Cohen EN, Bellville JW, Brown BW Jr. Anesthesia, pregnancy, and miscarriage: a study of operating room nurses and anesthetists. Anesthesiology. 1971 Oct;35(4):343-7. doi: 10.1097/00000542-197110000-00005. PMID: 5114397.
10. University of Utah Department of Internal Medicine. GME Trainee Family Leave Policy 2025. Accessed September 24, 2025. https://medicine.utah.edu/internal-medicine/documents/trainee-family-leave-policy-2025

11. University of Washington Department of Surgery. Pregnancy Policy for Residents. Published 2021. Accessed September 24, 2025. https://uwsurgery.org/wp-content/uploads/2021/04/2021_3_24-Pregnancy-Policy-Residents.pdf
12. Chernoby KA, Pettit KE, Jansen JH, Welch JL. Flexible Scheduling Policy for Pregnant and New Parent Residents: A Descriptive Pilot Study. *AEM Educ Train*. 2020;5(2):e10504. Published 2020 Aug 5. doi:10.1002/aet2.10504
13. Gordon AJ, Sebok-Syer SS, Dohn AM, et al. The Birth of a Return to work Policy for New Resident Parents in Emergency Medicine. *Acad Emerg Med*. 2019;26(3):317-326. doi:10.1111/acem.13684
14. MacVane CZ, Puissant M, Fix M, et al. Scheduling practices for pregnant emergency medicine residents. *AEM Educ Train*. 2022;6(6):e10813. doi:10.1002/aet2.10813
15. Equal Employment Opportunity Commission. Summary of Key Provisions of EEOC's Final Rule to Implement the Pregnant Workers Fairness Act (PWFA). Accessed September 24, 2025. https://www.eeoc.gov/summary-key-provisions-eeocs-final-rule-implement-pregnant-workers-fairness-act-pwfa
16. What You Should Know about the Pregnant Workers Fairness Act. U.S. Equal Employment Opportunity Commission. Accessed September 24, 2025. https://www.eeoc.gov/wysk/what-you-should-know-about-pregnant-workers-fairness-act.
17. Behbehani S, Tulandi T. Obstetrical complications in pregnant medical and surgical residents. *J Obstet Gynaecol Can*. 2015;37(1):25-31. doi:10.1016/S1701-2163(15)30359-5
18. Grunebaum A, Minkoff H, Blake D. Pregnancy among obstetricians: A comparison of births before, during, and after residency. *Am J Obstet Gynecol*. 1987;157:79-83.
19. Gabbe SG, Morgan MA, Power ML, Schulkin J, Williams SB. Duty hours and pregnancy outcome among residents in obstetrics and gynecology. *Obstet Gynecol.* 2003;102:948-951.
20. Casilla-Lennon M, Hanchuk S, Zheng S, et al. Pregnancy in physicians: A scoping review. *Am J Surg*. 2022;223(1):36-46. doi:10.1016/j.amjsurg.2021.07.011
21. Rangel EL, Smink DS, Castillo-Angeles M, et al. Pregnancy and Motherhood During Surgical Training. *JAMA Surg*. 2018;153(7):644-652. doi:10.1001/jamasurg.2018.0153

## RELEVANT AMA POLICY

### Policies for Parental, Family and Medical Necessity Leave H-405.960

Our American Medical Association adopts as policy the following guidelines for, and encourages the implementation of, Parental, Family and Medical Necessity Leave for Medical Students and Physicians:

1. Our AMA urges residency training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage development of leave policies, including parental, family, and medical leave policies, as part of the physician's standard benefit agreement.
2. Recommended components of parental leave policies for physicians include:
    a. duration of leave allowed before and after delivery;
    b. category of leave credited;
    c. whether leave is paid or unpaid;
    d. whether provision is made for continuation of insurance benefits during leave, and who pays the premium;
    e. whether sick leave and vacation time may be accrued from year to year or used in advance;
    f. how much time must be made up in order to be considered board eligible;
    g. whether make-up time will be paid;
    h. whether schedule accommodations are allowed; and
    i. leave policy for adoption.
3. Our AMA policy is expanded to include physicians in practice, reading as follows:
    a. residency program directors and group practice administrators should review federal law concerning maternity leave for guidance in developing policies to assure that pregnant physicians are allowed the same sick leave or disability benefits as those physicians who are ill or disabled;
    b. staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in other physicians' workloads, particularly in residency programs; and
    c. physicians should be able to return to their practices or training programs after taking parental leave without the loss of status.
4. Our AMA recommends that medical practices, departments, and training programs strive to provide 12 weeks of paid parental, family, and medical necessity leave in a 12-month period for their attending and trainee physicians as needed, with the understanding that no parent be required to take a minimum leave.
5. Residency program directors should review federal and state law for guidance in developing policies for parental, family, and medical leave.
6. Medical students and physicians who are unable to work because of pregnancy, childbirth,

abortion or stillbirth, and other related medical conditions should be entitled to such leave and other benefits on the same basis as other physicians who are temporarily unable to work for other medical reasons.

7. Residency programs should develop written policies on leave for physicians. Such written policies should include the following elements:
    a. leave policy for birth or adoption;
    b. duration of leave allowed before and after delivery;
    c. duration of leave allowed after abortion or stillbirth;
    d. category of leave credited (e.g., sick, vacation, parental, unpaid leave, short term disability);
    e. whether leave is paid or unpaid;
    f. whether provision is made for continuation of insurance benefits during leave and who pays for premiums; (g) whether sick leave and vacation time may be accrued from year to year or used in advance;
    g. extended leave for resident physicians with extraordinary and long-term personal or family medical tragedies for periods of up to one year, without loss of previously accepted residency positions, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life;
    h. how time can be made up in order for a resident physician to be considered board eligible;
    i. what period of leave would result in a resident physician being required to complete an extra or delayed year of training;
    j. whether time spent in making up a leave will be paid; and
    k. whether schedule accommodations are allowed, such as reduced hours, no night call, modified rotation schedules, and permanent part-time scheduling.
8. Medical schools should develop written policies on parental leave, family leave, and medical leave for medical students. Such written policies should include the following elements:
    a. leave policy for birth or adoption;
    b. duration of leave allowed before and after delivery;
    c. extended leave for medical students with extraordinary and long-term personal or family medical tragedies, without loss of previously accepted medical school seats, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life;
    d. how time can be made up in order for a medical students to be eligible for graduation with minimal or no delays;
    e. what period of leave would result in a medical student being required to complete an extra or delayed year of training; and
    f. whether schedule accommodations are allowed, such as modified rotation schedules, no night duties, and flexibility with academic testing schedules.
9. Our AMA endorses the concept of equal parental leave for birth and adoption as a benefit for resident physicians, medical students, and physicians in practice regardless of gender or gender identity.
10. Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in the workloads of other physicians, particularly those in residency programs.
11. Physicians should be able to return to their practices or training programs after taking parental leave, family leave, or medical leave without the loss of status.
12. Residency program directors must assist residents in identifying their specific requirements (for example, the number of months to be made up) because of leave for eligibility for board certification and must notify residents on leave if they are in danger of falling below minimal requirements for board eligibility. Program directors must give these residents a complete list of requirements to be completed in order to retain board eligibility.
13. Our AMA encourages flexibility in residency programs and medical schools incorporating parental leave and alternative schedules for pregnant trainees.
14. In order to accommodate leave protected by the federal Family and Medical Leave Act, our

AMA encourages all specialties within the American Board of Medical Specialties (ABMS) to allow graduating residents to extend training after the traditional residency completion date while still maintaining board eligibility, in the event of leave beyond six weeks. Our AMA encourages specialty boards to develop flexible policies for board certification for those physicians who take leave beyond the minimum of six weeks of family or medical leave (per ABMS policy) and whose residency programs are able to certify that residents meet appropriate competencies for program completion.

15. Our AMA will work with appropriate stakeholders to encourage that residency programs annually publish and share with FREIDA and other appropriate stakeholders, self-identified and other demographic data, including but not limited to the composition of their program over the last 5 years by age; historically marginalized, minoritized, or excluded status; sexual orientation and gender identity.
16. Our AMA will encourage the Accreditation Council for Graduate Medical Education and other relevant stakeholders to annually collect data on childbirth and parenthood from all accredited US residency programs and publish this data with disaggregation by gender identity and specialty.
17. These policies as above should be freely available online through FREIDA and in writing to all current trainees and applicants to medical school, residency or fellowship.
18. Medical schools are encouraged to develop clear, equitable parental leave policies and determine how a 12-week parental, family, or medical leave may be incorporated with alternative, timely means of completing missed curriculum while still meeting competency requirements necessary to complete a medical degree.
19. Our AMA opposes any discrimination related to physicians taking protected leave during training and/or medical practice for medical, religious, and/or family reasons.
20. Our AMA will encourage relevant stakeholders to survey physicians and medical students who have taken family leave, in an effort to learn about the experiences of various demographic groups and identify potential disparities in career progression trends.

[CCB/CLRPD Rep. 4, A-13; Modified: Res. 305, A-14; Modified: Res. 904, I-14; Modified: Res. 307, A-22; Modified: Res. 302, I-22; Modified: Res. 312, I-22; Modified: CME Rep. 01 and Res. 306, I-23; Modified: Res. 302, I-24]

**Improving and Standardizing Pregnancy and Lactation Accommodations for Medical Board Examinations H-275.915**

1. Our American Medical Association supports and will advocate for the implementation of a minimum of 60 minutes of additional, scheduled break time for all test takers who are pregnant and/or lactating during all medical licensure and certification examinations.
2. Our AMA supports the addition of pregnancy comfort aids, including but not limited to ginger teas, saltines, wastebaskets, and antiemetics, to any medical licensure or certification examination's pre-approved list of Personal Item Exemptions (PIEs) permitted in the secure testing area for all test takers who are pregnant and/or lactating.

[Res. 321, A-22]

**Infant Mortality D-245.994**

1. Our AMA will work with appropriate agencies and organizations towards reducing infant mortality by providing information on safe sleep positions and preterm birth risk factors to physicians, other health professionals, parents, and child care givers.
2. Our AMA will work with Congress and the Department of Health and Human Services to improve maternal outcomes through: (a) maternal/infant health research at the NIH to reduce the prevalence of premature births and to focus on obesity research, treatment and prevention; (b) maternal/infant health research and surveillance at the CDC to assist states in setting up maternal mortality reviews; modernize state birth and death records systems to the 2003-recommended guidelines; and improve the Safe Motherhood Program; (c) maternal/infant health programs at HRSA to improve the Maternal Child Health Block grant; (d) comparative effectiveness research into the interventions for preterm birth; (e) disparities research into maternal outcomes, preterm birth and pregnancy-related depression; and (f) the development, testing and implementation of quality improvement measures and initiatives. [Res. 410, A-10; Reaffirmed: CSAPH Rep. 01, A-20]

**Effects of Work on Pregnancy H-420.960**

1. Our American Medical Association supports the right of employees to work in safe workplaces that do not endanger their reproductive health or that of their unborn children.
2. Our AMA supports workplace policies that minimize the risk of excessive exposure to toxins with known reproductive hazards irrespective of gender or age.
3. Our AMA encourages physicians to consider the potential benefits and risks of occupational activities and exposures on an individual basis and work with patients and employers to define a healthy working environment for pregnant people.
4. Our AMA encourages employers to accommodate increased physical requirements of pregnant people; recommended accommodations include varied work positions, adequate rest and meal breaks, access to regular hydration, and minimizing heavy lifting.
5. Our AMA acknowledges that future research done by interdisciplinary study groups composed of obstetricians/gynecologists, occupational medicine specialists, pediatricians, and representatives from industry can best identify adverse reproductive exposures and appropriate accommodations.

[CSA Rep. 9, A-99; Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmation A-12; Modified: CSAPH Rep. 1, A-22]

**Research into Preterm Birth and Related Cardiovascular and Cerebrovascular Risks in Women D-420.992**

1) Our AMA will advocate for more research on ways to identify risk factors linking preterm birth to cardiovascular or cerebrovascular disease in pregnant women.

[Res. 504, A-17; Modified: Speakers Rep. 02, I-24]

**Reducing Inequities and Improving Access to Insurance for Maternal Health Care H-185.917**

1) Our American Medical Association acknowledges that structural racism and bias negatively impact the ability to provide optimal health care, including maternity care, for people of color.
2) Our AMA encourages physicians to raise awareness among colleagues, residents and fellows, staff, and hospital administrators about the prevalence of racial and ethnic inequities and the effect on health outcomes, work to eliminate these inequities, and promote an environment of trust.
3) Our AMA encourages physicians to pursue educational opportunities focused on embedding equitable, patient-centered care for patients who are pregnant and/or within 12 months postpartum into their clinical practices and encourages physician leaders of health care teams to support similar appropriate professional education for all members of their teams.
4) Our AMA will continue to monitor and promote ongoing research regarding the impacts of societal (e.g., racism or unaffordable health insurance), geographical, facility-level (e.g., hospital quality), clinician-level (e.g., implicit bias), and patient-level (e.g., comorbidities, chronic stress or lack of transportation) barriers to optimal care that contribute to adverse and disparate maternal health outcomes, as well as research testing the effectiveness of interventions to address each of these barriers.
5) Our AMA will promote the adoption of federal standards for clinician collection of patient-identified race and ethnicity information in clinical and administrative data to better identify inequities. The federal data collection standards should be:
    a) Informed by research (including real-world testing of technical standards and standardized definitions of race and ethnicity terms to ensure that the data collected accurately reflect diverse populations and highlight, rather than obscure, critical distinctions that may exist within broad racial or ethnic categories),
    b) Carefully crafted in conjunction with clinician and patient input to protect patient privacy and provide non-discrimination protections.
    c) Lead to the dissemination of best practices to guide respectful and non-coercive collection of accurate, standardized data relevant to maternal health outcomes.
6) Our AMA supports the development of a standardized definition of maternal mortality and the allocation of resources to states and Tribes to collect and analyze maternal mortality data (i.e., Maternal Mortality Review Committees and vital statistics) to enable stakeholders to better understand the underlying causes of maternal deaths and to inform evidence-based policies to improve maternal health outcomes and promote health equity.

7) Our AMA supports the development of a standardized definition of maternal mortality and the allocation of resources to states and Tribes to collect and analyze maternal mortality data (i.e., Maternal Mortality Review Committees and vital statistics) to enable stakeholders to better understand the underlying causes of maternal deaths and to inform evidence-based policies to improve maternal health outcomes and promote health equity.
8) Our AMA encourages hospitals, health systems, and state medical associations and national medical specialty societies to collaborate with non-clinical community organizations with close ties to minoritized and other at-risk populations to identify opportunities to best support pregnant persons and new families.
9) Our AMA encourages the development and funding of resources and outreach initiatives to help pregnant individuals, their families, their communities, and their workplaces to recognize the value of comprehensive prepregnancy, prenatal, peripartum, and postpartum care. These resources and initiatives should encourage patients to pursue both physical and behavioral health care, strive to reduce barriers to pursuing care, and highlight care that is available at little or no cost to the patient.
10) Our AMA supports adequate payment from all payers for the full spectrum of evidence-based prepregnancy, prenatal, peripartum, and postpartum physical and behavioral health care.
11) Our AMA encourages hospitals, health systems, and states to participate in maternal safety and quality improvement initiatives such as the Alliance for Innovation on Maternal Health program and state perinatal quality collaboratives.
12) Our AMA will advocate for increased access to risk-appropriate care by encouraging hospitals, health systems, and states to adopt verified, evidence-based levels of maternal care.

[Joint CMS/CSAPH Rep. 1, I-21]

**Parental Leave and Planning Resources for Medical Students D-295.308**

1. Our American Medical Association will work with key stakeholders to advocate that parties involved in medical training (including but not limited to residency programs, administration, fellowships, away rotations, physician evaluators, and research opportunities) do not discriminate against students who take family/parental leave.
2. Our AMA encourages medical schools to create comprehensive informative resources that promote a culture that is supportive of their students who are parents, including information and policies on parental leave and relevant make up work, options to preserve fertility, breastfeeding, accommodations during pregnancy, and resources for childcare that span the institution and the surrounding area.

[Res. 307, A-22]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 310
(I-25)

Introduced by: Resident and Fellow Section

Subject: Remedying the Harms of AMA's Role in the Flexner Report

Referred to: Reference Committee C

---

Whereas, the publication of Abraham Flexner's 1910 report ("The Flexner Report"), funded by the AMA and the Carnegie Foundation, caused the closure of all but two historically Black medical schools, depleting the health workforce of over 35,000 Black physicians over the ensuing century[1-2]; and

Whereas, historically Black medical schools have a transformational role in diversifying the health workforce, representing only 2.4% of medical schools in the country while producing 14% of Black medical graduates[3]; and

Whereas, diversification of the physician workforce is critical for the health of the nation, yet our workforce is far from representative[4-7]—even if the proportion of Black, Hispanic, and Indigenous medical students were immediately doubled, it would take 66, 92, and 51 years, respectively, to reach parity with national demographics[8-9]; and

Whereas, our American Medical Association (AMA) has "[recognized] the harm caused by the Flexner Report to historically Black medical schools, the diversity of the physician workforce, and the outcomes of minoritized and marginalized patient populations" (H-350.960); and

Whereas, our AMA policy directs our organization to "advocate for and promote racism-conscious, reparative, community engaged interventions at the health system, organized medical society, local, and federal levels which seek to identify, evaluate, and address the health, economic, and other consequences of structural racism in medicine" (H-65.943); and

Whereas, our AMA has committed to "[taking] a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community" (D-200.985); and

Whereas, our AMA has highlighted an obligation for physicians to acknowledge the spillover effects of the Flexner Report, hold ourselves and other responsible parties accountable for the Report's impacts, and strive to remedy the direct harms caused[10-12]; and

Whereas, the Department of Education provided upwards of $100 million to Historically Black Graduate Institution programs each year in 2023 and 2024 for developing, maintaining, and improving key infrastructure for these institutions,[13] and any disruptions to this and other federal funding sources would significantly impact historically Black medical schools; therefore be it

RESOLVED, that our American Medical Association partner with relevant public and private sector organizations and community stakeholders to make a transformative financial investment into the opening of new medical schools and sustainability of existing medical schools affiliated with Historically Black Colleges & Universities (HBCUs), Tribal Colleges & Universities (TCUs),

and other Minority Serving Institutions (MSIs), remedying the harms of the 1910 Flexner Report in regards to the diversity of the physician workforce, and advancing population health equity (Directive to Take Action); and be it further

RESOLVED, that our AMA prioritize our organization's efforts to bolster diversity, equity, and inclusion across the medical education continuum, as part of our strategic commitments to remedying the harms of the 1910 Flexner Report, diversifying the physician workforce, and advancing population health equity. (Directive to Take Action)

Fiscal Note: Major - To Be Determined

Received: 9/29/25

**REFERENCES**

1. Flexner A. *Medical Education in the United States and Canada*. Carnegie Foundation for the Advancement of Education; 1910. Accessed April 2, 2025. http://archive.carnegiefoundation.org/publications/pdfs/elibrary/Carnegie_Flexner_Report.pdf
2. Campbell KM, Corral I, Infante Linares JL, Tumin D. Projected Estimates of African American Medical Graduates of Closed Historically Black Medical Schools. *JAMA Netw Open*. 2020;3(8):e2015220. doi:10.1001/jamanetworkopen.2020.15220
3. Rodríguez JE, López IA, Campbell KM, Dutton M. The Role of Historically Black College and University Medical Schools in Academic Medicine. J Health Care Poor Underserved. 2017;28(1):266-278. doi: 10.1353/hpu.2017.0022. PMID: 28239001.
4. McAneny BL. Why the AMA is committed to a diverse physician workforce. American Medical Association. April 24, 2019. Accessed September 24, 2025. https://www.ama-assn.org/about/leadership/why-ama-committed-diverse-physician-workforce
5. Marrast LM, Zallman L, Woolhandler S, Bor DH, McCormick D. Minority physicians' role in the care of underserved patients: diversifying the physician workforce may be key in addressing health disparities. JAMA Intern Med. 2014;174(2):289-291. doi: 10.1001/jamainternmed.2013.12756
6. Meadows AM, Skinner MM, Hazime AA, Day RG, Fore JA, Day CS. Racial, Ethnic, and Sex Diversity in Academic Medical Leadership. *JAMA Netw Open*. 2023;6(9):e2335529. Published 2023 Sep 5. doi:10.1001/jamanetworkopen.2023.35529
7. Fitzhugh Mullan Institute for Health Workforce Equity. *Health Workforce Diversity Tracker*. George Washington University; 2023. Accessed September 24, 2025. https://www.gwhwi.org/diversitytracker.html
8. Mora H, Obayemi A, Holcomb K, Hinson M. The National Deficit of Black and Hispanic Physicians in the US and Projected Estimates of Time to Correction. *JAMA Netw Open*. 2022;5(6):e2215485. doi:10.1001/jamanetworkopen.2022.15485
9. Lopez-Carmen VA, Redvers N, Calac AJ, Landry A, Nolen L, Khazanchi R. Equitable representation of American Indians and Alaska Natives in the physician workforce will take over 100 years without systemic change. *Lancet Reg Health - Am*. Published online October 8, 2023:100588. doi:10.1016/j.lana.2023.100588
10. Laws T. How Should We Respond to Racist Legacies in Health Professions Education Originating in the Flexner Report? *AMA J Ethics*. 2021;23(3):271-275. doi:10.1001/amajethics.2021.271
11. AMA adopts new policy to increase diversity in physician workforce. American Medical Association. June 17, 2021. Accessed September 24, 2025. https://www.ama-assn.org/press-center/press-releases/ama-adopts-new-policy-increase-diversity-physician-workforce
12. Madara J. Reckoning with medicine's history of racism. American Medical Association. February 17, 2021. Accessed September 24, 2025. https://www.ama-assn.org/about/leadership/reckoning-medicine-s-history-racism
13. U.S. Department of Education. Title III Part B, Strengthening Historically Black Graduate Institutions Program | U.S. Department of Education. July 15, 2025. Accessed September 24, 2025. http://www.ed.gov/grants-and-programs/grants-higher-education/grants-hbcus/title-iii-part-b-strengthening-historically-black-graduate-institutions-program

## RELEVANT AMA POLICY

**Redressing the Harms of Misusing Race in Medicine H-65.943**

1. Our American Medical Association recognizes the exacerbation of health and economic inequities due to race-based algorithms as a manifestation of racism within the medical field.
2. Our AMA will revise the AMA Guides to the Evaluation of Permanent Impairment, in accordance with existing AMA policy on race as a social construct and national standards of care, to modify recommendations that perpetuate racial essentialism or race-based medicine.
3. Our AMA advocates for and promotes racism-conscious, reparative, community engaged interventions at the health system, organized medical society, local, and federal levels which seek to identify, evaluate, and address the health, economic, and other consequences of structural racism in medicine. [Res. 014, A-23]

**Underrepresented Student Access to US Medical Schools H-350.960**

1. Our American Medical Association recommends that medical schools should consider in their planning: elements of diversity including but not limited to gender, racial, cultural and economic, reflective of the diversity of their patient population.
2. Our AMA supports the development of new and the enhancement of existing programs that will identify and prepare underrepresented students from the high-school level onward and to enroll, retain and graduate increased numbers of underrepresented students.
3. Our AMA recognizes some people have been historically underrepresented, excluded from, and marginalized in medical education and medicine because of their race, ethnicity, disability status, sexual orientation, gender identity, socioeconomic origin, and rurality, due to racism and other systems of exclusion and discrimination.
4. Our AMA is committed to promoting truth and reconciliation in medical education as it relates to improving equity.
5. Our AMA recognizes the harm caused by the Flexner Report to historically Black medical schools, the diversity of the physician workforce, and the outcomes of minoritized and marginalized patient populations.
6. Our AMA will urge medical schools to develop or expand the reach of existing pathway programs for underrepresented middle school, high school and college aged students to motivate them to pursue and prepare them for a career in medicine.
7. Our AMA will encourage collegiate programs to establish criteria by which completion of such programs will secure an interview for admission to the sponsoring medical school.
8. Our AMA will recommend that medical school pathway programs for underrepresented students be free-of-charge or provide financial support with need-based scholarships and grants.
9. Our AMA will encourage all physicians to actively participate in programs and mentorship opportunities that help expose underrepresented students to potential careers in medicine.
10. Our AMA will consider quality of K-12 education a social determinant of health and thus advocate for implementation of Policy H-350.979, encouraging state and local governments to make quality elementary and secondary education available to all.

[Res. 908, I-08; Reaffirmed in lieu of Res. 311, A-15; Appended: CME Rep. 5, A-21; Appended: Res. 305, I-22]

**Promising Practices Among Pathway Programs to Increase Diversity in Medicine D-350.980**

Our American Medical Association will establish a task force to guide organizational transformation within and beyond the AMA toward restorative justice to promote truth, reconciliation, and healing in medicine and medical education.

[CME Rep. 5, A-21]

**Strategies for Enhancing Diversity in the Physician Workforce D-200.985**

1. Our American Medical Association, independently and in collaboration with other groups such as the Association of American Medical Colleges (AAMC), will actively work and advocate for funding at the federal and state levels and in the private sector to support the following:
    a. Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school.
    b. Diversity or minority affairs offices at medical schools.
    c. Financial aid programs for students from groups that are underrepresented in medicine.
    d. Financial support programs to recruit and develop faculty members from underrepresented groups.
2. Our AMA will work to obtain full restoration and protection of federal Title VII funding, and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically-underserved areas.
3. Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community.
4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty.
5. Our AMA will develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population.

6. Our AMA will provide on-line educational materials for its membership that address diversity issues in patient care including, but not limited to, culture, religion, race and ethnicity.
7. Our AMA will create and support programs that introduce elementary through high school students, especially those from groups that are underrepresented in medicine (URM), to healthcare careers.
8. Our AMA will create and support pipeline programs and encourage support services for URM college students that will support them as they move through college, medical school and residency programs.
9. Our AMA will recommend that medical school admissions committees and residency/fellowship programs use holistic assessments of applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education with the goal of improving health care for all communities.
10. Our AMA will advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to URM status collected from Electronic Residency Application Service (ERAS) applications through the National Resident Matching Program (NRMP).
11. Our AMA will continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities.
12. Our AMA unequivocally opposes legislation that would dissolve affirmative action or punish institutions for properly employing race-conscious admissions as a measure of affirmative action in order to promote a diverse student population.
13. Our AMA will work with the AAMC and other stakeholders to create a question for the AAMC electronic medical school application to identify previous pipeline program (also known as pathway program) participation and create a plan to analyze the data in order to determine the effectiveness of pipeline programs.

[CME Rep. 1, I-06; Reaffirmation I-10; Reaffirmation A-13; Modified: CCB/CLRPD Rep. 2, A-14; Reaffirmation: A-16; Appended: Res. 313, A-17; Appended: Res. 314, A-17; Modified: CME Rep. 01, A-18; Appended: Res. 207, I-18; Reaffirmation: A-19; Appended: Res. 304, A-19; Appended: Res. 319, A-19; Modified: CME Rep. 5, A-21; Modified: CME Rep. 02, I-22; Modified: Res. 320, A-23]

**Racism as a Public Health Threat H-65.952**

1. Our American Medical Association acknowledges that, although the primary drivers of racial health inequity are systemic and structural racism, racism and unconscious bias within medical research and health care delivery have caused and continue to cause harm to marginalized communities and society as a whole.
2. Our AMA recognizes racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care.
3. Our AMA encourages the development, implementation, and evaluation of undergraduate, graduate, and continuing medical education programs and curricula that engender greater understanding of:
    a. The causes, influences, and effects of systemic, cultural, institutional, and interpersonal racism.
    b. How to prevent and ameliorate the health effects of racism.
4. Our AMA:
    a. supports the development of policy to combat racism and its effects.
    b. encourages governmental agencies and nongovernmental organizations to increase funding for research into the epidemiology of risks and damages related to racism and how to prevent or repair them.
5. Our AMA will work to prevent and combat the influences of racism and bias in innovative health technologies.

[Res. 5, I-20; Reaffirmed: Res. 013, A-22; Modified: Speakers Rep., A-22; Reaffirmed: Res. 320, A-24]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 801
(I-25)

Introduced by: Michigan

Subject: Excessive Cost of Multi-State DEA Licensure

Referred to: Reference Committee J

---

Whereas, many physicians seek licensure in multiple states due to locum tenens work, telehealth work, and/or coverage of patients who seek jobs or education in other states; and

Whereas, many physicians seek medical licensure and Drug Enforcement Administration (DEA) licensure in multiple states to legally provide these services across state lines; and

Whereas, a DEA license is a federal license; and

Whereas, DEA licensure requires a separate application and the full DEA licensure fee for each state in which licensure is desired; and

Whereas, obtaining a multi-state DEA licensure application is inconvenient and expensive despite DEA licensure being a federal (national) license; and

Whereas, the DEA has been encouraging improved access to controlled substances utilized as medications for opioid use disorder to reduce opioid-related overdoses as a federal concern; and

Whereas, the DEA has changed the educational requirements for obtaining an initial or a renewed DEA license to reflect this concern with a one-time attestation for this educational requirement at the federal level; and

Whereas, the time and monetary expense of obtaining DEA licensure in multiple states may limit access rather than encourage access to controlled substances utilized as medications for opioid use disorder; therefore be it

RESOLVED, that our American Medical Association continue its support of person-specific rather than site-specific Drug Enforcement Administration (DEA) registration numbers and a one-time DEA registration fee by reaffirming existing AMA policies, “One Fee One Number D-100.975” and “One Fee, One Number D-100.980.” (Reaffirm HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 9/3/25

**RELEVANT AMA POLICY**

**One Fee One Number D-100.975**
1. Our AMA will work with the Drug Enforcement Administration (DEA) and Congress to move toward a system in which individual physician DEA registration numbers are person-specific rather than site-specific within a state. Additionally, the AMA will work with the DEA to ensure that the full DEA registration fee is paid only once, when the provider initially registers. Following the initial registration, provider should only pay a small re-registration fee every three years to fund the work of the Diversion Control Program.

2. Our AMA will work with the DEA, Congress and state licensing boards to explore changes to the DEA registration system so that a single DEA registration number can be used by physicians who prescribe, dispense, and/or administer controlled substances in multiple states. Our AMA will explore the possible development of a national DEA standard which would be greater than or equal to the most stringent state requirements for controlled substances. Providers could choose whether they would like to apply for the national DEA standard, or, more likely for those practicing in a single state, remain registered with the DEA under their single state requirements.

3. Our AMA continues to monitor implementation of the National Provider Identifier (NPI) system and work with physicians and payers to ensure proper and prompt payment for physician claims. Additionally, the AMA will monitor physician privacy concerns associated with the public consumption of the NPI database.

**One Fee, One Number D-100.980**
Our AMA will work with the appropriate agencies to require only one federal DEA number that would be physician-specific and not site-specific.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 803
(I-25)

Introduced by: Integrated Physician Practice Section

Subject: Ensuring Physician Input in the Development of Alternative Payment Models (APMs)

Referred to: Reference Committee J

---

Whereas, AMA policy D-385.950 "CMMI Payment Reform Models" and H-330.894 "Demonstration Project Regarding Medicare Part D" are against mandatory and for voluntary Center for Medicare and Medicaid Innovation (CMMI) models; and

Whereas, AMA policy H-385.901 "Expanding AMA Payment Reform Work and Advocacy to Medicaid and Other Non-Medicare Payments for Pediatric Health Care and Specialty Populations" advocates for CMMI models that serve specialties and policies not served by current models; and

Whereas, the Physician-Focused Payment Model Technical Advisory Committee (PTAC), which was created by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), was intended to improve the efficiency and effectiveness of healthcare using proposed solutions from frontline stakeholders[1]; and

Whereas, to date, there have been no PTAC recommended models that have been tested or implemented by CMMI[2,3]; and

Whereas, CMMI has not been transparent about why PTAC recommended models are rejected for testing or implementation[4]; and

Whereas, CMMI has recently signaled its new strategic direction, which includes amongst others, "increas[ing] independent provider participation in value-based payment programs;"[5] therefore be it

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

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/10/25

**REFERENCES**
1. Physician-Focused Payment Model Technical Advisory Committee. PTAC frequently asked questions. Office of the Assistant Secretary for Planning and Evaluation, United States Department of Health and Human Services. https://aspe.hhs.gov/collaborations-committees-advisory-groups/ptac/ptac-faqs Accessed May 23, 2025.
2. Raths, D. (2024, April 11). Surgeon leader to Congress: Make CMMI test physician-developed APMs. Healthcare Innovation. https://www.hcinnovationgroup.com/policy-value-based-care/alternative-payment-models/news/55017602/surgeon-leader-to-congress-make-cmmi-test-physician-developed-apms Accessed May 23, 2025.
3. Berlin, J. (April 2020). Going nowhere: APM committee resignations cast doubt on payment model's future. Texas Medical Association. https://www.texmed.org/Template.aspx?id=53087 Accessed May 23, 2025
4. Raths, D. (2019, Nov 20). PTAC members resign, frustrated with HHS rejection of payment model proposals. Healthcare Innovation. https://www.hcinnovationgroup.com/policy-value-based-care/alternative-payment-models/news/21115452/ptac-members-resign-frustrated-with-hhs-rejection-of-payment-model-proposals Accessed May 23, 2025.
5. Centers for Medicare & Medicaid Services. (2025). CMS Innovation Center 2025 strategy to make America healthy again. https://www.cms.gov/priorities/innovation/about/strategic-direction Accessed May 23, 2025.

## RELEVANT AMA POLICY

**CMMI Payment Reform Models D-385.950**
Our AMA will: (1) continue to advocate against mandatory Center for Medicare and Medicaid Innovation (CMMI) demonstration projects; (2) advocate that the Centers for Medicare and Medicaid Services seek innovative payment and care delivery model ideas from physicians and groups such as medical specialty societies to guide recommendation of the Physician-Focused Payment Model Technical Advisory Committee (PTAC) and work of the CMMI to propose demonstration projects that are voluntary and can be appropriately tested; and (3) advocate that CMMI focus on the development of multiple pilot projects in many specialties, which are voluntary and tailored to the needs of local communities and the needs of different specialties. Citation: Res. 213, A-21

**Demonstration Project Regarding Medicare Part D H-330.894**
1. Our American Medical Association will continue its policy of promoting beneficiary choice and market based options in the context of the Medicare prescription drug benefit program (Part D).
2. Our AMA encourages the development of voluntary models under the auspices of the CMS Innovation Center (CMMI) to test the impact of offering Medicare beneficiaries additional enhanced alternative health plan choices that offer lower, consistent, and predictable out-of-pocket costs for select prescription drugs.

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

**Expanding AMA Payment Reform Work and Advocacy to Medicaid and Other Non-Medicare Payment Models for Pediatric Health Care and Specialty Populations H-385.901**
1. Our American Medical Association supports appropriate demonstration projects, carve outs, and adjustments for pediatric patients and services provided to pediatric patients within the payment reform arena.
2. Our AMA will extend ongoing payment reform research, education, and advocacy to address the needs of specialties and patient populations not served by current CMMI models or other Medicare-focused payment reform efforts.
3. Our AMA will support and work with national medical specialty societies that are developing alternative payment models for specific conditions or episodes, target patient populations including pediatric populations, and medical and surgical specialties and continue to advocate that the Centers for Medicare and Medicaid Services, including the Center for Medicare and Medicaid Innovation; state Medicaid agencies; and other payers implement physician-developed payment models.
4. Our AMA will consider improved Medicaid payment rates to be a priority given the critical impact these payment rates have on patient care and patient access to care.
5. Our AMA will support and collaborate with state and national medical specialty societies and other interested parties on the development and adoption of physician-developed alternative payment models for pediatric health care that address the distinct prevention and health needs of children and take long-term, life-course impact into account. Citation: Res. 817, I-23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 810
(I-25)

Introduced by: Private Practice Physicians Section

Subject: Opposing Unilateral Downcoding of Physician Services by Insurance Companies

Referred to: Reference Committee J

---

Whereas, insurance companies, including Cigna and Aetna, have announced new reimbursement policies that authorize downcoding of evaluation and management (E/M) services[1,2]; and

Whereas, these unilateral downcoding practices reduce reimbursement one level below what physicians bill, based on the insurer's internal review, even when the services were performed and documented according to AMA E/M guidelines ; and

Whereas, the policies require physicians to submit full patient records through burdensome reconsideration and appeal processes, shifting administrative costs and burdens onto physicians and their practices; and

Whereas, such unilateral actions directly interfere with the physician's professional judgement, undermine proper valuations of complex cognitive services, and contradict the AMA's long-standing advocacy for fair, accurate physician payment based on CPT® and E/M guidelines; and

Whereas, patients may be harmed if practices are forced to limit services, shorten visits, or withdraw from payer networks due to unsustainable payment policies; and

Whereas, our AMA exists to protect and represent its physician membership against the systematic harassment of our practices by insurance company behaviors; therefore be it

RESOLVED, that our American Medical Association vigorously oppose unilateral downcoding of evaluation and management (E/M) services by insurance companies, including but not limited to Cigna's "Evaluation and Management Coding Accuracy (R49)" program and Aetna's "Claim and Code Review Program (CCRP)" (New HOD Policy); and be it further

RESOLVED, that our AMA advocate the insurers adhere to AMA CPT® and E/M guidelines as the nationally recognized standard for coding and reimbursement, without unilateral reinterpretation (Directive to Take Action); and be it further

RESOLVED, that our AMA work with state medical associations, specialty societies, and regulatory authorities to challenge these payer policies through regulatory, legislative, and when appropriate, legal channels (Directive to Take Action); and be it further

RESOLVED, that our AMA report back on payer downcoding practices, their effects on physicians and patients, and strategies for collective advocacy at the 2026 Annual Meeting. (Directive to Take Action)

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

Received: 9/22/25

**REFERENCES**

1. Cigna Healthcare. (2025). Evaluation and Management Coding and Accuracy. Reimbursement policy: R49. https://static.cigna.com/assets/chcp/secure/pdf/resourceLibrary/clinReimPolsModifiers/R49_Evaluation_and_Management_Coding_Accuracy.pdf. Accessed September 2, 2025.
2. Aetna. (2023). Claim and Code Review Program (CCRP) update. March, 2023: https://www.aetna.com/health-care-professionals/newsletters-news/office-link-updates-march-2023/90-day-notices-march-2023/claim-code-review-program-update.html. Accessed September 2, 2025.
3. Centers for Medicare & Medicaid Services. Evaluation & management visits. May 23, 2025: https://www.cms.gov/medicare/payment/fee-schedules/physician/evaluation-management-visits. Accessed September 2, 2025.

## RELEVANT AMA POLICY

### Medicare Guidelines for Evaluation and Management Codes H-70.952

Our AMA (1) seeks Federal regulatory changes to reduce the burden of documentation for evaluation and management services; (2) will use all available means, including development of new Federal legislation and/or legal measures, if necessary, to ensure appropriate safeguards for physicians, so that insufficient documentation or inadvertent errors in the patient record, that does not meet evaluation and management coding guidelines in and of itself, does not constitute fraud or abuse; (3) urges CMS to adequately fund Medicare Carrier distribution of any documentation guidelines and provide funding to Carriers to sponsor educational efforts for physicians; (4) will work to ensure that the additional expense and time involved in complying with documentation requirements be appropriately reflected in the Resource Based Relative Value Scale (RBRVS); (5) continues to advise and educate physicians about the guidelines, any revisions, and their implementation by CMS; and (6) AMA policy is that in medical documentation the inclusion of any items unrelated to the care provided (e.g., irrelevant negatives) not be required.

Citation: Sub. Res. 801, I-97; Reaffirmed: I-00; Reaffirmed: CMS Rep. 6, A-10; Modified: CMS Rep. 01, A-20

### Automatic Downcoding of Claims D-320.972

1. Our American Medical Association vigorously opposes health plans using software, algorithms, or methodologies, other than manual review of the patient's medical record, to deny or downcode evaluation and management services, except correct coding protocol denials, based solely on the Current Procedural Terminology/Healthcare Common Procedure Coding System codes, International Classification of Diseases, 10th revision, codes, and/or modifiers submitted on the claim.
2. Our AMA supports that, after review of the patient’s medical record and determination that a lower level of evaluation and management code is warranted, the explanation of benefits, remittance advice documents, or other claim adjudication notices provide notice that clearly indicates a service was downcoded using the proper claim adjustment reason codes and/or remittance advice remark codes.
3. Our AMA will advocate for legislation to provide transparency and prohibit automated denials, other than National Correct Coding Initiative denials, or downcoding of evaluation and management services based solely on the Current Procedural Terminology/Healthcare Common Procedure Coding System codes, International Classification of Diseases, 10th Revision, codes, or modifiers submitted on the claim.
4. Our AMA will further evaluate what legislative and/or legal action is needed to bar insurers from automatic downcoding and to provide transparency on all methodology of processing claims.

Citation: Res. 714, A-24
**Bundling and Downcoding of CPT Codes H-70.937**

Our AMA: (1) vigorously opposes the practice of unilateral, arbitrary recoding and/or bundling by all payers;

(2) makes it a priority to establish national standards for the appropriate use of CPT codes, guidelines, and modifiers and to advocate the adoption of these standards;

(3) formulates a national policy for intervention with carriers or payers who use unreasonable business practices to unilaterally recode or inappropriately bundle physician services, and support legislation to accomplish this; and

(4) along with medical specialty societies, calls on its members to identify to our AMA specific CPT code bundling problems by payers in their area and that our AMA develop a mechanism for assisting our members in dealing with these problems with payers.

Citation: Res. 802, I-98; Reaffirmed: Res. 814, A-00; Modified: Sub. Res. 817; Reaffirmed: BOT Rep. 8, I-00; Reaffirmed: I-01; Reaffirmed: I-04; Reaffirmed: A-06; Reaffirmed: A-07; Reaffirmed: CMS Rep. 01, A-17

**Pay-for-Performance Principles and Guidelines H-450.947**

1. The following *Principles for Pay-for-Performance and Guidelines for Pay-for-Performance* are the official policy of our AMA.

PRINCIPLES FOR PAY-FOR-PERFORMANCE PROGRAMS

Physician pay-for-performance (PFP) programs that are designed primarily to improve the effectiveness and safety of patient care may serve as a positive force in our health care system. Fair and ethical PFP programs are patient-centered and link evidence-based performance measures to financial incentives. Such PFP programs are in alignment with the following five AMA principles:

1. Ensure quality of care - Fair and ethical PFP programs are committed to improved patient care as their most important mission. Evidence-based quality of care measures, created by physicians across appropriate specialties, are the measures used in the programs. Variations in an individual patient care regimen are permitted based on a physician's sound clinical judgment and should not adversely affect PFP program rewards.
2. Foster the patient/physician relationship - Fair and ethical PFP programs support the patient/physician relationship and overcome obstacles to physicians treating patients, regardless of patients' health conditions, ethnicity, economic circumstances, demographics, or treatment compliance patterns.
3. Offer voluntary physician participation - Fair and ethical PFP programs offer voluntary physician participation, and do not undermine the economic viability of non-participating physician practices. These programs support participation by physicians in all practice settings by minimizing potential financial and technological barriers including costs of start-up.
4. Use accurate data and fair reporting - Fair and ethical PFP programs use accurate data and scientifically valid analytical methods. Physicians are allowed to review, comment and appeal results prior to the use of the results for programmatic reasons and any type of reporting.
5. Provide fair and equitable program incentives - Fair and ethical PFP programs provide new funds for positive incentives to physicians for their participation, progressive quality improvement, or attainment of goals within the program. The eligibility criteria for the incentives are fully explained to participating physicians. These programs support the goal of quality improvement across all participating physicians.

GUIDELINES FOR PAY-FOR-PERFORMANCE PROGRAMS

Safe, effective, and affordable health care for all Americans is the AMA's goal for our health care delivery system. The AMA presents the following guidelines regarding the formation and implementation of fair and ethical pay-for-performance (PFP) programs. These guidelines augment the AMA's "Principles for Pay-for-Performance Programs" and provide AMA leaders, staff and members with operational boundaries that can be used in an assessment of specific PFP programs.

Quality of Care

- The primary goal of any PFP program must be to promote quality patient care that is safe and effective across the health care delivery system, rather than to achieve monetary savings.

- Evidence-based quality of care measures must be the primary measures used in any program.
1. All performance measures used in the program must be prospectively defined and developed collaboratively across physician specialties.
2. Practicing physicians with expertise in the area of care in question must be integrally involved in the design, implementation, and evaluation of any program.
3. All performance measures must be developed and maintained by appropriate professional organizations that periodically review and update these measures with evidence-based information in a process open to the medical profession.
4. Performance measures should be scored against both absolute values and relative improvement in those values.
5. Performance measures must be subject to the best-available risk- adjustment for patient demographics, severity of illness, and co-morbidities.
6. Performance measures must be kept current and reflect changes in clinical practice. Except for evidence-based updates, program measures must be stable for two years.
7. Performance measures must be selected for clinical areas that have significant promise for improvement.

- Physician adherence to PFP program requirements must conform with improved patient care quality and safety.

- Programs should allow for variance from specific performance measures that are in conflict with sound clinical judgment and, in so doing, require minimal, but appropriate, documentation.

- PFP programs must be able to demonstrate improved quality patient care that is safer and more effective as the result of program implementation.

- PFP programs help to ensure quality by encouraging collaborative efforts across all members of the health care team.

- Prior to implementation, pay-for-performance programs must be successfully pilot-tested for a sufficient duration to obtain valid data in a variety of practice settings and across all affected medical specialties. Pilot testing should also analyze for patient de-selection. If implemented, the program must be phased-in over an appropriate period of time to enable participation by any willing physician in affected specialties.

- Plans that sponsor PFP programs must prospectively explain these programs to the patients and communities covered by them.

Patient/Physician Relationship

- Programs must be designed to support the patient/physician relationship and recognize that physicians are ethically required to use sound medical judgment, holding the best interests of the patient as paramount.

- Programs must not create conditions that limit access to improved care.
1. Programs must not directly or indirectly disadvantage patients from ethnic, cultural, and socio-economic groups, as well as those with specific medical conditions, or the physicians who serve these patients.

2. Programs must neither directly nor indirectly disadvantage patients and their physicians, based on the setting where care is delivered or the location of populations served (such as inner city or rural areas).

- Programs must neither directly nor indirectly encourage patient de-selection.

- Programs must recognize outcome limitations caused by patient non-adherence, and sponsors of PFP programs should attempt to minimize non-adherence through plan design.

Physician Participation

- Physician participation in any PFP program must be completely voluntary.

- Sponsors of PFP programs must notify physicians of PFP program implementation and offer physicians the opportunity to opt in or out of the PFP program without affecting the existing or offered contract provisions from the sponsoring health plan or employer.

- Programs must be designed so that physician nonparticipation does not threaten the economic viability of physician practices.

- Programs should be available to any physicians and specialties who wish to participate and must not favor one specialty over another. Programs must be designed to encourage broad physician participation across all modes of practice.

- Programs must not favor physician practices by size (large, small, or solo) or by capabilities in information technology (IT).
1. Programs should provide physicians with tools to facilitate participation.
2. Programs should be designed to minimize financial and technological barriers to physician participation.

- Although some IT systems and software may facilitate improved patient management, programs must avoid implementation plans that require physician practices to purchase health-plan specific IT capabilities.

- Physician participation in a particular PFP program must not be linked to participation in other health plan or government programs.

- Programs must educate physicians about the potential risks and rewards inherent in program participation, and immediately notify participating physicians of newly identified risks and rewards.

- Physician participants must be notified in writing about any changes in program requirements and evaluation methods. Such changes must occur at most on an annual basis.

Physician Data and Reporting

- Patient privacy must be protected in all data collection, analysis, and reporting. Data collection must be administratively simple and consistent with the Health Insurance Portability and Accountability Act (HIPAA).

- The quality of data collection and analysis must be scientifically valid. Collecting and reporting of data must be reliable and easy for physicians and should not create financial or other burdens on physicians and/or their practices. Audit systems should be designed to ensure the accuracy of data in a non-punitive manner.
1. Programs should use accurate administrative data and data abstracted from medical records.
2. Medical record data should be collected in a manner that is not burdensome and disruptive to physician practices.
3. Program results must be based on data collected over a significant period of time and relate care delivered (numerator) to a statistically valid population of patients in the denominator.

- Physicians must be reimbursed for any added administrative costs incurred as a result of collecting and reporting data to the program.

- Physicians should be assessed in groups and/or across health care systems, rather than individually, when feasible.

- Physicians must have the ability to review and comment on data and analysis used to construct any performance ratings prior to the use of such ratings to determine physician payment or for public reporting.
1. Physicians must be able to see preliminary ratings and be given the opportunity to adjust practice patterns over a reasonable period of time to more closely meet quality objectives.
2. Prior to release of any physician ratings, programs must have a mechanism for physicians to see and appeal their ratings in writing. If requested by the physician, physician comments must be included adjacent to any ratings.

- If PFP programs identify physicians with exceptional performance in providing effective and safe patient care, the reasons for such performance should be shared with physician program participants and widely promulgated.

- The results of PFP programs must not be used against physicians in health plan credentialing, licensure, and certification. Individual physician quality performance information and data must remain confidential and not subject to discovery in legal or other proceedings.

- PFP programs must have defined security measures to prevent the unauthorized release of physician ratings.

Program Rewards

- Programs must be based on rewards and not on penalties.

- Program incentives must be sufficient in scope to cover any additional work and practice expense incurred by physicians as a result of program participation.

- Programs must offer financial support to physician practices that implement IT systems or software that interact with aspects of the PFP program.

- Programs must finance bonus payments based on specified performance measures with supplemental funds.

- Programs must reward all physicians who actively participate in the program and who achieve pre-specified absolute program goals or demonstrate pre-specified relative improvement toward program goals.

- Programs must not reward physicians based on ranking compared with other physicians in the program.

- Programs must provide to all eligible physicians and practices a complete explanation of all program facets, to include the methods and performance measures used to determine incentive eligibility and incentive amounts, prior to program implementation.

- Programs must not financially penalize physicians based on factors outside of the physician's control.

- Programs utilizing bonus payments must be designed to protect patient access and must not financially disadvantage physicians who serve minority or uninsured patients.

- Programs must not financially penalize physicians when they follow current, accepted clinical guidelines that are different from measures adopted by payers, especially when measures have not been updated to meet currently accepted guidelines.

2. Our AMA opposes private payer, Congressional, or Centers for Medicare and Medicaid Services pay-for-performance initiatives if they do not meet the AMA's "Principles and Guidelines for Pay-for-Performance."

Citation: BOT Rep. 5, A-05; Reaffirmed: A-06; Reaffirmed: Res. 210, A-06; Reaffirmed in lieu of: Res. 215, A-06; Reaffirmed in lieu of: Res. 226, A-06; Reaffirmed: I-06; Reaffirmed: A-07; Reaffirmed: A-09; Reaffirmed: BOT Rep. 18, A-09; Reaffirmed in lieu of: Res. 808, I-10; Modified: BOT Rep. 8, I-11; Reaffirmed: Sub. Res. 226, I-13; Appended: BOT Rep. 1, I-14; Reaffirmed in lieu of: Res. 203, I-15; Reaffirmed in lieu of: Res. 216, I-15; Reaffirmed: I-15; Reaffirmed; BOT Rep. 20, A-16; Reaffirmed in lieu of: Res. 712, A-17; Reaffirmed: A-18; Reaffirmed: A-22; Reaffirmed: CMS Rep. 07, A-25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 820
(I-25)

Introduced by: Private Practice Physicians Section

Subject: Establishing an AMA “First Responder Team” for Real-Time Physician Advocacy Against Adverse Insurance Company Actions

Referred to: Reference Committee J

---

Whereas, our American Medical Association has already established comprehensive policies opposing systemic insurance company processes designed to delay or obstruct legitimate billing claims and payment processing essential to patient care and physician practice operations; and

Whereas, despite these existing policies that guide the AMA legislative and public priorities on a macro level, individual physicians and small practices across the nation remain alone on the frontlines at the point of care, the micro-level defending against often punitive, daily increases in insurance payment hurdles against appropriate claim submissions to major insurers including Untied Healthcare, Cigna, and Aetna to name a few; and

Whereas, small practices have neither the resources, bandwidth, nor national scope to realize the coming storms that a national advocacy organization working in real-time with our practices can realize; and

Whereas, in 2025, our members of the Private Practice Physicians Section have separately reported an exponentially growing number of varied unreasonable and predatory examples of insurance company actions (punitive documentation requirements, “historical alternans” with regard to criteria for authorizations, and much more) which need an advocate in real-time rather than post-mortem; and

Whereas, insurance companies have demonstrated a pattern of mid-treatment coverage interruptions, with documented cases of physicians even being contacted during surgical procedures regarding coverage decisions, forcing providers to make costly decisions to operate out-of-network to avoid financial risk; and

Whereas, our AMA exists to protect and represent its physician membership against the systematic harassment of our practices by insurance company behaviors; and

Whereas, the current system leaves physicians alone with biased insurance company provider representatives, only to rarely adjudicate these complaints months to years later with the patients and the practice often long gone and system-wide changes, whether via the legal, legislative, or public policy routes, are helpful but are too often simply academic postmortems missing the real-time advocacy for which physicians on the frontlines are begging; and

Whereas, one example of many was recently when Optum demanded immediate and full repayment of the loans they provided some practices as a result of the Change Healthcare cybersecurity disaster; an AMA first responder team for physician advocacy against predatory insurance company actions for physicians to engage with would have been ideal here; and

Whereas, a 2024 AMA survey reveals that 93 percent of physicians experienced delays due to prior authorization and 82 percent reported that these processes cause patients to abandon

treatment altogether, with physicians warned that, “there’s good evidence that these kinds of delays literally kill people;” and

Whereas, insurance companies made similar reform pledges in 2018 and 2023 that resulted in little meaningful change and current 2024 pledges lack specific timelines and enforcement mechanisms, demonstrating that voluntary industry self-regulation is ineffective; and

Whereas, when physicians and their practices experience these systematic unpredictable storms of obstructions, their current recourse through state medical societies and insurance company provider representatives proves inadequate, with little to no influence, acknowledgement, response, or expediency in addressing urgent practice-threatening situations; and

Whereas, in countless other professional and activist contexts of American citizenry outside medicine, individuals facing harassment or punishment by larger predatory systems, be it from the government or corporations, members of advocacy organizations took to their representative organizations to provide immediate liaising, defense, and services, to protect their members from predatory intimidation; and

Whereas, small practices facing insurance company harassment have no current mechanism or avenues, let alone ones as capable as the AMA, for real-time advocacy and representation, leaving them vulnerable to financial insolvency while waiting for traditional bureaucratic channels; and

Whereas, the absence of immediate advocacy support against these predators contributes to physician dissatisfaction with our representative organizations as practicing physicians struggle to identify tangible, real-time benefits that address their most pressing daily operational challenges; therefore be it

RESOLVED, that our American Medical Association establish a “first responder team for physician advocacy against adverse insurance company actions” to provide urgent liaison services and advocacy representation for individual physicians and their practices when they are confronted with what appears to be predatory harassment, systematic obstruction, or punitive changes including, but not limited to:

- sudden increased in claim denials,
- arbitrarily onerous documentation requirements,
- mid-treatment coverage interruptions

(Directive to Take Action); and be it further

RESOLVED, that an AMA “first responder team for physician advocacy against adverse insurance company actions” be a pilot program for the first two years of operation that will develop ongoing protocols to prioritize future cases brought to them, catalog them, and then report back to the House of Delegates annually (Directive to Take Action); and be it further

RESOLVED, that an AMA “first responder team for physician advocacy against adverse insurance company actions” will coordinate relevant information and strategy with other existing AMA programs already engaged in implementing existing AMA policy protecting the rights of physicians and their practices from insurance company behaviors. (Directive to Take Action)

Fiscal Note: $393,195 – Establish First Responder Team

Received: 9/22/25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 902
(I-25)

Introduced by: New England Delegation

Subject: Advocating for Improvements in Systems of Care for Autism

Referred to: Reference Committee K

---

Whereas, one in 36 eight-year-old children is currently identified as having autism spectrum disorder (ASD)[1], a disorder that has no cure but has effective treatments to improve quality of life and academic and employment outcomes. Early diagnosis of ASD may allow for earlier and more successful interventions to optimize development and behavior[2]; and

Whereas, there are documented disparities in the age of initial ASD diagnosis of African American, Hispanic, non-English speaking, and immigrant children and primary care child health teams must also be alert to the potential for gender bias in symptom recognition[3, 4]; and

Whereas, there are waiting times ranging from six months to over a year for diagnostic evaluations of children who had positive screens for behaviors and developmental delays suggestive of autism spectrum disorder. In Massachusetts, the Autism Omnibus Act mandates a diagnosis be given by a physician or psychologist. There are specific pediatric subspecialty and child psychiatry workforce issues that along with a surge in demand for ASD evaluations are necessitating an adapted approach to ASD diagnosis centered on the primary care pediatric office. Academic medical centers in the Commonwealth are piloting a number of training projects for primary care pediatric offices to diagnose ASD[7]; and

Whereas, when the pediatric team in the medical home has a longitudinal relationship with families of young children and has received training on autism diagnosis, they can reliably diagnose autism spectrum disorder (ASD), especially when the symptoms present early in childhood[8,9]; and

Whereas, primary care pediatric teams that are clinically trained in the diagnosis of autism spectrum disorders (ASD) may be unable to successfully integrate the evidence-based autism evaluation and complex care coordination into their practices due to significant reimbursement and workflow barriers that make the numerous long visits and administrative time required for diagnosis unprofitable for a private practice or community health center[10]; and

Whereas, the American Academy of Pediatrics (AAP) has been supporting pediatric teams on equitable and sustainable solutions to reduce the barriers to ASD diagnosis and care. The AAP has distributed a “Dear Payer Letter,” which recommends adequate payment and appropriate coverage of diagnostic, therapeutic, and care coordination services for autism in the medical home[11]; therefore be it

RESOLVED, that our American Medical Association advocate for peer reviewed, evidence-based guidance for states on innovative health systems solutions to reduce specific barriers to the diagnosis of autism and complex care coordination in the medical home by primary care team members trained in the diagnosis of autism. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/18/25

**REFERENCES**

1. Shaw KA, Maenner MJ, Baio J, et al. Early Identification of Autism Spectrum Disorder Among Children Aged 4 Years — Early Autism and Developmental Disabilities Monitoring Network, Six Sites, United States, 2016. MMWR Surveillance Summaries. 2020;69(3):1-11. doi:https://doi.org/10.15585/mmwr.ss6903a1.https://www.cdc.gov/mmwr/volumes/72/ss/ss7202a1.htm?s_cid=ss7202a1_w
2. Guthrie, Whitney, Amy M. Wetherby, Juliann Woods, Christopher Schatschneider, Renee D. Holland, Lindee Morgan, and Catherine E. Lord. "The earlier the better: An RCT of treatment timing effects for toddlers on the autism spectrum." Autism 27, no. 8 (2023): 2295-2309.
3. Hyman SL, Levy SE, Myers SM. Identification, Evaluation, and Management of Children with Autism Spectrum Disorder. Pediatrics. 2020;145(1). https://doi.org/10.1542/peds.2019-3447
4. Maenner MJ. Prevalence and Characteristics of Autism Spectrum Disorder Among Children Aged 8 Years — Autism and Developmental Disabilities Monitoring Network, 11 Sites, United States, 2020. MMWR Surveillance Summaries. 2023;72(2):1-14. https://doi.org/10.15585/mmwr.ss7202a1
5. Weitlauf, Amy S., Alexandra Miceli, Alison Vehorn, Yewande Dada, Theodora Pinnock, Joyce W. Harris, Jeffrey Hine, and Zachary Warren. "Screening, diagnosis, and intervention for Autism: Experiences of black and multiracial families seeking care." Journal of autism and developmental disorders 54, no. 3 (2024): 931-942.
6. "SECTION 25. Chapter 118E of the General Laws is hereby amended by inserting after section 10G the following section:- Section 10H. Subject to the availability of federal financial participation, the division shall cover medically necessary treatments for persons younger than 21 years old who are receiving medical coverage under this chapter and who are diagnosed with an autism spectrum disorder by a licensed physician or a licensed psychologist. If federal funds are available to the commonwealth, said coverage shall include, but shall not be limited to, services for applied behavior analysis supervised by a board certified behavior analyst and dedicated and non-dedicated augmentative and alternative communication devices, including, but not limited to medically necessary tablets."
7. The Early Childhood Autism Diagnostic Project: https://www.umassmed.edu/psychiatry/clinicalservices/child-adolescent-clinical-services/early-childhood-autism-diagnosis-project/
8. Nasir, Arwa K., Whitney Strong-Bak, and Marie Bernard. "Diagnostic Evaluation of Autism Spectrum Disorder in Pediatric Primary Care." *Journal of primary care & community health* 15 (2024): 21501319241247997.
9. https://publications.aap.org/pediatrics/article/145/1/e20193447/36917/Identification-Evaluation-and-Management-of?autologincheck=redirected&_gl=1*187d8yn*_ga*ODYyMzQ0OTA0LjE3NDIwOTQ0MjQ.*_ga_FD9D3XZVQQ*MTc0MjQ4OTU0MC44LjEuMTc0MjQ5MDA1Ni4wLjAuMA..*_ga_GMZCQS1K47*MTc0MjQ4OTU0MC41LjEuMTc0MjQ5MDA1Ni4wLjAuMA..
10. Wieckowski, Andrea Trubanova, Katharine E. Zuckerman, Sarabeth Broder-Fingert, and Diana L. Robins. "Addressing current barriers to autism diagnoses through a tiered diagnostic approach involving pediatric primary care providers." Autism Research 15, no. 12 (2022): 2216-2222.
11. https://downloads.aap.org/AAP/PDF/Payer%20Letter%20PCV20.pdf

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 910
(I-25)

Introduced by: Women Physicians Section

Subject: Increasing Funding for Gynecological Cancer Research

Referred to: Reference Committee K

---

Whereas, gynecological cancers, defined as cervical, ovarian, uterine, fallopian tube, vaginal, and vulvar, have high morbidity and mortality due to a multitude of factors including no reliable screening methods for uterine, ovarian, vaginal, or vulvar cancers[1-4]; and

Whereas, gynecological cancers are underfunded compared to other cancer sites[5, 6]; and

Whereas, in 2016, the "Cancer Moonshot" bill aimed to expedite cancer research by allocating $1.8 billion dollars based on a Funding to Lethality Score (FLS), a method to standardize incidence, mortality, and life lost[5, 7]; and

Whereas, FLS is calculated using mortality to incidence ratio (MIR), person-years-of-life lost per incident case, and total amount of funding reported by the NCI[5]; and

Whereas, ovarian, cervical, and uterine cancers ranked 10th, 12th, and 14th, respectively, out of 18 cancer sites for average FLS[5]; and

Whereas, ovarian cancer received $97,000 through "Cancer Moonshot", cervical cancer $87,000, and uterine cancer $57,000[5]; and

Whereas, FLS for ovarian, cervical, and uterine cancers are decreasing over time, leading to growing disparities in research funding allocation[5]; and

Whereas, since 2020, NIH funding for ovarian cancer research has decreased from $188 to $171 million[6]; and

Whereas, since 2019, NIH funding for vaginal cancer research has decreased from $4 million to $3 million and is one of the most underfunded cancers by the NIH[6]; and

Whereas, there is no NIH funding allocation specifically for vulvar or fallopian tube cancer research[6]; and

Whereas, despite NIH funding for uterine and cervical cancer research funding increasing to $42 million and to $164 million in 2023, respectively, they remain underfunded compared to other cancer sites with decreasing or lower FLS[5, 6]; and

Whereas, although the FLS for prostate cancer has decreased, NIH funding for prostate cancer research has increased from $263 to $305 million since 2019[5, 6]; and

Whereas, disparities in cancer funding extend beyond reproductive cancers with liver and brain cancer research receiving higher NIH funding despite being less prevalent (0.01% prevalence each) compared to ovarian (0.06%) and uterine (0.07%) cancers in 2022[6]; and

Whereas, in 2023, NIH funding was $189 million for liver cancer research and $427 million for brain cancer research[6]; and

Whereas, underfunding leads to decreased trial enrollment and fewer trials available for patient enrollment, which impacts the number of high-level treatment recommendations[5]; and

Whereas, significant research funding for prostate cancer led to the establishment of prostate-specific antigen (PSA) screening as a widely utilized tool, resulting in a 50% reduction in annual prostate cancer mortality[8, 9]; and

Whereas, although cervical cancer screening advancements, including HPV-DNA testing with Pap smears, have improved detection rates, further research into additional tools such as HPV DNA methylation and liquid-based cytology, may enhance the identification of high-grade cervical lesions[10]; and

Whereas, due to critical underfunding, gynecological cancers remain an area of research with a lack of evidence-based guidelines for screening, diagnosis, and treatment for these conditions; and

Whereas, gynecological cancers disproportionately affect minority and underserved populations, with higher mortality rates due to limited access to preventative care, and treatments, emphasizing the need for increased research funding to address inequities[12]; and

Whereas, the Society of Gynecologic Oncology declared a crisis in gynecologic cancer clinical trial access and outlined a five-step plan to address the crisis, including increased funding for clinical trials[11]; therefore be it

RESOLVED, that our American Medical Association advocates for increased funding to gynecological cancer research from all available resources, both public and private (Directive to Take Action); and be it further

RESOLVED, that our AMA supports increased research efforts into current and the development of new screening methods for gynecological cancers (New HOD Policy); and be it further

RESOLVED, that our AMA supports increasing research to develop screening methods to increase early diagnosis of gynecologic malignancies. (New HOD Policy)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/5/25

**REFERENCES**
1. Centers for Disease Control. Gynecologic Cancers Basics. https://www.cdc.gov/gynecologic-cancer/about/index.html. Updated 2024. Accessed Jan 28, 2025
2. Centers for Disease Control. Screening for Uterine Cancer. https://www.cdc.gov/uterine-cancer/screening/index.html. Updated 2024. Accessed Jan 28, 2025
3. Centers for Disease Control. Screening for Ovarian Cancer. https://www.cdc.gov/ovarian-cancer/screening/index.html#:~:text=Ask%20your%20doctor%20if%20you,or%20rule%20out%20ovarian%20cancer. Updated 2024. Accessed Jan 28, 2025
4. Centers for Disease Control. Screening for Vaginal and Vulvar Cancers. https://www.cdc.gov/vaginal-vulvar-cancers/screening/index.html. Updated 2024. Accessed Jan 28, 2025
5. Kamath SD, Chen Y. Disparities in National Cancer Institute and Nonprofit Organization Funding Disproportionately Affect Cancers With Higher Incidence Among Black Patients and Higher Mortality Rates. *JCO Oncology Practice.* 2024;20(3):378–385
6. National Institute of Health. Estimates of Funding for Various Rearch, Cndition, and Disease Categories. https://report.nih.gov/funding/categorical-spending#/. Updated 2024. Accessed Jan 28, 2025
7. National Cancer Institute. Cancer Moonshot. https://www.cancer.gov/research/key-initiatives/moonshot-cancer-initiative. Updated 2023. Accessed Jan 28, 2025
8. Wei JT, Barocas D, Carlsson S, et al. Early detection of prostate cancer: AUA/SUO guideline (2023). *J Urol.* 2023;210(1):46–53
9. National Cancer Institute. U.S. Mortality Data, 1969 - 2022. https://seer.cancer.gov/mortality/. Updated 2022. Accessed Jan 28, 2025
10. Holcakova J, Bartosik M, Anton M, et al. New trends in the detection of gynecological precancerous lesions and early-stage cancers. *Cancers.* 2021;13(24):6339
11. Society of Gynecologic Oncology. The Crisis In Gynecologic Cancer Clinical Trial Access. https://www.sgo.org/wp-content/uploads/2012/09/SGO-Clinical-Trial-Crisis-FINAL.pdf. Updated 2017. Accessed Jan 28, 2025
12. Towner M, Kim JJ, Simon MA, Matei D, Roque D. Disparities in gynecologic cancer incidence, treatment, and survival: a narrative review of outcomes among black and white women in the United States. *International Journal of Gynecologic Cancer.* 2022;32(7)

## RELEVANT AMA POLICY

**D-420.989 Addressing Disparities and Lack of Research for Endometriosis**

1. Our American Medical Association will collaborate with stakeholders to recognize endometriosis as an area for health disparities research that continues to remain critically underfunded, resulting in a lack of evidence-based guidelines for diagnosis and treatment of this condition amongst people of color.
2. Our AMA will collaborate with stakeholders to promote awareness of the negative effects of a delayed diagnosis of endometriosis and the healthcare burden this places on patients, including health disparities among patients from communities of color who have been historically marginalized.
3. Our AMA will advocate for increased endometriosis research addressing health disparities in the diagnosis, evaluation, and management of endometriosis.
4. Our AMA will advocate for increased funding allocation to endometriosis-related research for patients of color, especially from federal organizations such as the National Institutes of Health.

[Res. 921, I-23]

**D-55.997 Cancer and Health Care Disparities Among Minority Women**
Our American Medical Association encourages research and funding directed at addressing racial and ethnic disparities in minority women pertaining to cancer screening, diagnosis, and treatment.
[Res. 509, A-08 Modified: CSAPH Rep. 01, A-18]

**H-460.888 Advanced Research Projects Agency for Health (ARPA-H )**
Our American Medical Association will urge Congress and the Administration to ensure that while providing adequate funding for the promising research conducted at Advanced Research Projects Agency for Health (ARPA-H), it also provides robust annual baseline increases in appropriations for other research agencies, centers, and institutes, including, but not limited to, the NIH and NCI.
[Res. 519, A-22]

**H-55.971 Screening and Treatment for Breast and Cervical Cancer Risk Reduction**
1. Our American Medical Association supports programs to screen all at-risk individuals for breast and cervical cancer and that government funded programs be available for low income individuals; the development of public information and educational programs with the goal of informing all at-risk individuals about routine cancer screening in order to reduce their risk of dying from cancer; and

increased funding for comprehensive programs to screen low income individuals for breast and cervical cancer and to assure access to definitive treatment.
2. Our AMA encourages state and local medical societies to monitor local public health screening programs to ensure that they are linked to treatment resources in the public or private sector.
3. Our AMA encourages the Centers for Medicare and Medicaid Services to evaluate and review their current cervical cancer screening policies to ensure coverage is consistent with current evidence-based guidelines.
4. Our AMA supports further research by relevant parties of HPV self-sampling in the United States to determine whether it can decrease health care disparities in cervical cancer screening**.**
[CCB/CLRPD Rep. 3, A-14 BOT Action Sept 2023]

**D-450.957 Clinical Guidelines and Evidence Regarding Benefits of Prostate Cancer Screening and Other Preventive Services**
Our AMA will: (1) continue to advocate for inclusion of relevant specialty societies and their members in guideline and performance measure development, including in technical expert panels charged with developing performance measures; (2) work with the federal government, specialty societies, and other relevant stakeholders to develop guidelines and clinical quality measures for the prevention or early detection of disease, such as prostate cancer, based on rigorous review of the evidence which includes expertise from any medical specialty for which the recommendation may be relevant to ultimately inform shared decision making; and (3) encourage scientific research to address the evidence gaps highlighted by organizations making evidence-based recommendations about clinical preventive services.
[Res. 225, I-15 Appended: CMS Rep. 06, A-19]

**D-425.999 Public and Private Funding of Prevention Research**
Our AMA seeks to work in partnership with the Centers for Disease Control and Prevention, the National Institutes of Health, and other Federal Agencies, the Public Health Community, and the managed care community to ensure that there is a national prevention research agenda.
[Res. 418, I-98 Reaffirmed: CSAPH Rep. 2, A-08 Modified: CSAPH Rep. 01, A-18]

**H-440.872 HPV Associated Cancer Prevention**
1. Our American Medical Association;
    a. strongly urges physicians and other health care professionals to educate themselves, appropriate patients, and patients' parents or caregivers when applicable, about HPV and associated diseases, the importance of initiating and completing HPV vaccination, as well as routine HPV related cancer screening; and
    b. encourages the development and **funding** of programs targeted at HPV vaccine introduction and HPV related cancer screening in countries without organized HPV related cancer screening programs.
2. Our AMA will work with interested parties to intensify efforts to improve awareness and understanding about HPV and associated diseases in all individuals, regardless of sex, such as, but not limited to, cervical cancer, head and neck cancer, anal cancer, and genital cancer, the availability and efficacy of HPV vaccinations, and the need for routine HPV related cancer screening in the general public.
3. Our AMA supports legislation and **funding** for **research** aimed towards discovering screening methodology and early detection methods for other non-cervical HPV associated cancers.
4. Our AMA;
    a. encourages the integration of HPV vaccination and appropriate HPV-related cancer screening into all appropriate health care settings and visits;
    b. supports the availability of the HPV vaccine and routine cervical cancer screening to appropriate patient groups, including but not limited to low-income and pre-sexually active populations; and
    c. recommends HPV vaccination for all groups for whom the federal Advisory Committee on Immunization Practices recommends HPV vaccination.
5. Our AMA supports efforts by states to increase HPV vaccine availability and accessibility, and HPV vaccination rates through a combination of policies such as facilitating administration of HPV vaccinations in community-based settings including local health departments and schools, reminder-based interventions, school-entry requirements, and requirements for comprehensive and evidence-based sexual education.

6. Our AMA encourages collaboration with interested parties to make available human papillomavirus vaccination, according to ACIP recommendations, to people who are incarcerated for the prevention of HPV-associated cancers.
7. Our AMA advocate that racial, ethnic, socioeconomic, and geographic differences in high-risk HPV subtype prevalence be taken into account during the development, clinical testing, and strategic distribution of next-generation HPV vaccines.
8. Our AMA will encourage continued **research** into (a) interventions that equitably increase initiation of HPV vaccination and completion of the HPV vaccine series; (b) the impact of broad opt-out provisions on HPV vaccine uptake; and (c) the impact of the COVID-19 pandemic and vaccine misinformation on HPV vaccine uptake.

[Res. 503, A-07 Appended: Res. 6, A-12 Reaffirmed: CSAPH Rep. 1, A-22 Reaffirmation: A-22 Modified: Res. 916, I-22 BOT Action Sept. 2023 Modified: CSAPH Rep. 02, I -24]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 913
(I-25)

Introduced by: New Jersey

Subject: Establish AMA Policy and Project to Compile and Distribute JAMA Patient Pages to Enhance Public Medical Literacy

Referred to: Reference Committee K

---

Whereas, medical literacy is essential for patients to make informed decisions about their care and improve health outcomes; and

Whereas, the Journal of the American Medical Association (JAMA) has published “JAMA Patient Pages” for years as a trusted source of accessible, evidence-based medical information for patients and the public; and

Whereas, these patient pages cover a wide range of common health conditions, preventive care measures, and treatment options, providing valuable guidance to patients in understandable language; and

Whereas, these patient pages cover a wide range of common health conditions, preventive care measures, and treatment options, providing valuable guidance to patients in understandable language; and

Whereas, existing JAMA Patient Pages represent a substantial, high-quality repository of patient education materials that could be more widely utilized to promote medical literacy; and

Whereas, easily accessible and well-organized patient education materials can support patients in managing their health, understanding treatment options, and fostering effective partnerships with physicians in their care and recovery; and

Whereas, making these patient pages available to the general public in a consolidated, searchable, and freely accessible format would enhance public understanding of medical issues and contribute to health equity by reducing disparities in medical literacy; and

Whereas, our American Medical Association has a long-standing commitment to advancing public health and promoting informed patient decision-making; therefore be it

RESOLVED, that our American Medical Association support publicizing the existence and value of JAMA Patient Pages as a resource for public health education and medical literacy (New HOD Policy); and be it further

RESOLVED, that our AMA support compiling and organizing previously published JAMA Patient Pages into a publicly accessible database or repository for the purpose of improving medical literacy and fostering patient-physician partnerships (Directive to Take Action); and be it further

RESOLVED, that our AMA explores opportunities to promote awareness and utilization and ease of use of JAMA Patient Pages among patients, physicians and healthcare institutions. (Directive to Take Action)

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

Received: 9/26/25

[1]AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 914
(I-25)

Introduced by: New Jersey

Subject: Develop Climate-Conscious Resources for Physicians

Referred to: Reference Committee K

---

Whereas, climate change poses a significant and immediate threat to public health, with impacts that include increased heat-related illnesses, respiratory conditions, vector-borne diseases, and disruptions to healthcare delivery; and

Whereas, the healthcare sector, including the U.S. healthcare system, is both affected by climate change and a significant contributor to greenhouse gas emissions; and

Whereas, physicians and other healthcare professionals play a vital role in advocating for environmentally sustainable practices within the healthcare system and in educating patients about the health impacts of climate change; and

Whereas, initiatives developed by a national foundation has been very successful at decreasing unnecessary tests, treatments, and procedures; and

Whereas, a national foundation has developed a comprehensive resource, broken down by specialty, focused on the intersection of climate change and healthcare, providing guidance, educational materials, and actionable recommendations to reduce the environmental impact of clinical practices; therefore be it

RESOLVED, that our American Medical Association support compiling and maintaining a resource for U.S. physicians, focused on education physicians and other healthcare professionals about the health impacts of climate change and the role of the healthcare sector in contributing to greenhouse gas emissions (New HOD Policy); and be it further

RESOLVED, that our AMA support providing practical, evidence-based recommendations for reducing the environmental footprint of clinical practices and healthcare systems (New HOD Policy); and be it further

RESOLVED, that our AMA support offering resources and tools to support physicians in advocating for environmentally sustainable policies and practices within their organization and communities (New HOD Policy); and be it further

RESOLVED, that our AMA facilitates collaboration and sharing of best practices among healthcare professionals and institutions committed to addressing climate change and promoting sustainability. (Directive to Take Action)

Fiscal Note: Major -

Received: 9/26/25

**REFERENCES**

1. Wise J. Climate crisis: Over 200 health journals urge world leaders to tackle "catastrophic harm" BMJ 2021; 374 :n2177 doi:10.1136/bmj.n2177
2. Eckelman MJ, Huang K, Lagasse R, et al. Health care pollution and public health damage in the United States: An update. Health Affairs. 2020;39(12): https://doi.org/10.1377/hlthaff.2020.01247
3. Choosing Wisely. Retrieved from https://www.choosingwisely.org Accessed January 24, 2025.
4. Choosing Wisely and Climate Action - Choosing Wisely Canada. Retrieved from https://choosingwiselycanada.org/climate/#resources Accessed January 24, 2025.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 915
(I-25)

Introduced by: New Jersey

Subject: Reduce Environmental Impact of Medical Journals

Referred to: Reference Committee K

---

Whereas, the U.S. healthcare system generates a tremendous amount of waste, contributing 8.5% of greenhouse gas emissions and producing 4 billion pounds of waste annually; and

Whereas, there are over 1 million physicians in the United States, each of whom receives, on average, multiple medical journals monthly; and

Whereas, these journals are commonly wrapped in low-density polyethylene (LDPE), a material that, according to the Environmental Protection Agency (EPA), contributed 500,000 tons to U.S. landfills in 2015; and

Whereas, plastics, including LDPE, have been found in human blood, stool, and urine, and are known to cause cell death, allergic reactions, and inflammation; and

Whereas, a majority of physicians in a recent study expressed a preference for digital formats over print versions of medical journals; therefore be it

RESOLVED, that our American Medical Association continue to explore environmentally sustainable practices and that medical journals be provided via electronic-only means by default, and that physicians and other recipients be required to opt in to receive print versions (Directive to Take Action); and be it further

RESOLVED, that our AMA encourage specialty societies to require physicians to opt in to receive print versions of journals, with the default option being to receive electronic-only versions. (New HOD Policy)

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

Received: 9/26/25

**REFERENCES**

1. Wormer BA, Augenstein VA, Carpenter CL, Burton PV, Yokeley WT, Prabhu AS, et al. The green operating room: simple changes to reduce cost and our carbon footprint. Am Surg 2013;79(7):666-71.
2. Quevada K, Cerceo E, O'Neill L, Gudla V, Ahmed-Zaidi S, Germaine P. Survey of physician journal subscription experiences: Environmental packaging. J Clim Change and Health. 2023; 14:100266.
3. United States Environmental Protection Agency. Containers and packaging: product-specific data; 2022 [accessed 11 February 2023]. Available from: https:// www.epa.gov/facts-and-figures-about-materials-waste-and-recycling/containers-and-packaging-product-specific#PlasticC&P
4. Secchi ER, Zarzur S. Plastic debris ingested by a Blainville's beaked whale, Mesoplodon densirostris, washed ashore in Brazil. Aquatic Mammals 1999;25(1):21-4.
5. Barnes DK, Galgani F, Thompson RC, Barlaz M. Accumulation and fragmentation of plastic debris in global environments. Philosoph Trans R Soc B Biol Sci 2009;364(1526):1985-98 Jul 27.
6. Shimao M. Biodegradation of plastics. Curr Opin Biotechnol 2001;12(3):242-7 Jun 1.
7. Ghatge S, Yang Y, Ahn JH, Hur HG. Biodegradation of polyethylene: a brief review. Appl Biol Chem 2020;63(1):1-4 Dec.
8. Achilias DS, Roupakias C, Megalokonomos P, Lappas AA, Antonakou EV. Chemical recycling of plastic wastes made from polyethylene (LDPE and HDPE) and polypropylene (PP). J Hazard Mater 2007;149(3):536-42 Nov 19.
9. Leslie HA, et al. Discovery and quantification of plastic particle pollution in human blood. Environ Internatl 2022;163:107199 May.
10. Zhang J, Wang L, Trasande L, Kannan K. Occurrence of polyethyelene teraphthalate and polycarbon microplastics in infant and adult feces. Environ Sci Technol Lett 2021;8(11):989-99.
11. Pironti C, Notarstefano V, Ricciardi M, Motto O. First evidence of microplastics in human urine, a preliminary study of intake in the human body. Toxics 2022;11 (1):40.
12. Danopoulos E, Twiddy M, West R, Rotchell JM. A rapid review and meta-regression analyses of the toxicological impacts of microplastic exposure in human cells. J Haz Mat 2022;427:127861.
13. Blackburn K, Green D. The potential effects of microplastics on human health: what is known and what is unknown. Ambio 2022;51(3):518-30.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 916
(I-25)

Introduced by: New Jersey

Subject: Studying the Environmental Impact of Ambient Clinical Intelligence Use

Referred to: Reference Committee K

---

Whereas, ambient clinical intelligence is proving to be an important technology tool for strengthening the physician-patient relationship and reducing physician burnout; and

Whereas, the demand for ambient clinical intelligence tools is significantly increasing and has a projected growth of by 38.62% from 2025 to 2030; and

Whereas, the growth of data centers to support ambient clinical intelligence is also being built to accommodate demand and place a significant strain on the electrical grid with potential public health implications; and

Whereas, data centers, as part of their routine operation, account for 1% of global electricity usage and this percentage is predicted to grow to 21% by 2030; and

Whereas, training a single AI model can emit over 284,000 kg of carbon dioxide; and

Whereas, built data centers come with an additional environmental cost of soil damage in areas where mineral extraction is done, pollution from the manufacturing of data center components and electronic waste from retired hardware, which have grown to more than 50 million pounds annually with only about 20% of it is recycled; and

Whereas the direct impact on public health and infrastructure caused by data centers have been quantified to be as high as $5.4 billion dollars in a 5-year period; therefore be it

RESOLVED, that our American Medical Association in collaboration with state medical societies, develop a framework to study the public health impact and ecological challenges posed by the growth of ambient clinical intelligence (Directive to Take Action); and be it further

RESOLVED, that our AMA support efforts to voluntarily report emissions, water use, and e-waste from data centers to allow for public health entities to anticipate care and coverage costs to affected populations (New HOD Policy); and be it further

RESOLVED, that our AMA works with stakeholders to encourage state and federal legislatures to offer specific tax incentives to ambient clinical intelligence vendors to work toward using 100% sustainable energy sources (Directive to Take Action); and be it further

RESOLVED, that our AMA works with other industry healthcare associations to help establish clear guidelines on the responsible disposal of AI-enabled medical devices as well as AI purposed hardware. (Directive to Take Action)

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

Received: 9/26/25

**REFERENCES**

1. AI In Healthcare Market Size, Share | Industry Report, 2030
2. Stackpole, Beth, "AI has high data center energy costs-but there are solutions. MIT Sloan School of Management." Retrieved from https://mitsloan.mit.edu/ideas-made-to-matter/ai-has-high-data-center-energy-costs-there-are-solutions on August 21, 2025
3. MIT Technology Review. (2021). The Hidden Costs of AI's Energy Consumption. Retrieved from www.technologyreview.com August 21,2025
4. Doyle, Alyson, "The Dark Side of AI: How Artificial Intelligence is Harming the Environement"
5. The unpaid toll: Quantifying the public health impact of ai,Y Han, Z Wu, P Li, A Wierman, S Ren - arXiv preprint arXiv:2412.06288, 2024 - arxiv.org

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 928
(I-25)

Introduced by: New Jersey

Subject: AMA's Continued Support for COVID-19 Vaccination in Pregnant Individuals and Children

Referred to: Reference Committee K

---

Whereas, on May 27, 2025, the CDC removed its recommendation for COVID-19 vaccination in healthy pregnant individuals and children aged 6 months–17 years (1); and

Whereas, pregnancy is a recognized high-risk condition for severe COVID-19 illness and infants born to unvaccinated mothers are more vulnerable in the first six months of life (2); and

Whereas, the AMA has previously demonstrated that the COVID-19 vaccination during pregnancy is safe for both mother and infant with no increase in miscarriage, preterm birth, or adverse fetal outcomes (3); and

Whereas, existing AMA policy D-440.921 ("An Urgent Initiative to Support COVID-19 Vaccination and Information Programs") emphasizes the necessity to promote the integrity of COVID-19 vaccine information; and

Whereas, the AMA does not have existing policy explicitly recommending ongoing Covid-19 vaccination for healthy pregnant individuals and children aged 6 months through 17 years old; therefore be it

RESOLVED, that our American Medical Association calls on the U.S. Centers for Disease Control and Prevention, Health and Human Services, and the Department of Health and Human Services to restore explicit recommendations for COVID-19 vaccination of pregnant individuals and young children aged 6 months to 17 years. (Directive to Take Action)

Fiscal Note: Minimal – less than $1,000

Received: 9/30/25

**REFERENCES**


1. https://apnews.com/author/mike-stobbe. Kennedy vaccines lawsuit: Doctors and public health organizations sue over policy change. AP News. Published July 7, 2025. https://apnews.com/article/lawsuit-vaccines-kennedy-95a1aa23c3f015f7a35a570f5ef8da36
2. 2,Grünebaum A, Chervenak FA. Professional Responsibility for COVID-19 Vaccination in Pregnancy. JAMA. Published online June 25, 2025. doi:10.1001/jama.2025.11328
3. What doctors wish patients knew about COVID-19 vaccines and pregnancy. American Medical Association. Published November 12, 2021. https://www.ama-assn.org/delivering-care/public-health/what-doctors-wish-patients-knew-about-covid-19-vaccination

**RELEVANT AMA POLICY**

**An Urgent Initiative to Support COVID-19 Vaccination and Information Programs D-440.921**
Our AMA will institute a program to promote the integrity of a COVID-19 vaccination information program by: (1) educating physicians on speaking with patients about COVID-19 infection and vaccination, bearing in mind the historical context of “experimentation” with vaccines and other medication in communities of color, and providing physicians with culturally appropriate patient education materials; (2) educating the public about up-to-date, evidence-based information regarding COVID-19 and associated infections as well as the safety and efficacy of COVID-19 vaccines, by countering misinformation and building public confidence; (3) forming a coalition of health care and public health organizations inclusive of those respected in communities of color committed to developing and implementing a joint public education program promoting the facts about, promoting the need for, and encouraging the acceptance of COVID-19 vaccination; (4) supporting ongoing monitoring of COVID-19 vaccines to ensure that the evidence continues to support safe and effective use of vaccines among recommended populations; (5) educating physicians and other healthcare professionals on means to disseminate accurate information and methods to combat medical misinformation online; and (6) supporting the public purchase and cost-free distribution and administration of COVID-19 booster vaccine doses.

## Informational Reports

**Report(s) of the Board of Trustees**

09 2025 AMA Advocacy Efforts

14 AMA Efforts on Medicare Payment Reform and Increasing Transparency of AMA Medicare Payment Reform Strategy

17 Establishing an Advisory Committee on AI/AN Affairs

20 AMA Reimbursement of Necessary HOD Business Meeting Expenses for Delegates and Alternates

**Opinion(s) of the Council on Ethical and Judicial Affairs**

01 Contracts to Deliver Health Care Services

02 Organ Transplantation Allocation Decisions

**Report(s) of the Council on Science and Public Health**

01 Drug Shortages: 2025 Update

**Report(s) of the Speakers**

03 Speaker Recorded Interviews for AMA Elections

REPORT 09 OF THE BOARD OF TRUSTEES (I-25)
2025 AMA Advocacy Efforts

## EXECUTIVE SUMMARY

This report is submitted for the information of the House of Delegates (HOD). Policy G-640.005, "AMA Advocacy Analysis," calls on the Board of Trustees (the Board) to provide a report to the HOD at each Interim Meeting highlighting the year's advocacy activities and should include efforts, successes, challenges, and recommendations/actions to further optimize advocacy efforts. The Board has prepared the following report to provide an update on American Medical Association (AMA) advocacy activities for the year to date. This report also includes an update on Policy D-65.972, "Updating the AMA Definition of Infertility." (Note: This report focuses heavily on the first half of the year based on approval deadlines, so more recent developments may not be reflected.)

In 2025, a new Administration and Congress took power in Washington, DC. The AMA's advocacy agenda initially focused on several issues that have been recent priorities for the AMA, including Medicare payment, prior authorization, physician-led team-based care, physician wellness, and practice/technology developments. Several other issues emerged as Congress started to dig in on its legislative agenda, including Medicaid, the Affordable Care Act, and student loans. While Congress did enact a 2.5 percent increase in Medicare payment for 2026, it also passed provisions that will make access to health care more difficult for some patients and hinder some potential medical students from receiving the loans that they need to further their education. The AMA has also spoken out about Administration actions on immunizations, preventive services, research funding, and other key issues.

As 2025 continues, the AMA will remain steadfast in its advocacy on the most important health care issues for physicians and patients. The AMA provides updates through several channels and resources discussed in this report that allow physicians to stay informed of its work and urges all physicians to act on the AMA's grassroots alerts to maximize their impact. This is a crucial time on a host of issues, and engagement is vital.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 09-I-25

Subject: 2025 AMA Advocacy Efforts

Presented by: David H. Aizuss, MD, Chair

---

This report is submitted for the information of the House of Delegates (HOD). Policy G-640.005, "AMA Advocacy Analysis," calls on the Board of Trustees (the Board) to provide a report to the HOD at each Interim Meeting highlighting the year's advocacy activities and should include efforts, successes, challenges, and recommendations/actions to further optimize advocacy efforts. The Board has prepared the following report to provide an update on American Medical Association (AMA) advocacy activities for the year to date. This report also includes an update on Policy D-65.972, "Updating the AMA Definition of Infertility." (Note: This report focuses heavily on the first half of the year based on approval deadlines, so more recent developments may not be reflected.)

DISCUSSION OF 2025 ADVOCACY EFFORTS

In 2025, a new Administration and Congress took power in Washington, DC. The AMA's advocacy agenda initially focused on several issues that have been recent priorities for the AMA, including Medicare payment, prior authorization, physician-led team-based care, physician wellness, and practice/technology developments. Several other issues emerged as Congress started to dig in on its legislative agenda, including Medicaid, the Affordable Care Act (ACA), and student loans. This led the AMA to attempt to mitigate some of the provisions in the sweeping legislative package. Initially, the AMA communicated its concerns in direct conversations outside the public eye but pivoted to a more public position once the legislative text was revealed. The AMA did reduce the harm caused by some of the more problematic provisions in the "*One Big Beautiful Bill Act*" (OBBBA), but the bill became law and ended up including several policy changes that will lead to fewer Americans having health insurance and fewer students being able to access needed medical school loans. The AMA is deeply disappointed with this result. Efforts will now turn to focus on providing physician practices information on how to limit the effects of the law on patients and recommendations for state implementation of new requirements in a way that minimizes coverage loss.

So far in 2025, the AMA has sent close to 100 comment letters to federal and state policymakers, as well as organized another 17 sign-on letters, on a host of issues. These efforts include some of the topics discussed above, but they also range from climate change to the overdose epidemic to immigration to maternal health and many others. AMA advocacy letters are available in the AMA's Federal and State Correspondence Finder. The AMA also offers the now weekly Advocacy Update newsletter as a way to stay abreast of AMA federal and state lobbying efforts. The AMA also urges physicians to attend the State Advocacy Summit and the National Advocacy Conference (NAC) as ways to learn about key issues, and with the NAC, lobby federal lawmakers directly in our nation's capital. And of course, please consider contributing to AMPAC.

© 2025 American Medical Association. All rights reserved.

*Medicare Payment*

The AMA is urging Congress to fix a broken Medicare payment system that is placing enormous financial pressure on physicians and threatening access to the care they provide. The fiscal stability of physician practices and long-term viability of the U.S. health care system is at stake because Medicare physician payment rates have plummeted 33 percent since 2001 (adjusted for inflation in practice costs). Congress failed to prevent or reverse a 2.83 percent payment cut that took effect on January 1, 2025, adding salt to the wound of prior cuts. Medicare payment reform is needed to remove a major financial stressor that physicians face, ensure access to care for patients, and put the overall health care system on a more sustainable path.

The AMA has rallied the Federation to support legislative efforts based on four key components:

- Automatic annual inflation-based updates;
- Budget neutrality;
- Revising the Medicare Merit-based Incentive Payment System (MIPS); and
- Supporting the development of Alternative Payment Models (APM).

The AMA sought to reverse the 2025 payment cut at the end of 2024, and this effort continued into 2025. At AMA's urging, over 170 House members signed on to support H.R. 879 that would reverse the cut and include a two percent payment increase. The AMA also prompted and is strongly supportive of the companion bill in the Senate (S. 1640). Congress needs to act before the situation deteriorates further.

In the House version of the OBBBA, there was a provision that included payment updates tied to the Medicare Economic Index (MEI) which the AMA supported. The Senate considered this option but chose to include a one-time 2.5 percent payment update in 2026 instead. The Senate version became the final version when OBBBA was enacted.

So far in 2025, the AMA Fix Medicare Now campaign has delivered strong grassroots results, generating over 85 million earned media and ad impressions, more than 2.2 million media and ad engagements, 670,000+ pageviews, 633,000+ site users, and 68,000+ contacts to Congress urging action on Medicare physician payment reform. The campaign has also secured over 150 third-party targeted media placements in influential publications and key congressional districts nationwide, reaching a total audience of more than 500 million.

There are signs of progress on other fronts, including MedPAC recommending to Congress that the 2026 Medicare payment update and the default payment update for all future years be linked to increases in the cost of providing care. Also, in its 2025 report, the Medicare Trustees said that, under current law, they "expect access to Medicare-participating physicians to become a significant issue in the long term."

An AMA-conducted claims analysis for Medicare add-on code G2211 found that the 2024 budget neutrality adjustment was overstated by nearly $1 billion. While this issue was not corrected in the proposed 2026 Medicare physician fee schedule (MPFS), the AMA will continue to call for the Centers for Medicare & Medicaid Services (CMS) to address this in the final MPFS rule. Under the Administration proposal, most physicians would see a conversion factor increase of 3.3 percent in 2026, while qualifying physicians in advanced APM would see an increase of 3.8 percent in 2026. These increases are primarily due to action by Congress to provide the temporary, one-year 2.5 percent pay boost for physicians in the OBBBA. However, these updates would be offset by a

proposed negative 2.5 percent "efficiency adjustment" that would be applied to all non-time-based services, including 8,961 physician services, and cuts to payments for physician services provided in the hospital or ambulatory surgery center due to the CMS belief that those physicians no longer maintain a separate office with separate overhead and non-clinical staff expenses. The AMA will continue to review the proposed MPFS and submit thorough comments on numerous issues.

The AMA also submitted the results of the Physician Practice Information Survey to CMS in early 2025. The resulting data impacting the MEI distributions and practice expense data were presented to national medical specialty societies and MedPAC.

Further, the AMA is lobbying the Administration on MIPS reform as part of its regulatory burden reduction efforts. Responding to AMA advocacy, CMS is allowing hardship exemptions for the 2025 MIPS cost category due to issues impacting practice operations, such as a cyberattack, and a new hardship exemption for 2024 MIPS due to the nationwide shortage of IV fluids.

For a more detailed discussion of the AMA's 2025 efforts on Medicare payment reform, please see Board Report 14-I-25 which focuses solely on this topic.

*Access to Care*

When it became clear that the Administration and Congress would propose making significant changes to health care safety net programs in 2025, the AMA engaged in conversations with individual members of Congress to share its policy and urge lawmakers to protect vulnerable patients. The AMA made the point repeatedly during the health care reform debate in 2009 that the uninsured live sicker and die younger, and that statement was still very relevant in the 2025 debate. While there were incremental improvements during the legislative discussions that will keep some potentially affected patients enrolled in health plans (e.g., per capita caps were not imposed, Federal Medical Assistance Percentage rates were not decreased, and the Medicaid expansion eligibility pathway was not eliminated), the end result is that nearly 10 million patients will lose their current coverage.

For months, the AMA engaged with specific "grasstops" physicians and states to express concerns about significant disruptions to Medicaid. When the House bill was released in early May, AMA issued a formal letter opposing the proposed Medicaid provisions. When the House was considering its reconciliation bill, the AMA wrote to Speaker Mike Johnson (R-LA) and Democratic Leader Hakeem Jeffries (D-NY) urging them to preserve Medicaid and the Children's Health Insurance Program, ACA coverage, and medical education loan availability. The AMA then launched a broader grassroots campaign calling for its physician and patient grassroots advocates to contact Congress on these issues too. When the House bill passed, the AMA turned its focus to the Senate and made the same requests to Majority Leader John Thune (R-SD) and Minority Leader Charles Schumer (D-NY). In the end, the OBBBA was enacted and included some difficult provisions on access to care including:

- The OBBBA creates new administrative requirements and conditions on eligibility (including work requirements) for patients seeking to enroll in or maintain Medicaid coverage and restricts states' ability to use provider taxes to finance their Medicaid programs.
- The OBBBA imposes verification requirements for patients in ACA marketplace plans receiving premium tax credits, including pre-enrollment verification requirements that will effectively end automatic re-enrollment for these patients. (The OBBBA does not address the scheduled expiration of enhanced tax credits at the end of 2025.)

- The OBBBA, in part, removes the ability for medical students to receive Federal Direct Stafford Loans and Federal Direct PLUS Loans, caps the amount that can be borrowed for school, and limits federal student loan borrowers to only two repayment options.

Moving forward on access to care, the AMA will seek to help physicians work with their patients to maintain eligibility. Further, the AMA is a member of a wide-ranging coalition, Keep Americans Covered, that is focused on extending the ACA subsidies which are set to expire at the end of 2025. The AMA will also seek ways to influence issues tied to OBBBA implementation to limit some of its harsher provisions. For example, the AMA recently submitted comments to CMS expressing strong concerns with a proposed rule that would establish new criteria to limit certain forms of Medicaid provider taxes impacting seven states, as well as prevent future states from adopting similar taxes. The AMA reiterated its support for provider taxes under certain circumstances and pointed out that allowing such reforms to be implemented will create significant gaps in state budgets, forcing states to raise taxes or reduce benefits, coverage, or provider payments, or a combination thereof. The next shoe to drop would then likely be practice and hospital closures and jeopardized access in vulnerable communities.

*Prior Authorization*

Physicians and patients remain frustrated by the excessive use of prior authorization by insurers to delay or deny much-needed care. The AMA is fighting to remove obstacles to patient care by reforming the prior authorization process in a way that lessens the burdens on physicians, reduces burnout, and leads to improved outcomes for patients.

According to the most recent AMA research:

- Patient harm – More than one in four physicians (29 percent) reported that prior authorization has led to a serious adverse event for a patient in their care, including hospitalization, permanent impairment, or death.
- Bad outcomes – More than nine in 10 physicians (94 percent) reported that prior authorization has a negative impact on patient clinical outcomes.
- Delayed care – More than nine in 10 physicians (93 percent) reported that prior authorization delays access to necessary care.
- Disrupted care – More than three-fourths of physicians (82 percent) reported that patients abandon treatment due to authorization struggles with health insurers.
- Shifted costs – Four in five physicians (80 percent) reported that prior authorization delays or denials "at least sometimes" make patients pay out of pocket for medications.
- Lost workforce productivity – More than half of physicians (58 percent) who cared for patients in the workforce reported that prior authorizations had impeded a patient's job performance.

AMA secured an important victory for physicians in 2024 in the CMS final rule that requires government-regulated health plans to reduce the timeframes for prior authorization decisions and to publicly report program metrics, which will reduce care delays and improve transparency. AMA continues to monitor implementation to ensure that the goals of the rule come to fruition.

In June 2025, AHIP and Blue Cross Blue Shield Association (BCBSA) announced that over 50 of their member/licensed plans were pledging to voluntarily improve prior authorization. The AMA response to the announcement highlighted the role of AMA advocacy in this development and noted the similarity between this most recent commitment and agreements plans made in the 2018 Consensus Statement on Improving the Prior Authorization Process. The AMA is pleased with the

announcement but will remain vigilant in monitoring insurer compliance. The AMA was also encouraged that CMS Administrator Mehmet Oz, MD, and Department of Health and Human Services (HHS) Secretary Robert F. Kennedy, Jr, held a press event coinciding with the June 2025 AHIP/BCBSA announcement that supported the industry reforms.

Despite these developments, on June 27 CMS announced a new CMMI model called the Wasteful and Inappropriate Service Reduction (WISeR) Model. The WISeR Model will create new prior authorization requirements in Medicare Fee for Service (FFS) for 17 services in six states over six performance years, beginning in January 2026. Prior authorization reviews will be conducted by vendors using augmented intelligence and machine learning. The AMA sent a letter to CMS expressing significant concerns about this development and urging a pause in implementation.

The AMA continues to work to provide medical societies with legislative language, talking points, testimony, data, and other resources to push for important prior authorization reforms in state legislatures. More than 20 prior authorization bills have been enacted in the last year (AZ, AR, CO, GA, HI, IN, IA, MD, MT, NE, NM, ND, NV, OK, OR, RI, TN, TX, UT, VA, VT, WA). Broadly, state bills are aiming to decrease the growing volume of PA requirements, reduce delays in patient care associated with prior authorization, improve the transparency of prior authorization rules, and increase reporting of prior authorization data. AMA resources have been critical to state success. The AMA continues to advocate to national policymaking organizations (e.g., the National Association of Insurance Commissioners and the National Council of Insurance Legislators) on the importance of reform and enforcement. The AMA works closely with coalitions of other impacted organizations, including patient advocacy groups, to make the case for important patient protections from payers' utilization management requirements. In addition, the AMA testified before an advisory council tasked with recommending to the Department of Labor (DOL) possible regulatory changes to improve how employer-sponsored health plans regulated under the Employee Retirement Income Security Act of 1974 use PA requirements to manage their claims and appeals procedures. The AMA urged the advisory council to recommend changes to DOL's rules to reduce the burden and harm these programs have on physicians and patients. The advisory council's report aligned with many of the AMA's recommendations.

At the AMA's urging, the House and Senate reintroduced the "Improving Seniors' Timely Access to Care Act of 2025" (H.R. 3514; S. 1816). This bicameral, bipartisan legislation seeks to reform prior authorization in Medicare Advantage plans by improving transparency through public reporting of program metrics and streamlining the process using standard electronic transactions. As of July, the legislation has already garnered tremendous bipartisan congressional support, specifically securing 51 Senate and 135 House cosponsors. Additionally, the House reintroduced the "Reducing Medically Unnecessary Delays in Care Act of 2025" (H.R. 2433), bipartisan legislation that seeks to reform prior authorization requirements in Medicare, Medicare Advantage, and Part D prescription drug plans by ensuring that only specialty board-certified physicians review treatment decisions.

*Physician-led Team-based Care*

Patients want, expect, and deserve medical care led by a physician, whose expertise and training are unmatched in medicine. The AMA is fighting inappropriate scope expansion attempts at both the state and federal levels. The AMA Scope of Practice Partnership (SOPP), a coalition of 113 national, state and specialty medical and osteopathic associations, has been instrumental in pushing back on expansion efforts that could harm patients and has awarded more than $4.8 million in grants to states to fund advocacy tools and campaigns since 2007. The SOPP Steering Committee

has awarded 14 grants to SOPP members in 2025: AZ, GA, ID, IN, KY, ME, MD/AAO-HNS, NE, NH, NM, OH, PA, SC and TX.

So far in 2025, over 40 states have seen scope expansion efforts, and the AMA, in conjunction with the Federation, has achieved success on over 100 bills, with key wins in MO, MS, NM, TX, and WA. The common bill topics are attempts to: remove physician supervision of or collaboration with nurse practitioners or advanced practice registered nurses (APRN); allow optometrists to perform surgery; remove/weaken physician supervision or collaboration of physician assistants; pass pharmacist test and treat legislation; allow nurse anesthetists to provide anesthesia care without any physician involvement; create a license for naturopaths and/or allows naturopaths to prescribe medications, perform minor surgeries, or order and interpret diagnostic tests; and permit psychologists to prescribe.

At the federal level, the AMA continues to lead a coalition to oppose the Department of Veterans Affairs (VA) Supremacy Project, which aims to set national standards of practice for all health professionals that provide care in the VA system. The AMA also submitted a Federation sign-on letter in opposition to H.R. 3164, the "Ensuring Community Access to Pharmacist Services (ECAPS) Act." Despite efforts to modify the text of this legislation from the 118th Congress, this bill still has numerous shortcomings, including inappropriately allowing pharmacists to perform services that would normally only be authorized and covered if they were furnished by a physician, testing and treating patients for certain illnesses, and expanding Medicare payment for pharmacists in limited but significant ways.

Finally, the AMA continues to update and create new resources to educate lawmakers on the importance of physician-led care and why inappropriate scope expansions threaten patient safety, including our data series modules, GEOMAPS, Health Workforce Mapper, Issue Briefs, and one-pager series.

*Physician Wellness*

The AMA remains steadfast in its advocacy to advance physician wellness. At the federal level, the AMA is calling for the reauthorization of the "Dr. Lorna Breen Health Care Provider Protection Act." Further, after more than a year working with Senator Tim Kaine's (D-VA) office, the annual National Defense Authorization Act (NDAA) legislation will require the Department of Defense (DoD) to review its policies for credentialing health care workers to remove barriers to accessing mental health care. The combined efforts of the AMA and the Dr. Lorna Breen Heroes' Foundation identified areas in DoD policy inconsistent with AMA policy to avoid using stigmatizing, inappropriate language concerning mental and behavioral health. Working together, the AMA provided technical analysis and language for the NDAA, and will continue to work with Sen. Kaine and the U.S. Senate to ensure that the language will stay in the final must-pass bill. AMA will also continue to work with Sen. Kaine and DoD to provide ongoing technical support.

At the state and health system levels, the AMA continues to advocate for removing requirements for physicians to disclose whether they have received treatment for a mental health, behavioral health, or other health condition when there is no current impairment. AMA direct advocacy and resources supported the enactment of four new state laws (CO, AZ, MT, VA), changes by six state medical boards (AK, CA-DO, NV, PA-MD, PA-DO, WA-DO), and updates by 181 new hospitals across 20 health systems this year. AMA advocacy helped reverse a decision by New Hampshire regulators to discontinue the state physician health program.

*Ensuring Technology Works for Physicians*

Technology has an increasingly important role to play in care delivery, streamlining the physicians' workday and improving patient outcomes. It is critical that digital health tools work as they are supposed to and are not just one more burden placed on physicians. Many health technology tools that come to market are poorly designed and fail to deliver on their exciting promise in the clinical environment. The AMA is working to ensure that new health technology, including augmented intelligence (AI) and telehealth, reaches its full clinical potential by providing support for technology adoption, developing the appropriate guardrails for implementation, and by giving physicians a seat at the table in the early stages of technology design.

This is a broad category of topics, but highlights of the AMA's efforts include: working closely with the Federation to shore up gaps in Health Insurance Portability and Accountability Act regulations; providing substantive feedback on federal and state AI requests for information, regulations, and legislation—which is reflected in several proposed policies; participating in a National Conference of State Legislatures work group on AI; and establishing an AI Medical Specialty Collaborative of over 35 organizations, including front-line physicians.

Recent successes include the Food and Drug Administration releasing significant draft guidance for AI developers that incorporates AMA recommendations; three states (AZ, MD, NE) have enacted laws this year to place guardrails on payers'/health plans' use of AI, consistent with AMA policy/AI principles; and electronic health record developers being prohibited from using technical, contractional, or financial roadblocks to prevent physician-provider and physician-patient information exchange.

Finally, the AMA wrote an opinion piece in The Hill on the new Administration AI proposal. In the piece, the AMA called for a "broad, well-coordinated federal regulatory approach to AI design and integration," and also stated "strong physician representation must be present at every stage" if AI in health care will meet its full potential.

*Student Loans*

The OBBBA created more barriers to prospective students pursuing careers in medicine despite AMA objections. In letters to House and Senate leaders, the AMA expressed its deep concern about the negative ramifications of this bill and asked that, at a minimum, carveouts be provided for medical school education to ensure that the nation can continue to educate the next generation of physicians. Medical education remains the most expensive post-secondary education in the U.S. with about 71 percent of medical students graduating with a mean of over $212,000 in educational debt. Unfortunately, the final provisions in the OBBBA disqualify graduate and professional students from receiving Federal Direct PLUS Loans after July 1, 2026; place a ceiling on the amount of Federal Direct Unsubsidized Stafford Loans that will not fully cover medical school costs for some students; places new requirements on loan repayment; and will limit the ability of borrowers to defer loans based on unemployment or economic hardship, among other new requirements. The AMA will monitor the effect of these provisions closely and will seek ways to blunt their impact.

*Advisory Committee on Immunization Practices (ACIP)*

The AMA was extremely concerned with the proposed changes to the Advisory Committee on Immunization Practices (ACIP) membership. The AMA issued a statement opposing the removal of the sitting members of ACIP, as well as a subsequent statement expressing concern over the

selection of new members without transparency and proper vetting. The AMA also sent a letter to Senator Bill Cassidy, MD, (R-LA) urging, "An inquiry as to the circumstances surrounding the decision to remove and replace all sitting members of ACIP." In addition, the AMA and nearly 100 state medical associations and national medical specialty societies sent a sign-on letter to HHS Secretary Robert F. Kennedy, Jr., expressing deep concern over the termination of the 17 ACIP members. The AMA continues to monitor this situation and seek ways to ensure that ACIP recommendations maintain their scientific integrity.

The AMA also joined several Federation members and other health care groups to write an open letter to the American public regarding vaccines and respiratory viruses. The groups reaffirmed support for vaccinations as the best way to protect against the flu, COVID-19, and RSV. The letter authors also called on insurers, hospitals, and public health agencies to ensure vaccines remain available to patients without cost sharing.

The AMA weighed in again when it was announced that volunteer members from the AMA and other physician and health care organizations would be removed from ACIP work groups. The removal of these medical experts is very alarming. On a similar front, the AMA expressed its concern regarding mRNA research funding cuts announced on August 5, 2025. The AMA stated "COVID-19 vaccines using mRNA technology helped saved countless lives during the pandemic. We urge the Administration to continue vital research to improve mRNA vaccines, not throw the baby out with the bathwater by effectively preventing research from moving forward."

*United States Preventive Services Task Force (USPSTF)*

When media reports started to circulate in late July that the members of the United States Preventive Services Task Force (USPSTF) could be removed, the AMA wrote to Secretary Kennedy and urged him not to do so. The AMA reiterated that the USPSTF plays a critical, non-partisan role in guiding physicians' efforts to prevent disease and improve the health of patients by helping to ensure access to evidence-based clinical preventive services. Besides asking the Secretary to retain the previously appointed members of the USPSTF, the AMA also called for his commitment to the long-standing process of regular meetings to ensure the important work of the USPSTF can continue without interruption. The USPSTF has long played an essential role in making evidence-based recommendations for clinical prevention of disease. USPSTF members have been selected through an open, public nomination process and are nationally recognized experts in primary care, prevention and evidence-based medicine. They serve on a volunteer basis, dedicating their time to help reduce disease and improve the health of all Americans. Importantly, the USPSTF puts forth recommendations that dictate coverage policy for health insurers nationwide. By law, insurers must cover USPSTF-recommended services without cost sharing.

*Research Funding*

The AMA has voiced its concern over the impact of proposed and implemented research funding cuts. On July 16, the AMA sent a letter to the House and Senate Appropriations Committees advocating against proposed cuts to the National Institutes of Health (NIH). In the letter, the AMA stressed the concern surrounding the proposed cuts to the NIH. While the AMA shares the Administration's goals of reducing chronic disease and is strongly committed to prioritizing actions to ensure a healthier America, these proposed cuts would have serious negative consequences for the development of new treatments and cures, and the overall health of the American people. The AMA will continue to work with the Chair and Ranking Members of both the House and Senate Appropriation Committees to ensure that the NIH does not see a 40 percent reduction in funding.

*Reproductive Health*

The AMA strongly opposes the interference of government in the practice of medicine and strongly opposes laws that prohibit physicians from providing evidence-based medical care that is in the best interest of their patients. The AMA supports patients' access to the full spectrum of reproductive health care options, including abortion and contraception, as a right. The AMA continues to work closely with state medical associations to make sense of confusing legal obligations in restrictive states, identifying strategies to mitigate harm, and advocating against new restrictive laws.

The AMA Task Force to Preserve the Patient-Physician Relationship convened in-person meetings in February and July. The Task Force includes 29 physician leaders from AMA Councils, state medical associations, and national medical specialty societies. The February agenda addressed payment and reimbursement for gender-affirming care and the July meeting agenda addressed challenges in workforce, training, and education stemming from abortion and gender-affirming care restrictions. The Task Force identified multiple potential deliverables to expand access to care, as well as training opportunities and support for the physician workforce. These deliverables are in addition to ongoing projects of the task force including support for legal defense resources and legal guidance for physicians, development of a website to serve as a resource hub for physicians, collaboration on guidance for institutions, opinion research to inform advocacy messaging, and others. The resource hub website will be released prior to the Interim Meeting.

In accordance with Policy D-65.972, the AMA expressed concern to the health insurance industry that some health plans discriminate in coverage of fertility services on the basis of marital status, sexual orientation, or gender identity. Further, the AMA Advocacy Resource Center communicated with state medical associations and national medical specialty societies about the AMA's willingness to work with interested organizations on policies to address such discrimination in coverage of fertility services. Use of marital status, sexual orientation, or gender identity in the definition of infertility is restrictive and outdated. These exclusions are not medically justified and serve only to entrench inequities in access to reproductive care. The AMA calls for health plans to adopt infertility coverage policies that reflect the American Society for Reproductive Medicine definition of infertility to protect patients from discrimination on the basis of who they are or how they form their families.

*Maternal Health*

The AMA continues to address disparities in maternal health outcomes. In line with the Administration's efforts to reduce regulatory burden, the AMA has advocated that CMS revoke expensive, burdensome conditions of participation that require all hospitals and critical access hospitals (CAHs) to meet numerous requirements to provide obstetrical services, which could exacerbate the growth in maternal health deserts. At a minimum, CMS should exempt rural hospitals and CAHs. On April 14, the AMA sent a letter to the House and Senate in support of the Rural Obstetrics Readiness Act (H.R. 1254/S. 380), which would provide grant funding toward evidence-based training programs on emergency obstetrics services for rural health care facilities without dedicated obstetrics units. On March 28, the AMA sent a letter in support of the Connected MOM Act (S. 141), which would require CMS to report on, and provide resources for states related to, coverage of remote physiologic devices and related services (e.g., blood glucose monitors) under Medicaid.

*Overdose Epidemic*

The nation's drug-overdose epidemic killed more than 80,000 Americans in 2024—a welcome decrease from recent years—but still a historic and tragic level. The AMA continues its advocacy to policymakers and other stakeholders—including health insurers, pharmacy benefit management companies, and national pharmacy chains—to remove barriers to evidence-based care for opioid use disorder and for pain and increase access to naloxone and other proven harm reduction initiatives. The AMA supports H.R. 2483, the "SUPPORT for Patients and Communities Reauthorization Act of 2025" to reauthorize billions of dollars in federal funding to help combat the opioid crisis. This legislation passed overwhelmingly in the House and is pending in the Senate. The AMA urges states to use opioid litigation settlement funds on public health and treatment initiatives, and the AMA is working with several national patient advocacy groups to help ensure states are transparent and accurately reporting where settlement funds are being spent. The AMA helped at least three states (CO, VA, WA) strengthen their mental health and substance use disorder parity laws in 2025.

*Climate Change*

The AMA has been very active in the area of climate change and health. In the summer of 2025, the AMA hosted a successful three-part webinar series on climate change and health covering: The Hidden Health Impacts of Climate Change, Climate Resiliency in Health Care, and Decarbonizing the Health Care Sector. The AMA provided public comment on the risk of repealing the Endangerment Finding related to vehicle emission standards. The AMA also provided public comment in response to the EPA proposed rule, "Repeal of Greenhouse Gas Emissions Standards for Fossil Fuel-Fired Electric Generating Units." The AMA maintains a strong presence with the Medical Societies Consortium on Climate and Health (MSCCH), a group that comprises over 100 medical societies and allied health groups in the US. The AMA serves on the executive committee of the consortium. Additionally, through the MSCCH the AMA represents the US to the Global Climate and Health Alliance. The *AMA Journal of Ethics* in August 2025 considered physicians' duties amid nuclear and climate threats. The AMA also hosted a webinar on improving environmental sustainability in medical practice. Also, earlier in 2025, the MSCCH gathered 86 groups to thank the Occupational Safety and Health Administration (OSHA) for proposing a new heat injury and prevention standard to better protect workers from heat-related health risks. There has been long-term interest in this issue, and with summers getting hotter and heat waves more frequent and severe, this is an urgent issue. The Consortium called on OSHA to finalize and implement this proposed standard quickly to save lives and protect the communities the signing organizations serve.

*Pharmacy Benefit Managers (PBMs)*

The AMA is supporting H.R. 4317, the "Pharmacy Benefit Manager (PBM) Reform Act of 2025," a bipartisan effort to bring long-overdue transparency, accountability, and fairness to the PBM industry. The PBM Reform Act of 2025 encompasses a comprehensive set of provisions designed to increase transparency, accountability, and fairness in the prescription drug supply chain. The bill would ban spread pricing in Medicaid and establish a transparent reimbursement model to ensure pharmacies are fairly compensated for serving beneficiaries. It would also decouple PBM compensation from drug costs, enhance transparency for employers and patients, and authorize the HHS to define and enforce reasonable contract terms.

The AMA furthered its PBM research base this year with the release of the *Competition in PBM Markets and Vertical Integration of Insurers with PBMs: 2025 Update*. Key findings include that

the four largest PBMs collectively had a 67 percent share of the national PBM market in 2023. OptumRx was the largest PBM in the U.S. in 2023 with a 22.2 percent market share—up slightly from 20.8 percent in 2022. It is followed by CVS Health with an 18.9 percent share—down from 21.3 percent in 2022. Express Scripts was third largest with a 15.5 percent share, followed by Prime Therapeutics with a 10.6 percent share. Nationally in 2023, 77 percent of prescription drug plan (PDP) lives were covered by an insurer that is vertically integrated with a PBM.

*Physician Shortages*

The U.S. is facing a rising shortage of physicians largely due to the growth and aging of the general population and the impending retirement of many physicians. There is a projected shortage of up to 86,000 physicians by 2036. The AMA is supporting H.R. 3890, the "Resident Physician Shortage Reduction Act of 2025," to address the projected shortfalls. This bipartisan legislation would gradually raise the number of Medicare-supported graduate medical education positions by 2,000 per year for seven years, for a total of 14,000 new slots. A share of these positions would be targeted at hospitals with diverse needs including hospitals in rural areas, hospitals serving patients from health professional shortage areas, especially those hospitals affiliated with historically Black medical schools, hospitals in states with new medical schools or branch campuses, and hospitals already training over their caps.

*International Medical Graduates*

The AMA recognizes the critical role that non-U.S. citizen International Medical Graduates (IMG) play in alleviating the physician shortage by providing health care to many Americans, especially in communities in need. The AMA is supporting several bills that would alleviate some of the more onerous issues that IMG physicians face. In April, the AMA sent a letter expressing support for H.R. 1201, the "Doctors in our Borders Act," which would expand the number of Conrad 30 waivers a state or regional commission can receive from 30 to 100. Earlier in March, the AMA sent a letter to both the House and Senate expressing support for H.R. 1585/S. 709, the "Conrad State 30 and Physician Access Reauthorization Act," which would reauthorize and make targeted improvements to the J-1 visa waiver program in a manner that helps alleviate the shortage of physicians, especially in rural and underserved areas, and promotes a more diversified workforce. Also in March, the AMA signed onto a letter to both the House and Senate co-signed with 45 organizations in strong support of the introduction of the "Conrad State 30 and Physician Access Reauthorization Act" (H.R. 1585/S. 709).

Finally, the AMA sent a letter to Secretary of State Marco Rubio regarding J-1 appointments for foreign national physicians which were paused by the U.S. Department of State (DOS). The AMA HOD adopted Resolution 237-A-25 in response to concerns over this pause. Shortly after the AMA's letter was submitted, the DOS announced that interviews for visas will no longer be paused and that interview availability for physicians will be prioritized. The Educational Commission for Foreign Medical Graduates (ECFMG), the universal sponsor for J-1 physicians, worked aggressively to provide an exception and prioritization for physicians throughout this interview pause that began in May of 2025. The AMA was in constant contact with and supported ECFMG in this effort.

*Medical Liability Reform*

The AMA has been working with state medical associations to enact medical liability reforms that would stop, or at least limit, efforts to scale back existing tort reforms. The AMA is working with the Montana Medical Association to protect existing tort reforms anticipating challenges in next

year's session. More recently, at the request of the Florida Medical Association, the AMA wrote a letter to the Governor of Florida to veto a bill that would have greatly expanded physician malpractice liability in wrongful death cases, and the Governor did in fact veto that bill. The AMA also supported the Rhode Island Medical Society in an effort to defeat a bill that would have repealed Rhode Island's collateral source rule. A recently published AMA Policy Research Perspective finds a clear upward trend in the prevalence of medical liability premium increases over the past six years (2019-2024), a pattern not observed since the early 2000s and which merits further monitoring. The AMA also published an updated version of MLR Now! which is a good resource on this topic.

*Physician-owned Hospitals*

The AMA is supporting the "Patient Access to Higher Quality Health Care Act of 2025," which would repeal the ACA's restrictions on the whole hospital exception to the Stark physician self-referral law, thereby eliminating statutory and regulatory barriers that prevent the formation or expansion of physician-owned hospitals (POHs). POHs provide high quality care to patients and introduce much-needed competition in the health care industry. Unfortunately, the ACA imposed severe restrictions on POHs, banning new physician-led hospitals and sharply limiting the ability of existing POHs to grow. These constraints have been compounded by regulatory changes made in 2022 which reversed a prior effort to ease restrictions on POHs serving Medicaid populations and further narrowed the circumstances under which expansion is allowed. The AMA has urged HHS and CMS to rescind the latter regulatory barriers.

*No Surprises Act*

On July 24, the AMA wrote to both the House (H.R. 4710) and the Senate (S. 2420) to support the "No Surprises Act Enforcement Act." The AMA continues to stand behind the intended goal of the No Surprises Act (NSA)—to protect patients from surprise medical bills while ensuring physicians and health care providers receive fair payment for services provided. A careful balance was reached with passage of the NSA, and successful implementation of the law requires all parties to abide by the requirements of the statute. Unfortunately, many health plans are failing to do so. It is the AMA's understanding that many physicians are not receiving payment from health plans within the statutory 30-day time period following an Independent Dispute Resolution (IDR) decision in their favor, and in fact, many physicians continue to report receiving no payment at all. These bills would help enforce IDR decisions and reestablish the balance achieved in the statute.

AMA ADVOCACY ONGOING UPDATES AND MEETINGS

The AMA offers several ways to stay up to date on our advocacy efforts, and we urge the HOD to avail themselves of all of them to stay informed and advance our grassroots efforts:

- As mentioned earlier in the report, please sign up for AMA Advocacy Update a weekly newsletter that provides updates on AMA legislative, regulatory, and private sector efforts. We try to make sure all HOD members are on the email list, but if you are not receiving AMA Advocacy Update, please subscribe and encourage your colleagues to do so as well. Subscribers can read stories from previous editions here.
- Join the Physicians Grassroots Network for updates on AMA calls to action on federal legislative issues. And if you have connections with members of Congress, or are interested in developing one, the Very Influential Physician (VIP) program can help grow these relationships.
- Connect with the Physicians Grassroots Network on Facebook, X, and Instagram.

The AMA also encourages HOD members to attend the State Advocacy Summit and National Advocacy Conference. The 2026 State Advocacy Summit will take place on Jan. 8-10 at the Terranea Resort in Rancho Palos Verdes, California. The 2026 National Advocacy Conference will occur on Feb. 23-25 at the Grand Hyatt in Washington, D.C.

Finally, please consider contributing to AMPAC as another way to engage in AMA advocacy efforts.

CONCLUSION

The AMA and the Federation of Medicine are fighting for physicians and patients on the top health care issues in 2025. There has been progress on some priorities, but there have also been some setbacks. The AMA will continue to fight to make inroads at both the federal and state levels. Please stay informed of the AMA's efforts through the resources listed in this report, and it is vital that physicians make their voices heard when the AMA issues grassroots calls to action.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 14-I-25

Subject: AMA Efforts on Medicare Payment Reform and Increasing Transparency of AMA Medicare Payment Reform Strategy

Presented by: David H. Aizuss, MD, Chair

---

This report is submitted for the information of the House of Delegates (HOD). At the 2023 American Medical Association (AMA) Annual Meeting of the HOD, the HOD adopted Policy D-385.945, "Advocacy and Action for a Sustainable Medical Care System" and amended Policy D-390.922, "Physician Payment Reform and Equity." Together, they declare Medicare physician payment reform as an urgent advocacy and legislative priority, call on the AMA to implement a comprehensive advocacy campaign, and for the Board of Trustees (the Board) to report back to the HOD at each Annual and Interim meeting highlighting the progress of our AMA in achieving Medicare payment reform until a predictable, sustainable, fair physician payment system is achieved. In addition, the House adopted Policy D-400.981, "Increasing Transparency of AMA Medicare Payment Reform Strategy," which calls on the AMA to:

1. Our American Medical Association provide a summary of findings and actionable recommendations from both internal and external advocacy consultants regarding Medicare payment reform. The report must primarily focus on barriers identified, gaps in the current strategy, and specific recommendations for improving and accelerating advocacy efforts.

2. Our AMA share with its members comprehensive reports on our Medicare payment reform advocacy efforts, including consultant findings on major barriers, strategy gaps, and recommendations for improvement, at both the Interim and Annual Meetings beginning at I-25, and more frequently as legislative dynamics dictate.

The Board has prepared the following report to provide an update on AMA activities for the year to date. (Note: This report was prepared in August based on approval deadlines, so more recent developments may not be reflected in it.)

## AMA ACTIVITIES ON MEDICARE PHYSICIAN PAYMENT REFORM

The AMA's Medicare physician payment reform efforts were initiated early in 2022, following the development of a set of principles outlining the "Characteristics of a Rational Medicare Payment System" that was endorsed by 124 state medical associations and national medical specialty societies. These principles identified strategies and goals to: (1) ensure financial stability and predictability for physician practices; (2) promote value-based care; and (3) safeguard access to high quality care.

Subsequently, the AMA worked with Federation organizations to identify four general strategies to reform the Medicare payment system, including:

© 2025 American Medical Association. All rights reserved.

- Automatic annual payment updates based on the Medicare Economic Index (MEI);
- Updated policies governing when and how budget neutrality adjustments are made;
- Simplified and clinically relevant policies under the Merit-based Incentive Payment System (MIPS); and
- Greater opportunities for physician practices wanting to transition to advanced alternative payment models.

At the heart of the AMA's unwavering commitment to reforming the Medicare physician payment system lie four central pillars that underscore our strategic approach: legislative advocacy; regulatory advocacy; federation engagement; and grassroots, media, and outreach initiatives. Grounded in principles endorsed by a unified medical community, our legislative efforts drive the advancement of policies that foster payment stability and promote value-based care. We actively champion reform through regulatory channels, tirelessly engaging with crucial agencies such as the Centers for Medicare & Medicaid Services (CMS) and the White House to address impending challenges and ensure fair payment policies. Our federation engagement fosters unity and consensus within the broader medical community, pooling resources and strategies to amplify our collective voice. Lastly, our continued grassroots, media, and outreach efforts bridge the gap between policymakers and the public, ensuring our mission is well-understood and supported from all quarters. Together, these pillars fortify our endeavors to achieve a more rational Medicare physician payment system that truly benefits all.

*Legislative Advocacy*

The AMA shares its members' deep frustration over persistent Medicare payment cuts. While Congress mitigated approximately half of the 2024 cuts initially implemented in January 2024, physicians continue to sound the alarm that two decades of annual reductions are jeopardizing practice viability and limiting patient access to care. Unfortunately, the final 2025 Medicare Physician Fee Schedule imposed an additional 2.83 percent cut.

An early draft of a year-end legislative package in December 2024 included a proposal to address 2.5 percent of the scheduled cut. However, the larger draft proposal collapsed under political pressure largely resulting from an Elon Musk tweet, and the scaled-down spending package that ultimately passed, failed to address the payment cuts. As a result, physicians faced Medicare cuts for the fifth consecutive year, which went into effect on January 1, 2025. Meanwhile, the MEI increased by 3.5 percent in 2025, further widening the gap between what Medicare pays physicians and the actual cost of delivering quality care.

The financial stability of physician practices and the long-term sustainability of our nation's health care system are at serious risk. Medicare physician payment rates have effectively plummeted 33 percent from 2001 to 2025, when adjusted for inflation in practice costs. Addressing this widening gap is essential to ensure physicians can continue providing high-quality care to Medicare patients.

Fixing our unsustainable Medicare payment system remains an urgent advocacy and legislative priority for the AMA. The need to stop the annual cycle of pay cuts and patches and enact permanent Medicare payment reform could not be clearer. With Congress failing to reverse these cuts, millions of seniors will find it more difficult to access high-quality care, and physicians will be less able to accept new Medicare patients. The impact will be especially detrimental in rural and underserved areas and for small, independent physician practices that care for our nation's most vulnerable patients.

As a result of the continued advocacy by the AMA, Federation partners, and the broader physician community, common sense legislation has been introduced to reform the broken Medicare payment system. These bills reflect elements of the AMA-developed framework, "Characteristics of a Rational Medicare Physician Payment System."

Medicare Reform: Automatic Annual Inflation-Based Updates

The AMA and our Federation partners continue to press Congress to reverse the 2.83 percent cut that took effect on January 1, 2025. At the same time, we are urging lawmakers to enact automatic, annual inflation-based payment updates to ensure that Medicare payment keeps pace with rising practice costs.

Medicare Payment Reform: Budget Neutrality

In 2024, the GOP Doctors Caucus introduced H.R. 6371, a bill that would have addressed long-standing flaws in Medicare's budget neutrality policies. Strongly supported by the AMA, this legislation sought to compel CMS to correct inaccurate utilization projections and raise the budget neutrality threshold from $20 million to $53 million. While this bill did not pass, the AMA is now advocating for similar provisions in the 119th Congress to help mitigate the compounding impact of flawed budget adjustments on physician payment.

Medicare Payment Reform: Revising the MIPS Program

The AMA, working with Federation organizations, has also developed legislative language to reform MIPS. These reforms would target the program's disproportionate burden on small and rural practices, seek to provide physicians with more timely and actionable data from CMS, and streamline MIPS to make it more clinically relevant and less administratively complex.

*119th Congress AMA Advocacy Highlights*

In January 2025, Representatives Greg Murphy, MD (R-NC), and Jimmy Panetta (D-CA) introduced H.R. 879, the Medicare Patient Access and Practice Stabilization Act. Backed by more than 120 bipartisan cosponsors, the bill sought to reverse the 2.83 percent Medicare payment cut and replace it with a two percent increase. The following month, the AMA led a broad coalition of more than 80 organizations, including all 50 state medical associations and the Medical Society of the District of Columbia, in a sign-on letter urging Congress to pass the bill. In March, the AMA and its partners pressed for H.R. 879 to be included in the continuing resolution. That effort ultimately failed because the White House insisted on a "clean package" so neither H.R. 879 nor any related provisions made it into the final package. The cut remained in place, further destabilizing physician practices

*National Advocacy Conference – February 2025*

At the February 2025 National Advocacy Conference, the AMA launched its "Fix Medicare Now" campaign with a kickoff event at the Cannon House Office Building. Lawmakers including Representatives Murphy, Panetta, Schrier, Miller-Meeks, Joyce, Ruiz, Bera, and Kennedy joined to show their support. More than 350 physicians participated in Capitol Hill meetings, urging lawmakers to pass H.R. 879 and take Senate action. The AMA amplified its message with a full-page ad in The Hill and distributed advocacy kits that emphasized the 33 percent drop in Medicare payments since 2001, adjusted for inflation. The event also featured remarks from other key

Representatives, including Conaway, Onder, Krishnamoorthi, Dexter, Morrison, DeGette, and McCormick.

*Grassroots, Media, and Outreach*

The AMA has maintained a continuous drumbeat of grassroots contacts through its Physicians Grassroots Network, Patients Action Network, and its Very Influential Physicians program. Op-eds have been placed in various publications from AMA leaders, as well as from "grasstops" contacts in local newspapers. Digital advertisements are running targeted specifically to publications read on Capitol Hill, and media releases have been issued to highlight significant developments.

The AMA has a dedicated Medicare payment reform web site, www.FixMedicareNow.org, which includes a range of AMA-developed advocacy resource material, updated payment graphics and a new "Medicare basics" series of papers describing in plain language specific challenges presented by current Medicare payment policies and recommendations for reform.

To support the Medicare legislation cited above, the AMA has been engaged in a major grassroots campaign to engage patients and physicians in our lobbying efforts. The following statistics from January through the end of June 2025 result from the Fix Medicare Now campaign and engagement with the Physician Grassroots Network and Patients Action Network.

- 85+ million in earned media and ad impressions
- 2.2+ million media and ad engagements
- 670,000+ pageviews
- 633,000+ site users
- 68,000+ contacts to Congress
- 150+ third-party media placements and grass top contacts made in key Congressional districts

*Senate Legislation and H.R. 1*

In April, Senator Roger Marshall (R-KS) introduced the Senate companion bill, S. 1640. AMA advocacy staff were highly involved in drafting this legislation, ensuring it was responsive to the real-time 2025 Medicare cuts.

Separately, H.R. 1, the One Big Beautiful Bill Act (OBBBA) initially included strong Medicare physician payment reform provisions, including a 75 percent MEI update for 2026 and a permanent annual update of 10 percent MEI thereafter. These provisions marked the first time since the Medicare Access and CHIP Reauthorization Act (MACRA) in 2015 that physician payment updates would be permanently built into baseline Medicare rates.

The AMA advocacy team was instrumental in the development and inclusion of these House-passed Medicare provisions. Section 44304, which linked the update to inflation in practice costs using the MEI, reflected AMA policy and decades of advocacy, and was recently echoed in recommendations by the Medicare Payment Advisory Commission.

These provisions passed the House of Representatives. However, the Senate scaled the proposal back to a temporary 2.5 percent update for 2026.

The final version of H.R. 1, passed by the Senate, retained only the temporary one-year 2.5 percent conversion factor update—with no permanent, inflation-adjusted fix. Still, the inclusion of any

update represented forward movement and provides important momentum for continued advocacy in the 119th Congress.

*Advocacy with MedPAC and Looking Forward*

The AMA has continued to engage directly with the Medicare Payment Advisory Commission (MedPAC) to push for reforms aligned with physician needs. Earlier in 2025, MedPAC signaled a notable shift by recommending an MEI minus 1 percent update for 2026, a departure from its longstanding reluctance to support any inflation-based adjustments. By June, MedPAC went further, voting to recommend permanent annual payment updates tied to MEI growth. This marked a major policy milestone and a clear acknowledgment of the financial pressures facing physicians under the current system.

*Call to Action*

Congress must urgently address a broken Medicare payment system that places enormous financial pressure on physicians and threatens access to care. The AMA continues to urge lawmakers to:

- Reverse the 2.83 percent payment cut;
- Enact a positive update to keep up with inflation; and
- Implement a long-term fix that ensures payment adequacy and stability.

Physician practices have lost 33 percent to inflation since 2001. Physician ownership of practices has also collapsed, dropping from 61 percent in 2001 to under 50 percent in 2016. This erosion threatens the viability of community-based care.

Fixing this system will remove a major financial stressor for physicians, protect patient access, and stabilize our health care infrastructure. The House-passed provisions of H.R. 1 will serve as a critical foundation for comprehensive reform in the 119th Congress. Ensuring regular, adequate payment updates is vital to practice sustainability, advancing value-based care models, and safeguarding access to care for Medicare beneficiaries—especially in rural and underserved communities, where practices treat four times as many Medicare patients as those in metropolitan areas.

As physicians across the country continue to share their stories and advocate for reform, there is hope that our united efforts will eventually break through the political and financial barriers that have hindered progress. The AMA will continue to fight tirelessly until a sustainable, fair, and effective Medicare physician payment system is achieved.

STRATEGIC REVIEW OF MEDICARE PAYMENT REFORM ADVOCACY

In response to Policy D-400.981, the AMA is actively in the process of implementing a comprehensive review of its Medicare payment reform strategy. This includes identifying options for engaging external advocacy consultants and refining internal processes to identify barriers, uncover strategy gaps, and generate targeted recommendations. While the execution plan is still in the early stages at the time this report was drafted, the AMA remains committed to advancing this work and will provide further updates at I-25.

## CONCLUSION

The AMA will continue pressing Congress to fix the broken Medicare physician payment system and protect patient access to care. Despite ongoing challenges, sustained engagement from physicians remains critical. We urge all physicians to stay informed, follow Advocacy Update, participate in grassroots advocacy, and use resources such as FixMedicareNow.org to make their voices heard.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 17-I-25

Subject: Establishing an Advisory Committee on AI/AN Affairs

Presented by: David H. Aizuss, MD, Chair

---

At the 2025 AMA Annual Meeting, the House of Delegates (HOD) adopted Resolution 604, Advisory Committee on Tribal Affairs, as amended, which directs the AMA to:

1. Establish and report back at the 2025 Interim Meeting on the formation of a Task Force on Tribal Affairs composed of AMA members who themselves identify as American Indian and Alaska Native (AI/AN), have close professional relationships with AI/AN communities (e.g., members of Association of Native American Medical Students and Association of American Indian Physicians), or have direct experience working with AI/AN communities at Indian Health Service federal direct-care, Tribally-operated and/or Urban Indian Health Programs (I/T/U) the Indian Health Service to advise the Board of Trustees on how to implement policy specific to AI/AN communities, and that the Task Force report back at the 2026 Annual Meeting with recommendations for the establishment of an Advisory Committee to ensure sustained attention to tribal health equity and Indigenous physician representation; and

2. Promote and foster educational opportunities for AMA members and the medical community to better understand the contributions of AI/AN communities to medicine and public health, including cultivating a rich understanding and appreciation of AI/AN perspectives on health and wellness.

This report is informational.

Resolution 604-A-25, as originally presented to the HOD, directed the creation of an advisory committee to address issues relevant to AI/AN physicians, medical students, and patients. While testimony favored creation of an advisory committee, the Board noted in its testimony that advisory committees are established by action of the Board, not by directive of the HOD (AMA Bylaw 5.3.9). The Board further testified that it was willing to consider establishing such an advisory committee.

In response to the actions of the HOD, your Board of Trustees is taking the necessary steps to form an Advisory Committee on AI/AN Affairs and report back at the 2026 Annual Meeting.

© 2025 American Medical Association. All rights reserved.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 20-I-25

Subject: AMA Reimbursement of Necessary HOD Business Meeting Expenses for Delegates and Alternates

Presented by: David H. Aizuss, MD, Chair

---

At the 2024 Interim Meeting, the House of Delegates adopted Policy D-600.951, Reimbursement of Necessary Business Meeting Expenses for Delegates and Alternates. This informational report responds to the first directive of the policy:

1. Our American Medical Association will issue a report at the 2025 Annual Meeting, and each meeting thereafter, identifying the number of delegates and alternate delegates supported by the grants and the total amount provided under our AMA House of Delegates Emergency Assistance Program (HOD EAP).

AMA received requests from 21 societies to participate in the HOD EAP program. Three societies did not meet the criteria outlined in the policy adopted by the House. The EAP awarded grants to the remaining 18 federation societies who requested grant funding for 280 delegates and alternate delegates. Included in the grant funding requests from approved societies were 18 medical student section delegates and 15 regional resident and fellow sectional delegates.

Based on grant funding requests, a total of $420,000 was made available for the June meeting and 50 percent or $210,000 was paid to societies in advance of the June 2025 Annual Meeting.

Following the meeting, the actual number of delegates and alternate delegates that attended the meeting was reconciled with the initial requests and final payments were calculated to reflect actual attendance for each participating society.

For example, if a qualifying association had requested grant funding for four delegates and four alternates, two regional medical student delegates and one resident delegate, that society would be eligible for grant money for 11 attendees or $16,500. The initial payment would have been calculated and paid at 50 percent of the requested amount or $8,250.

Assuming only nine of those included in the initial request attended the meeting, the total grant would be recalculated at $1,500 times 9 attendees or $13,500 and the final payment would be the difference between the recalculated grant amount and the first installment payment or $5,250. This ensures that grant funding is used solely for actual delegates and alternate delegates attending the meeting.

The total number of delegates and alternate delegates attending the meeting from the 18 approved societies was 246, including 14 residents and 16 students and the grant amounts paid totaled $368,400 (one delegate attended for only three of five days).

The grant period is one year; the same 18 societies will be receiving grant money in November as well.

© 2025 American Medical Association. All rights reserved.

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Opinion 01-I-25

Subject: Contracts to Deliver Health Care Services

Presented by: Rebecca Brendel, MD, Chair

---

## INTRODUCTION

At the 2025 Annual Meeting, the American Medical Association House of Delegates adopted the recommendations of Council on Ethical and Judicial Affairs Report 05-A-25, "Protecting Physicians Who Engage in Contracts to Deliver Health Care Services." The Council issues this Opinion, which will appear in the next version of AMA PolicyFinder and the online edition of the *Code of Medical Ethics*.

E-11.2.3 – Contracts to Deliver Health Care Services

> Prioritizing profits over patients is incompatible with physicians' ethical obligations. No part of the health care system that supports or delivers patient care should place profits over such care. Physicians have a fundamental ethical obligation to put the welfare of patients ahead of other considerations, including personal financial interests. This obligation requires that before entering into contracts to deliver health care services, physicians consider carefully the proposed contract to assure themselves that its terms and conditions do not create untenable conflicts of interest or compromise their ability to fulfill their ethical and professional obligations to patients. Those physicians who enter into contracts with corporate entities, such as private equity firms, management service organizations, professional services corporations, insurance companies, or pharmaceutical benefit managers, who act within their capacity as a physician, even as administrators or intermediaries, also have a duty to uphold the ethical obligations of the medical profession.
>
> Ongoing evolution in the health care system continues to bring changes to medicine, including changes in reimbursement mechanisms, models for health care delivery, restrictions on referral and use of services, clinical practice guidelines, and limitations on benefits packages. While these changes are intended to enhance quality, efficiency, and safety in health care, they can also put at risk physicians' ability to uphold professional ethical standards and can impede physicians' freedom to exercise independent professional judgment and tailor care to meet the needs of individual patients.
>
> As physicians seek capital to support their practices or enter into various differently structured contracts to deliver health care services—with group practices, hospitals, health plans,

* Opinions of the Council on Ethical and Judicial Affairs will be placed on the Consent Calendar for informational reports, but may be withdrawn from the Consent Calendar on motion of any member of the House of Delegates and referred to a Reference Committee. The members of the House may discuss an Opinion fully in Reference Committee and on the floor of the House. After concluding its discussion, the House shall file the Opinion. The House may adopt a resolution requesting the Council on Ethical and Judicial Affairs to reconsider or withdraw the Opinion.

© 2025 American Medical Association. All rights reserved.

investment firms, or other entities—they should be mindful that while some arrangements have the potential to promote desired improvements in care, other arrangements have the potential to put patients' interests at risk and to interfere with physician autonomy.

When contracting with entities, or having a representative do so on their behalf, to provide health care services, physicians should:

(a) Carefully review the terms of proposed contracts, preferably with the advice of legal and ethics counsel, to assure themselves that the arrangement:

(i) minimizes conflict of interest with respect to proposed reimbursement mechanisms, financial or performance incentives, restrictions on care, or other mechanisms intended to influence physicians' treatment recommendations or direct what care patients receive, in keeping with ethics guidance;

(ii) does not compromise the physician's own financial well-being or ability to provide high-quality care through unrealistic expectations regarding utilization of services or terms that expose the physician to excessive financial risk;

(iii) ensures the physician can appropriately exercise professional judgment;

(iv) includes a mechanism to address grievances and supports advocacy on behalf of individual patients;

(v) is transparent and permits disclosure to patients;

(vi) enables physicians to have significant influence on, or preferably outright control of, decisions that impact practice staffing;

(vii) prohibits the corporate practice of medicine.

(b) Negotiate modification or removal of any terms that unduly compromise physicians' ability to uphold ethical or professional standards.

When entering into contracts as employees, preferably with the advice of legal and ethics counsel, physicians should:

(c) Advocate for contract provisions to specifically address and uphold physician ethics and professionalism.

(d) Advocate that contract provisions affecting practice align with the professional and ethical obligations of physicians and negotiate to ensure that alignment.

(e) Advocate that contracts do not require the physician to practice beyond their professional capacity and provide contractual avenues for addressing concerns related to good practice, including burnout or related issues.

(f) Not enter into any contract that would require the physician to violate their professional ethical obligations.

When contracted by a corporate entity involved in the delivery of health care services, physicians should:

(g) Terminate any contract that requires the physician to violate their professional ethical obligations and report any known or suspected ethical violations through the appropriate oversight mechanisms. (I, II, III, V, VI, VIII, IX)

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Opinion 02-I-25

Subject: Organ Transplantation Allocation Decisions

Presented by: Rebecca Brendel, MD, Chair

---

INTRODUCTION

At the 2025 Annual Meeting, the American Medical Association House of Delegates adopted the recommendations of Council on Ethical and Judicial Affairs Report 08-A-25, "Laying the First Steps Towards a Transition to a Financial and Citizenship Need Blinded Model for Organ Procurement and Transplantation." The Council issues this Opinion, which will appear in the next version of AMA PolicyFinder and the online edition of the *Code of Medical Ethics*.

E-6.2.1.1 Organ Transplantation Allocation Decisions

When making organ transplantation allocation decisions, physicians have a responsibility to provide equitable and just access to health care, including only utilizing organ allocation protocols that are based on ethically sound and clinically relevant criteria.

When making allocation decisions for organ transplantation, physicians should not consider non-medical factors, such as socioeconomic and/or immigration status, except to the extent that they are clinically relevant.

Given the lifesaving potential of organ transplants, as a profession, physicians should:

(a) Make efforts to increase the supply of organs for transplantation.

(b) Strive to reduce and overcome non-clinical barriers to transplantation access.

(c) Advocate for health care entities to provide greater and more equitable access to organ transplants for all who could benefit. (I, III, V)

* Opinions of the Council on Ethical and Judicial Affairs will be placed on the Consent Calendar for informational reports, but may be withdrawn from the Consent Calendar on motion of any member of the House of Delegates and referred to a Reference Committee. The members of the House may discuss an Opinion fully in Reference Committee and on the floor of the House. After concluding its discussion, the House shall file the Opinion. The House may adopt a resolution requesting the Council on Ethical and Judicial Affairs to reconsider or withdraw the Opinion.

© 2025 American Medical Association. All rights reserved.

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 1-I-25

Subject: Drug Shortages: 2025 Update

Presented by: Padmini Ranasinghe, MD, MPH, Chair

---

American Medical Association (AMA) Policy H-100.956, "National Drug Shortages," directs the Council on Science and Public Health (CSAPH) to evaluate the drug shortage issue and report back at least annually to the House of Delegates (HOD) on progress made in addressing drug shortages in the United States. This report provides an update on continuing trends in national drug shortages and ongoing efforts to further evaluate and address this critical public health issue. CSAPH has issued 15 reports on drug shortages, with the most recent presented at the 2024 Interim Meeting. The remainder of this report will provide an update on drug shortages since the 2024 report was developed.

## METHODS

English-language reports were selected from a PubMed and Google Scholar search from September 2022 to June 2025, using the text terms "drug shortages." Additional articles were identified by manual review of the references cited in these publications. Further information was obtained from the Internet sites of the U.S. Food and Drug Administration (FDA), National Academies of Sciences, Engineering, and Medicine, U.S. Department of Health and Human Services (HHS), American Society of Health-System Pharmacists (ASHP), and Duke Margolis Institute for Health Policy, and contemporary media reporting.

## DISCUSSION

Drug shortages remain an ongoing and complex public health concern in the United States with new and emerging challenges to the supply chain. The FDA defines a drug shortage as "a period of time when the demand or projected demand for the drug within the United States exceeds the supply of the drug."[1] Drug shortages may occur for a variety of reasons, including disruptions to the supply chain, a limited number of manufacturers, small profit margins, regulatory burdens, natural disasters, or surges in demand.[2–5] The number of new drug shortages was reduced markedly, and total drug shortages were reduced modestly, in 2024 from all-time highs in 2023.[6] While this reduction in drug shortages is welcome news after a decade of growth, overall drug prices increased during that same period which may have future implications on drug shortages and their resolution based on changes in their financial margins.

The two primary data sources for information on drug shortages in the United States are the Drug Shortage Program at the FDA and the Drug Shortage Resource Center maintained by ASHP in cooperation with the University of Utah Drug Information Service (see Box 1 for links to these resources). The FDA collects drug shortage information for their database directly from the drug manufacturers via their voluntary submission of information and defines a drug shortage to be when a manufacturer cannot meet current market demand as self-identified. Alternatively, the ASHP drug shortages database is based on reports from health care practitioners or patients/caregivers, which is then verified with manufacturers by the University of Utah Drug

Information Service to confirm the shortage status for inclusion in their list. Since the FDA database has a more limited definition of a drug shortage and requires self-reporting from manufacturers, their drug shortage numbers and statistics tend to be smaller and vary somewhat from those reported in the ASHP drug shortages database statistics.

According to ASHP statistics (Appendix 1), trends in all active drug shortages have stabilized quarter by quarter in 2024 with a decrease from 2023 (Figure 1).[7] Overall, new drug shortages (130 per ASHP and 98 per USP/FDA) decreased in 2024 compared to new drug shortages (156 per ASHP and 125 per USP/FDA) in 2023 (Figure 2 and Figure 3).[6,8] The number of new drug shortages remained higher among injectable products compared to all other dosage forms, such as oral or topical products (Figure 3 and Figure 4). The majority of new drug shortages still involve injectable products; this proportion has remained relatively stable, despite continued supply chain challenges this past year with IV fluid products. The most common drug classes with active shortages (as of June 2025) include: central nervous system therapies (n=48), antimicrobials (n=36), fluids/electrolytes (n=26), hormones (n=25), and chemotherapies (n=23), consistent with trends across the last five years (Figure 5 and Figure 6).[7,8]

Despite fewer drug shortages in 2024, the complexities of the supply chain remain, causing each shortage to last longer, increasing the persistence of drug shortages in the market impacting patient care and practice. The average duration of a drug shortage in 2024 was 1,585 days (4.2 years) compared to 706 days (two years) in 2019 (Figure 7).[6,9] In December of 2024, there were approximately 25 drugs in shortage for longer than five years.[6,9] From FDA Center for Drug Evaluation and Research (CDER) data, 91 percent of the drug shortages in 2024 had persisted for over one year. All five drugs that have been in a shortage for greater than 10 years are injectable medications that are deemed essential medicines by either the FDA or the WHO, highlighting the challenge and impact these drug shortages can have.[6] The eleventh annual report on drug shortages from the FDA to Congress was published in early 2024 and summarized the work of the FDA in calendar year 2023 related to drug shortages.[10] The annual report for calendar year 2024 was not available at the time of this report.

The lack of clarity and shift in causes of drug shortages year-to-year makes targeted improvements challenging. The most common reason for drug shortages in 2024 was unknown or not reported (55 percent) [Figure 8], which is similar to 2023. However, hurricane damage to manufacturing was a unique reason for drug shortages in 2024 compared to 2023. Manufacturing, business decisions by pharmaceutical companies, and supply/demand remain the most common reasons noted, with raw material issues comprising a smaller component of drug shortages.[7,8]

*Hurricane Helene and IV Fluid Shortages*

In September 2024, a Baxter manufacturing plant in North Cove, North Carolina, was subject to devastating flooding from Hurricane Helene, closing the plant.[11,12] This manufacturing facility was the largest manufacturing facility of IV fluids and peritoneal dialysis (PD) solutions in the U.S. as well as being Baxter's largest manufacturing facility worldwide with over 1 million IV solutions produced daily onsite.[12] Baxter moved into an allocation model for distribution and also quickly began recovery measures for restoring the manufacturing plant, yet it took nearly eight weeks after the storm for the first products produced post-hurricane to be released.[12] Without this manufacturing facility that produced approximately 60 percent of IV fluids pre-hurricane, significant IV fluid shortages and PD solution shortages were imminent. The FDA responded by working with Baxter to extend "beyond use" dates of some IV fluid products from one year to two years in order to lessen the impact of the shortages.[13] The U.S. Department of Health and Human Services also responded with communications on IV fluid conservation practices for hospitals to help mitigate challenges from the IV fluid shortages.[14,15] Despite conservation measures and increased access with extended beyond use dates, the impacts of the IV fluid and PD solution shortages seriously affected hospitals, physicians and patients resulting in cancelled surgeries and delayed treatments.[16] Baxter was able to resume pre-hurricane production levels and removed all allocation procedures on their IV fluid and PD solution products in February of 2025, but many IV injectable shortages remain.[7,12] This was unfortunately not the first instance of extreme weather causing a drug shortage, but the regulatory flexibility with extended beyond use dates and allocation models supported

minimization of challenges.[15] Your Council notes that extreme weather events, whose location may be difficult to predict, may become a more frequent cause of drug shortages as climate change accelerates.

*The Hidden Cost of Drug Supply Chain Disruptions*

Vizient, a health care consulting firm, conducted a survey in summer 2024 of their member organizations, typically hospital or health-system pharmacy departments, to review the impact of drug shortages. The survey results highlighted the increased financial and workforce demand caused by drug shortages, including increases in time needed by staff to manage drug shortages and the associated cost on pharmacy budgets.[17] Beyond financial challenges, communication gaps were additionally identified, limiting the ability for proactive drug shortage stewardship efforts.[17,18] Finally, it was noted that pediatric facilities were impacted at higher rates than adult facilities due to the intricacies and risk of pediatric drug formulations.[17] This survey highlights the disproportionate and growing impact of drug shortages for patient care, the health care workforce, and on costs. A link to their survey results has been included in Box 1 of this report.

*U.S. Government Accountability Office Study*

As a provision of the Cares Act of 2020, the U.S. Government Accountability Office (GAO) was tasked with describing the trends in drug shortages and steps for the FDA to improve drug shortage prevention and response.[19] This report mirrored the detailed yearly trends reported by the ASHP and US Pharmacopeia (USP), highlighting the slight reduction in the number of drug shortages, but the stark increase in the duration to resolve a drug shortage compared to pre-pandemic statistics (Figure 10).[6,7,19] The GAO described key challenges that cause drug shortages including the lack of incentives for producing low profit drugs, limited ability to recognize manufacturers with high-level quality management systems to share best practices, and the complex and fragmented supply chain; all challenges addressed in previous CSAPH Drug Shortages reports.[19] Recognizing drug shortages are a complex issue impacting the U.S., the GAO recommended a collaborative, interagency governmental approach moving forward to reduce negative impacts. Key collaboration practices include: 1. Define common outcomes, 2. Ensure accountability, 3. Bridge organizational cultures, 4. Identify and sustain leadership, 5. Clarify roles and responsibilities, 6. Include relevant participants, 7. Leverage resources and information, and 8. Develop and update written guidance and agreements.[19]

## AN EVOLVING POLITICAL LANDSCAPE: POTENTIAL CHALLENGES FOR DRUG SHORTAGES

Drugs shortages are complex, multi-factorial problems, with small changes having large, cascading effects down the supply chain. In this year's survey of the drug shortages landscape, the evolving political landscape is challenging with uncertainty around both specific actions and timelines. This report highlights the key policy challenges and the potential impacts of pharmaceutical tariffs, and reduction in the FDA workforce on drug shortages in the U.S.

*Challenge: Pharmaceutical Tariffs*

As a mechanism for reducing drug shortages, there has been interest in onshoring or increasing domestic pharmaceutical manufacturing based on a common belief and myth that the majority of manufacturing is occurring internationally, particularly in China and India.[20] Data from USP Medicine Supply Map[21] show that while a majority of oral solid products (60 percent) are produced in India, the largest share of injectable products (45 percent) are manufactured in the U.S. (Figure 9).[9] Further, the majority of oral solid products (66 percent) and injectables (58 percent) that were in shortage at the end of 2024 were

manufactured in the U.S. (Figure 9). It is unclear whether shifting pharmaceutical manufacturing to the U.S. or nearby countries (onshoring or nearshoring) would have any impact on drug shortages in the U.S.

The Department of Commerce launched an investigation on April 1, 2025, under Section 232 of the Trade Expansion Act (19 U.S.C. 1862) to determine the effects on national security of imports of pharmaceuticals and pharmaceutical ingredients, and their derivative products. This includes both finished generic and non-generic drug products, medical countermeasures, critical inputs such as active pharmaceutical ingredients and key starting materials, and derivative products of those items.[22,23] This investigation calls for federal tariffs to be placed on a wide range of pharmaceutical products for potential national security concerns.[23] Reporting initially indicated that the tariffs on pharmaceutical products would be enacted within a month or two of the April investigation and could be as high as 200 percent. However, the implementation date and tariff level have shifted multiple times and at the time of this report, have yet to be implemented.[23,24] However, if implemented, companies would reportedly be provided a grace period of unknown duration.[25]

In response to the potential of tariffs on pharmaceutical products, pharmaceutical organizations, international allies, and stakeholders have responded swiftly. Pharmaceutical Research and Manufacturers of America (PhRMA) submitted formal comments to the U.S. Department of Commerce in response to the investigation indicating the imposition of tariffs on pharmaceutical products would be dire.[26] Among other reasons, PhRMA and other groups noted tariffs would hinder innovation and leadership stature in the pharmaceutical market.[26–28] The European Union was also quick to respond to the investigation, noting their longstanding trade partnerships and the interconnectivity of the markets, where U.S. tariffs could cause significant supply chain disruptions.[18,28] The generic drug supply may be at even further risk with the imposition of tariffs considering much of the generic oral agents are manufactured abroad and the financial margins on generic drugs are so small it would disincentivize continued production or pass along the cost to consumers.[6] Additional impacts are not completely known, however reduced innovation from increased costs, retaliatory trade measures from other countries, challenges accessing active pharmaceutical ingredients, decreased access to medications for patients, and increased out of pocket costs are all likely consequences.[29,30]

Pharmaceutical companies have responded to the threat of potential tariffs. In February, Eli Lilly announced plans to bolster U.S. manufacturing of their products by building four new manufacturing facilities.[31] AbbVie followed by announcing a $10 billion investment in U.S. manufacturing over 10 years, while AstraZeneca announced a $50 billion investment plan, with U.S. manufacturing facilities planned and research and development infrastructure, among other pharmaceutical companies announcing investments.[25,32] Despite the threat of tariffs on pharmaceutical products spurring announcements of investments in U.S. manufacturing, these investments are unlikely to have positive near term impact on drug supply due to the complexities of building a pharmaceutical manufacturing site and the lengthy regulatory pathway for approval of a site once it has been constructed.

*Challenge: Changing FDA Workforce*

On February 11, 2025 President Trump signed an executive order entitled, "*Implementing The President's "Department of Government Efficiency" Workforce Optimization Initiative (Workforce Optimization)*" which sought to 'eliminate waste, bloat, and insularity' in the federal government workforce.[33] Under the direction of the Office of Management and Budget and the Office of Personnel Management, federal agencies were instructed to 'seek reductions in components and positions that are non-critical,' amongst other areas for an overall reduction in force.[34]

The FDA saw approximately 3500 layoffs in March 2025, or nearly 20 percent of their workforce due to this action.[35,36] A U.S. GAO report highlighted the fragility and importance of the FDA inspectors

workforce since the COVID-19 pandemic caused a backlog of inspections as well as inspectors leaving their posts due to work-life balance concerns.[37] In light of this report, the Trump Administration vowed to not reduce the FDA inspector workforce. However, initial reports highlight significant cuts to the administrative staff of the FDA inspectors and freezing credit limits on work-issued credit cards, hamstringing their ability to make timely inspections, particularly in international locations.[38] FDA is also a critical contributor to onboarding new manufacturing facilities (like Lilly and AbbVie have promised) as they must provide regulatory approval for a site to begin manufacturing. Bottlenecks from reduced FDA staffing will slow down the pace of onshoring.

FDA's Center for Drug Evaluation and Research's (CDER) and the Center for Biologics Evaluation and Research's (CBER) were not immune to staffing cuts. In fiscal year 2025, CDER and CBER lost 353 and 34 employees, respectively. Collectively, this reduction in the workforce produces significant risks for drug shortages. FDA inspectors are critical components to bringing transparency to the supply chain and identifying quality concerns proactively.[6,38] CDER and CBER have important roles in communicating drug shortages from manufacturers to health professionals and the public.[39] Bioequivalence studies used to add additional manufacturing sites for a product require review by CDER/CBER, so products could go into shortage awaiting review. Usually, these sites also are subject to pre-approval inspections, so inspection delays could additionally delay this process. Further, the Senate Appropriations Committee and other pharmaceutical and biotechnology firms highlight the FDA reduction in force is hindering the drug review process that may have implications in innovation in the market, a necessary component of flexibility during times of drug shortages.[40,41]

Recently, the FDA has announced interest in utilizing augmented/artificial intelligence (AI) to support various functions, such as drug reviews and inspections, previously completed by the human workforce.[42] While the use of AI by the FDA is posited for efficiency in their work, the risk of hallucinations, which is where AI models provide false or misleading information, is always there. AI may mitigate or offset some of the backlog of work related to decreased staff, but in bulk, there will be errors that may cause harm and should always fallback to humans to ensure safe products.[43]

## ONGOING AMA ACTIVITIES

AMA staff continue to remain engaged in drug shortage activities. Staff are involved in the Drug Shortages Task Force, a multi-stakeholder, national task force effort to remain current on policies, drug shortage and supply chain issues, and to develop group recommendations on the topics, many of which are already contained within AMA policy. The effort includes over 20 organizations, including our AMA, ASHP, American Hospital Association, United States Pharmacopeia, American Society of Anesthesiologists, and the American Society of Clinical Oncology, among others to raise awareness of the severe harms of shortages and the causes behind them, provide insights to inform data-driven solutions, and advocate for reforms in a collaborative and productive manner.[44]

Additional advocacy efforts have been taken since the 2024 drug shortages report, including communication with the Federal Trade Commission regarding drug shortages,[45] correspondence with the Senate Finance Committee on a drug shortage discussion draft,[46] real-time collaborative efforts to partner with HHS in the aftermath of Hurricane Helene and the subsequent IV fluid shortages,[47] and communication with the Centers for Medicare & Medicaid Services on the potential for drug shortages with implementation of their $2 Drug List Model.[48]

In light of Hurricane Helene's destruction of manufacturing plants in North Carolina that caused ongoing, significant IV fluid shortages, our AMA has worked to provide better resources for our members regarding drug shortages beyond this annual report. The AMA Drug Shortages Resource Webpage is a

public site with information on ongoing shortages, links to resource pages with clinical information, and highlights additional efforts at our AMA on drug shortages (Box 1).

At the 2025 AMA Annual Meeting, two resolutions relevant to drug shortages were adopted by the HOD. Resolution 210-A-25 was adopted as amended. The resulting policy, D-110.981, "Impact of Tariffs on Healthcare Access and Costs," calls on our AMA to "actively monitor and assess the impact of current and proposed tariffs on healthcare costs and patient access to medical services" and "support legislative efforts aimed at mitigating the negative effects of tariffs on the healthcare system, ensuring that patient care, medical supplies, and pharmaceuticals remain accessible and affordable."

Resolution 522-A-25, resulting in policy D-100.959, "Access to Important and Essential Drugs," asks that our AMA urge Congress to pass comprehensive legislation to mitigate existing drug shortages and prevent future shortages of lifesaving and life-prolonging drugs. The policy also states that a comprehensive approach would include, but not be limited to the following:

- Address economic factors that drive generic manufacturers out of the market and consider stabilizing the market with long-term contracts and guaranteed prices.
- Reward reliable U.S. manufacturing of critical and supportive medications through prices that support continued quality production and investment in continuous manufacturing or other advanced manufacturing for critical drugs and active pharmaceutical ingredients (APIs), which could include onshoring or nearshoring as components of a solution.
- Recognize potential shortages earlier by increasing the FDA's visibility into the supply chain so the agency can predict and respond to potential shortages earlier.
- Relay information about potential shortages to health systems and providers to help them prepare for and mitigate possible supply challenges.

## CONCLUSION

Drug shortages continue to be a persistent problem resulting in risks to patient health and safety. In this annual update on drug shortages, trends highlight the reduction in overall drug shortages, but the increased time to resolve a shortage. New risks may be imminent for drug shortages secondary to changes in the political landscape and policy agenda, particularly with pharmaceutical tariffs and changes in the federal workforce. Extensive AMA policy has supported stakeholder engagement in 2024 and early 2025 and continues to allow the AMA to advocate for mechanisms to support pharmaceutical access by reducing drug shortages proactively and mitigating impact when they occur.

Fiscal Note: Minimal

CITED POLICIES

## National Drug Shortages H-100.956

1. Our American Medical Association considers drug shortages to be an urgent public health crisis, and recent shortages have had a dramatic and negative impact on the delivery and safety of appropriate health care to patients.
2. Our AMA supports recommendations that have been developed by multiple stakeholders to improve manufacturing quality systems, identify efficiencies in regulatory review that can mitigate drug shortages, and explore measures designed to drive greater investment in production capacity for products that are in short supply, and will work in a collaborative fashion with these and other stakeholders to implement these recommendations in an urgent fashion.
3. Our AMA supports authorizing the Secretary of the U.S. Department of Health and Human Services (DHHS) to expedite facility inspections and the review of manufacturing changes, drug applications and supplements that would help mitigate or prevent a drug shortage.
4. Our AMA will advocate that the US Food and Drug Administration (FDA) and/or Congress require drug manufacturers to establish a plan for continuity of supply of vital and life-sustaining medications and vaccines to avoid production shortages whenever possible. This plan should include establishing the necessary resiliency and redundancy in manufacturing capability to minimize disruptions of supplies in foreseeable circumstances including the possibility of a disaster affecting a plant.
5. The Council on Science and Public Health shall continue to evaluate the drug shortage issue, including the impact of group purchasing organizations and pharmacy benefit managers on drug shortages, and report back at least annually to the House of Delegates on progress made in addressing drug shortages.
6. Our AMA urges continued analysis of the root causes of drug shortages that includes consideration of federal actions, evaluation of manufacturer, Group Purchasing Organization (GPO), pharmacy benefit managers, and distributor practices, contracting practices by market participants on competition, access to drugs, pricing, and analysis of economic drivers, and supports efforts by the Federal Trade Commission to oversee and regulate such forces.
7. Our AMA urges regulatory relief designed to improve the availability of prescription drugs by ensuring that such products are not removed from the market or caused to stop production due to compliance issues unless such removal is clearly required for significant and obvious safety reasons.
8. Our AMA supports the view that wholesalers should routinely institute an allocation system that attempts to fairly distribute drugs in short supply based on remaining inventory and considering the customer's purchase history.
9. Our AMA will collaborate with medical specialty society partners and other stakeholders in identifying and supporting legislative remedies to allow for more reasonable and sustainable payment rates for prescription drugs.
10. Our AMA urges that during the evaluation of potential mergers and acquisitions involving pharmaceutical manufacturers, the Federal Trade Commission consult with the FDA to determine whether such an activity has the potential to worsen drug shortages.
11. Our AMA urges the FDA to require manufacturers and distributors to provide greater transparency regarding the pharmaceutical product supply chain, including production locations of drugs, any unpredicted changes in product demand, and provide more detailed information regarding the causes and anticipated duration of drug shortages.
12. Our AMA supports the collection and standardization of pharmaceutical supply chain data in order to determine the data indicators to identify potential supply chain issues, such as drug shortages.
13. Our AMA encourages global implementation of guidelines related to pharmaceutical product supply chains, quality systems, and management of product lifecycles, as well as expansion of global reporting requirements for indicators of drug shortages.
14. Our AMA urges drug manufacturers to accelerate the adoption of advanced manufacturing technologies such as continuous pharmaceutical manufacturing, and supports the use of incentives such as prioritized regulatory review, reduction of user fees, and direct grant opportunities for manufacturers seeking to invest in manufacturing processes.
15. Our AMA supports the concept of creating a rating system to provide information about the quality management maturity, resiliency and redundancy, and shortage mitigation plans, of pharmaceutical manufacturing facilities to increase visibility and transparency and provide incentive to manufacturers.

Additionally, our AMA encourages GPOs and purchasers to contractually require manufacturers to disclose their quality rating, when available, on product labeling.

16. Our AMA encourages electronic health records (EHR) vendors to make changes to their systems to ease the burden of making drug product changes.
17. Our AMA urges the FDA to evaluate and provide current information regarding the quality of outsourcer compounding facilities.
18. Our AMA urges DHHS and the U.S. Department of Homeland Security (DHS) to examine and consider drug shortages as a national security initiative and include vital drug production sites in the critical infrastructure plan.
19. Our AMA urges the Drug Enforcement Agency and other federal agencies to regularly communicate and consult with the FDA regarding regulatory actions which may impact the manufacturing, sourcing, and distribution of drugs and their ingredients.
20. Our AMA supports innovative approaches for diversifying the generic drug manufacturing base to move away from single-site manufacturing, increasing redundancy, and maintaining a minimum number of manufacturers for essential medicines.
21. Our AMA supports the public availability of FDA facility inspection reports to allow purchasers to better assess supply chain risk.
22. Our AMA opposes the practice of preferring drugs experiencing a shortage on approved pharmacy formularies when other, similarly effective drugs are available in adequate supply but otherwise excluded from formularies or coverage plans.
23. Our AMA shall continue to monitor proposed methodologies for and the implications of a buffer supply model for the purposes of reducing drug shortages and will report its findings as necessary.
24. Our AMA opposes increasing drug prices or waiving fee exemptions in a manner that incentivizes a drug manufacturer to have its drug be declared in shortage.
25. Our AMA opposes the use of punitive fees on physician practices that do not maintain buffer supplies of drugs.
26. Our AMA encourages the FDA, the FTC, or other relevant oversight entities, to examine the practice of compounding pharmacies and the entities that utilize them advertising drugs actively in shortage, particularly when targeted to new patients.

## Drug Shortages: 2024 Update D-100.961

1. Our American Medical Association opposes laws, regulations, or business practices which create artificial scarcity of drugs, such as limitations on pharmacy procurement or restrictions on which pharmacies a patient can use, which prevent the filling of an otherwise valid prescription from their physician.

2. Our AMA advocates for pharmacies and distributors subject to the national opioid litigation settlement to make public the specific metrics, formulas, data sources, algorithms, thresholds and other policies and analyses that are used to delay or deny orders to pharmacies, restrict physicians' prescribing privileges and other actions that impede patients' access to medication.

3. Our AMA advocates for pharmacies and distributors to provide physicians with all due process rights and opportunities to contest any decision to restrict a physician's prescribing privileges based on a pharmacy or distributor metric, formula, algorithm or other policy before such restriction is put into effect.

4. Our AMA urges the Centers for Medicare & Medicaid Services to implement policies to temporarily halt financial and other penalties for affected quality metrics during periods of documented medication and IV fluid shortages as well as in other emergencies in order to prevent physicians and hospitals from being penalized for circumstances beyond their control.

## Drug Manufacturing Safety H-100.945

1. Our American Medical Association supports efforts to ensure that the U.S. Food and Drug Administration (FDA) resumes inspections of all drug manufacturing facilities on a frequent and rigorous basis, as done in the past.
2. Our AMA will call for the FDA to:

a. assure the safety of the manufacture of drugs, drug ingredients and precursors.
b. work proactively with industry to prevent or minimize drug shortages.
c. work with the industry to oversee the adequacy of product in the pipeline.

## Non-Profit or Public Manufacturing of Drugs to Address Generic Drug Shortages H-100.942

1. Our American Medical Association supports activities which may lead to the stabilization of the generic drug market by non-profit or public entities. Stabilization of the market may include, but is not limited to, activities such as government-operated manufacturing of generic drugs, the manufacturing or purchasing of the required active pharmaceutical ingredients, or fill-finish. Non-profit or public entities should prioritize instances of generic drugs that are actively, at-risk of, or have a history of being, in shortage, and for which these activities would decrease reliance on a small number of manufacturers outside the United States.
2. Our AMA encourages government entities to stabilize the generic drug supply market by piloting innovative incentive models for private companies which do not create artificial shortages for the purposes of obtaining said incentives.

## Group Purchasing Organizations and Pharmacy Benefit Manager Safe Harbor D-100.967

Our AMA will: (1) renew efforts urging the federal government to support greater public transparency and accountability efforts involving the contracting mechanisms and funding structures subject to the Group Purchasing Organization and PBMs anti-kickback safe harbor, including the potential impact on drug pricing and drug shortages; (2) support efforts to update and modernize the fraud and abuse laws and regulations to address changes in the health care delivery and payment systems including the potential impact on drug pricing and drug shortages; and (3) via a letter, immediately ask the Secretary of HHS and other appropriate stakeholders to request the HHS OIG to examine the supply chain of pharmaceuticals, pharmacy benefit managers, Safe Harbor laws and regulations, and expeditiously make recommendations to make prescription drugs more accessible and affordable to patients with an emphasis on examining the governing contracts for drugs in short supply and/or that are exceedingly expensive to ensure compliance with all the safe harbor provisions.

## 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.

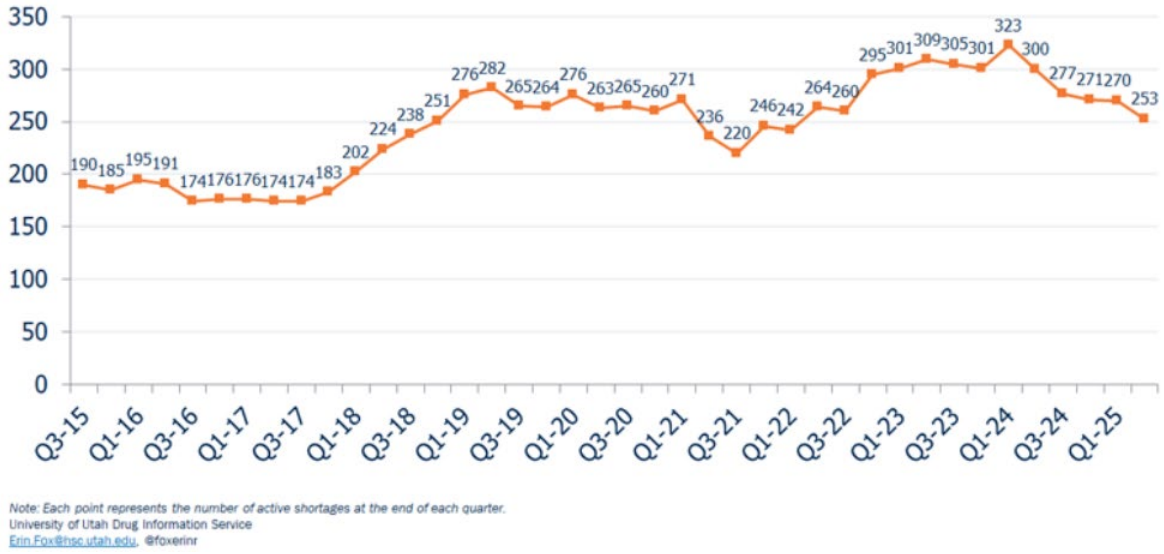
10. Our AMA supports:
    a. drug price transparency legislation that requires pharmaceutical manufacturers to provide public notice before increasing the price of any drug (generic, brand, or specialty) by 10% or more each year or per course of treatment and provide justification for the price increase;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

**Box 1. Resources available to assist in mitigation of drug shortages.**

1. FDA Drug Shortages Page (includes current shortages list, extended use dates, mobile app, and additional information)
2. ASHP Resource Center
3. ASHP list of current shortages
4. AMA Drug Shortages Resource Webpage
5. Vizient member survey on current drug shortages

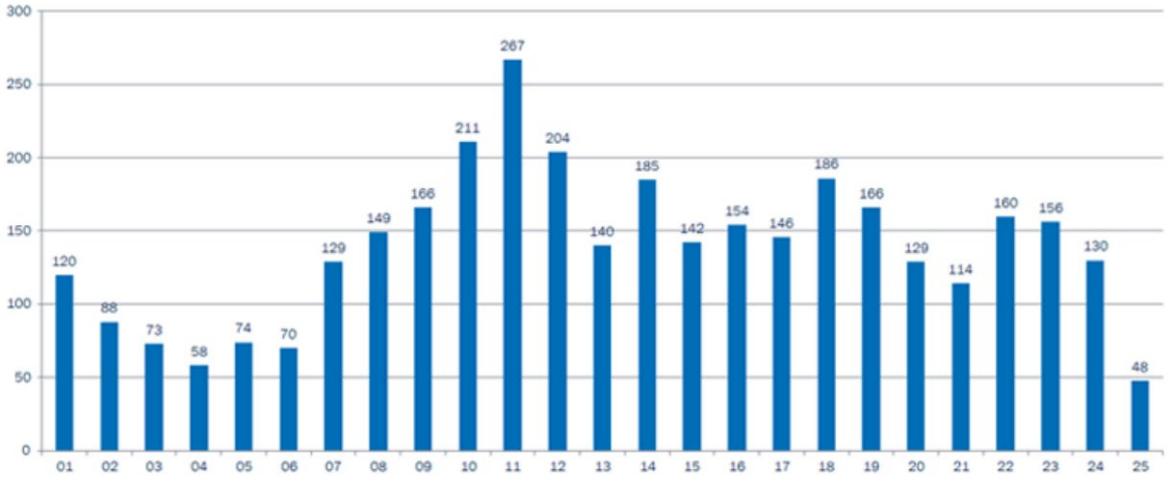
Appendix 1

**Figure 1. National Drug Shortages: Active Shortages by Quarter: 10 Year Trend**[7,8]




*Note: Each point represents the number of active shortages at the end of each quarter.*
University of Utah Drug Information Service
Erin.Fox@hsc.utah.edu, @foxerinr

**Figure 2. New Drug Shortages by Year: January 2001 to June 30, 2025 (ASHP)**[7,8]




***Note:** Each column represents the number of new shortages identified during that year.*
University of Utah Drug Information Service
Erin.Fox@hsc.utah.edu, @foxerinr

**Figure 3. New Drug Shortages by Year: 2014 to 2024 (USP/CDER)**[6]

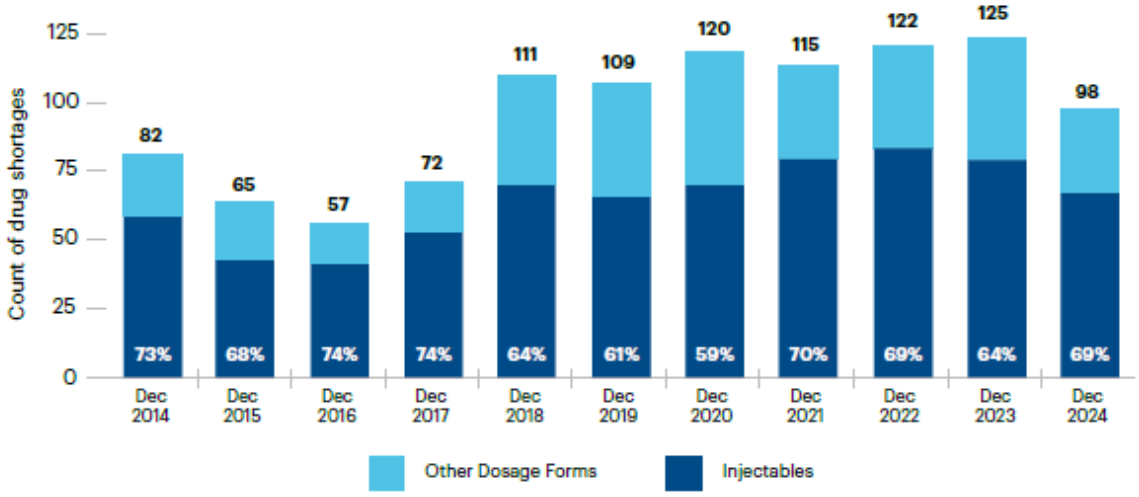



**Figure 4. National New Drug Shortages by Year: January 2001 to June 2025, % Injectable**[7,8]

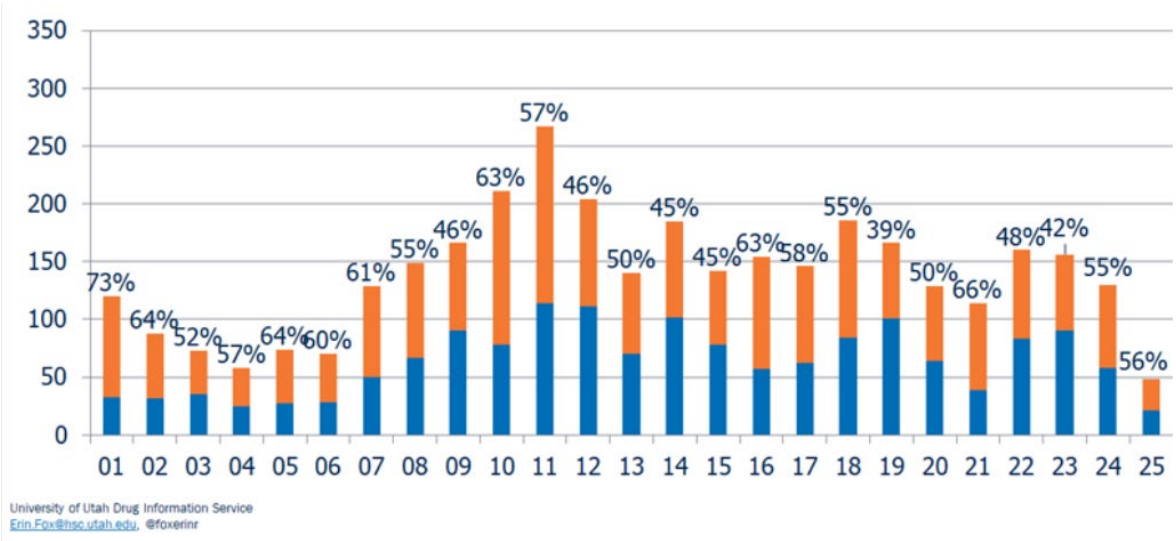


**Figure 5. National Active Drug Shortages: Top 5 Drug Classes**[7,8]

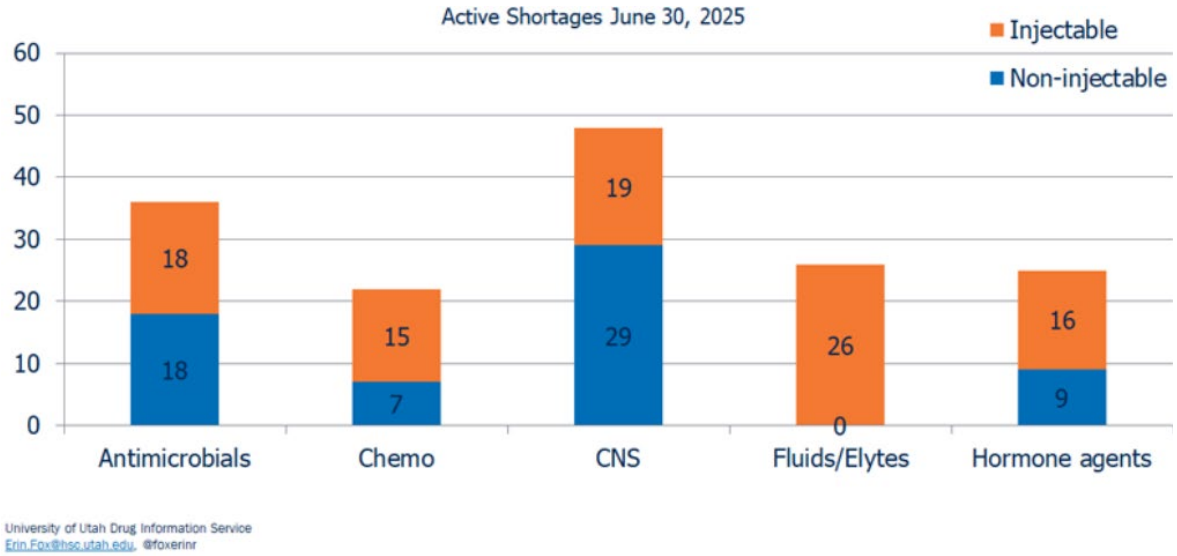



**Figure 6. Common Drug Classes in Short Supply: 5 Year Trend**[7,8]

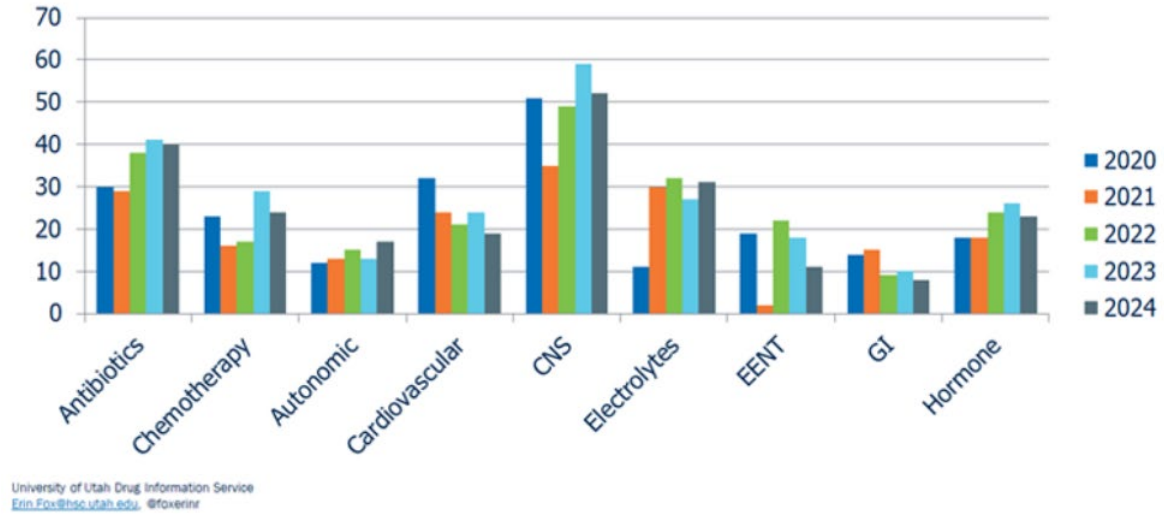


**Figure 7. Average Duration of Drug Shortages by Year (USP/CDER)**[6,9]

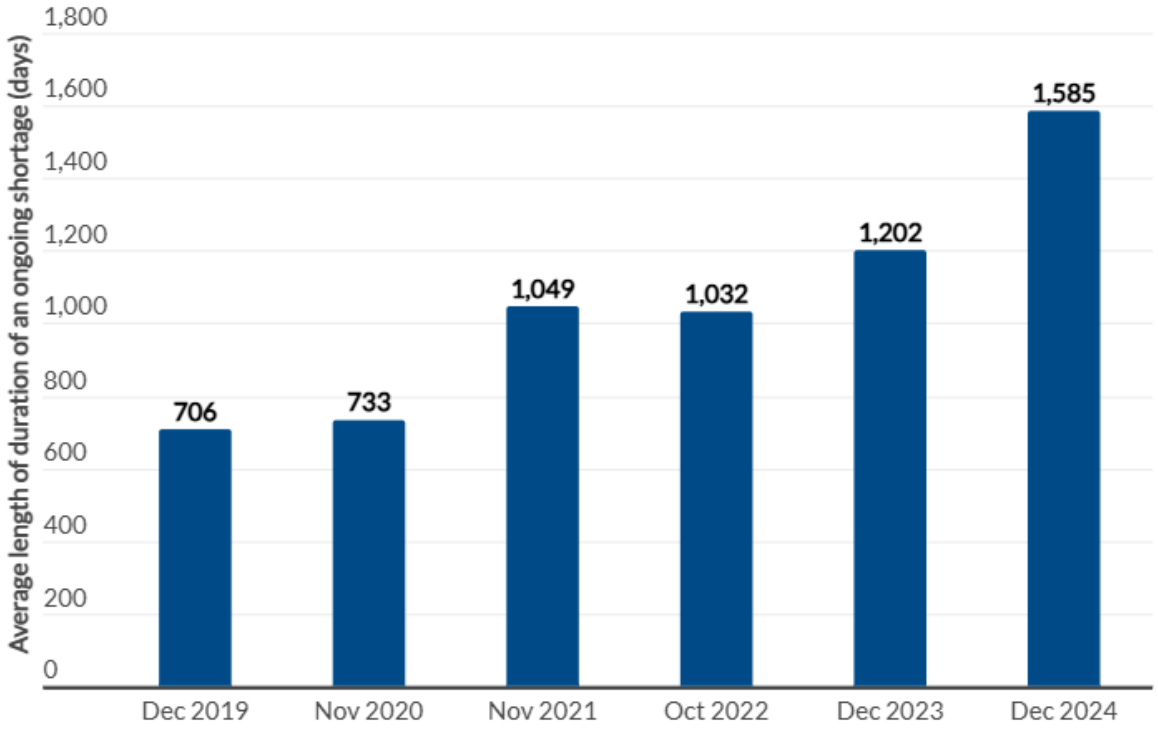


**Figure 8. Reasons for Drug Shortages as Reported by Manufacturers During UUDIS Investigation 2023 and 2024**[7,8]

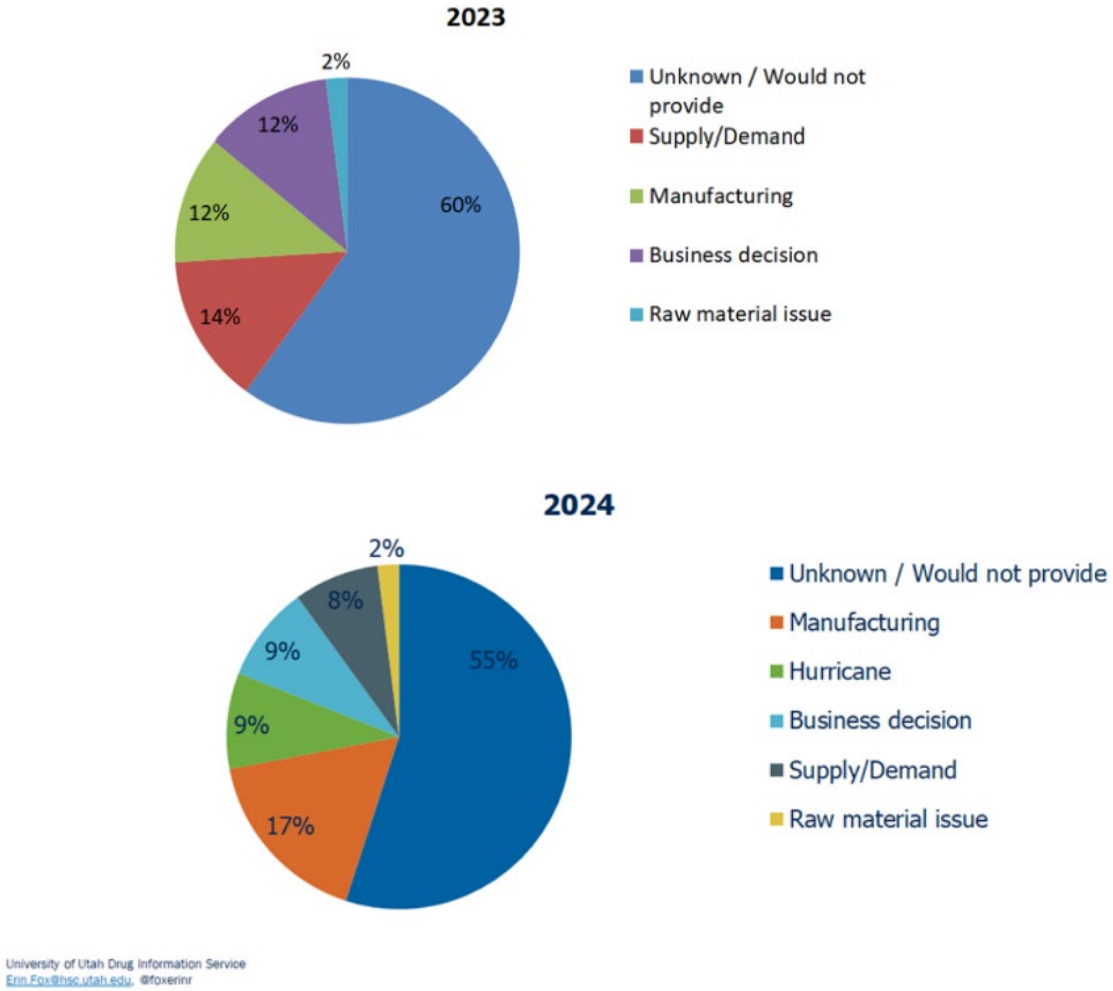
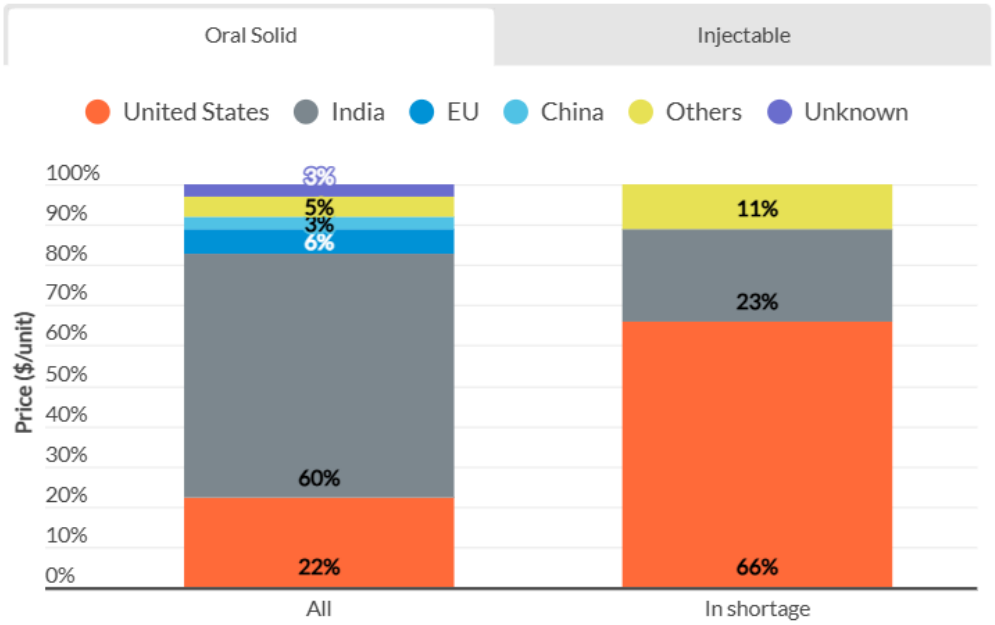


**Figure 9. Geographic Distribution of Manufacturing for Oral Solid (A) and Injectable Products (B) for All and In Shortage**

**A: Oral Solid Products**




**B: Injectable Products**

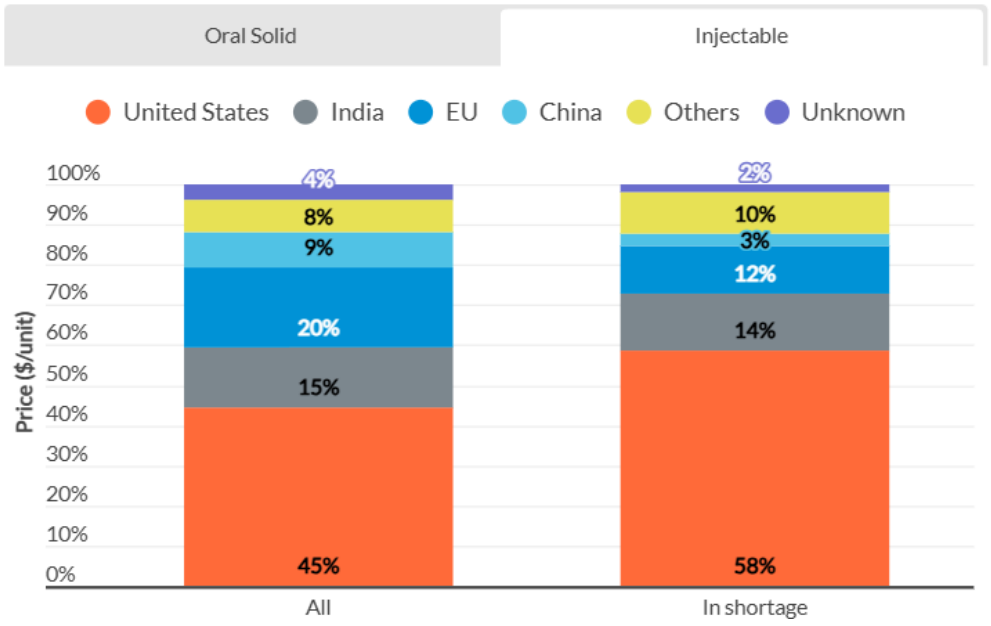
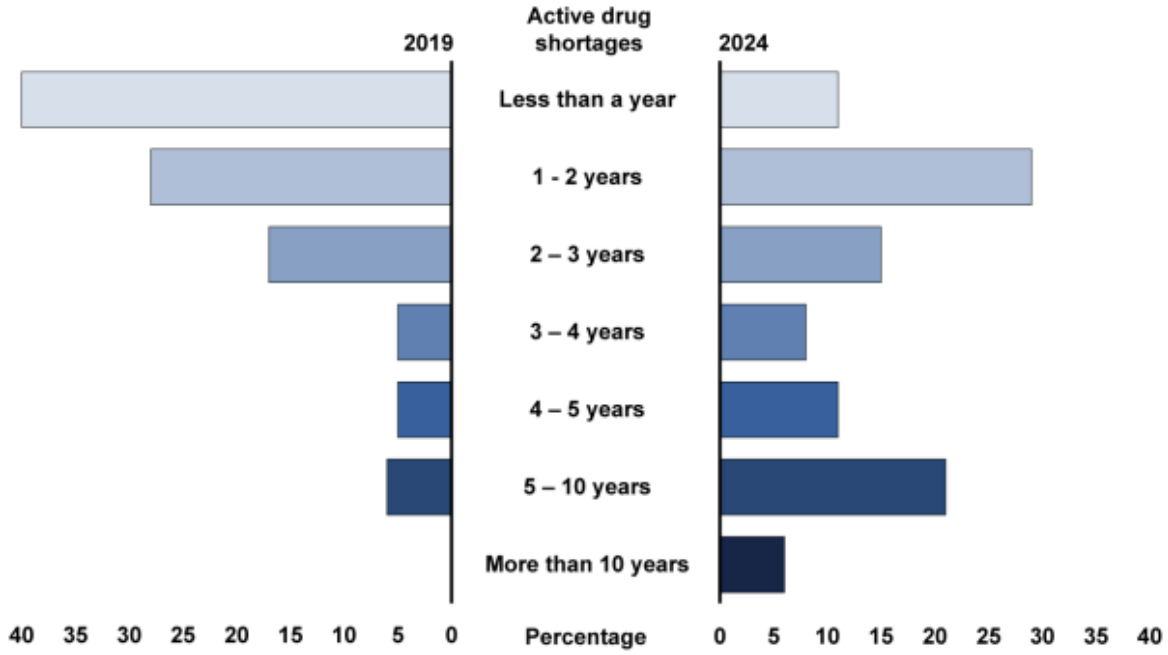


**Figure 10. Drug Shortage Duration from December 2019 versus July 2024**[19]



REFERENCE

1. US Food and Drug Administration. Frequently Asked Questions about Drug Shortages. December 18, 2024. Accessed August 18, 2025. https://www.fda.gov/drugs/drug-shortages/frequently-asked-questions-about-drug-shortages

2. Suda KJ, Tadrous M. Sum of the parts: Ensuring a resilient global drug supply chain. *Infect Control Hosp Epidemiol*. 2021;42(5):598-599. doi:10.1017/ice.2021.138

3. Badreldin HA, Atallah B. Global drug shortages due to COVID-19: Impact on patient care and mitigation strategies. *Res Soc Adm Pharm RSAP*. 2021;17(1):1946-1949. doi:10.1016/j.sapharm.2020.05.017

4. Hernandez I, Hershey TB, Donohue JM. Drug Shortages in the United States: Are Some Prices Too Low? *JAMA*. 2020;323(9):819-820. doi:10.1001/jama.2019.20504

5. Aronson JK, Heneghan C, Ferner RE. Drug shortages. Part 2: Trends, causes and solutions. *Br J Clin Pharmacol*. 2023;89(10):2957-2963. doi:10.1111/bcp.15853

6. US Pharmacopeia. *USP Annual Drug Shortage Report: Long-Standing Drug Shortages Persist in 2024.*; 2025. Accessed July 1, 2025. https://go.usp.org/2025drugshortagesreport?_gl=1*3figjb*_gcl_au*MTQxNzI1MTY0Ni4xNzUxNDcwOTQ5*_ga*NTkwODcyNzc5LjE3NTE0NzA5NDk.*_ga_DTGQ04CR27*czE3NTE5MTE3MTAkbzIkZzAkdDE3NTE5MTE3MjckajQzJGwwJGgw

7. American Society of Health-System Pharmacists. Drug Shortages Statistics. Published online 2025. Accessed July 15, 2025. https://www.ashp.org/drug-shortages/shortage-resources/drug-shortages-statistics

8. American Society of Health-System Pharmacists. *National Drug Shortages: January 2001 - June 2025.*; 2025. Accessed July 16, 2025. https://www.ashp.org/-/media/assets/drug-shortages/docs/Drug-Shortages-Report.pdf

9. US Pharmacopeia. Understanding Drug Shortages: Causes, Risks, and Supply Chain Data. Published online May 2025. Accessed July 16, 2025. https://www.usp.org/supply-chain/drug-shortages

10. US Food and Drug Administration. Report to Congress: Drug Shortages CY 2023. Published online 2024. Accessed July 12, 2025. https://www.fda.gov/media/179156/download?attachment=

11. Lupkin S. Storm damage closes N.C. factory that makes vital hospital supplies. October 4, 2024. Accessed July 24, 2025. https://www.npr.org/sections/shots-health-news/2024/10/04/g-s1-26383/iv-fluids-shortage-baxter-hurricane-helene

12. Baxter. North Cove Fact Sheet. Published online May 2025. Accessed July 18, 2025. https://www.baxter.com/sites/g/files/ebysai3896/files/2025-05/North-Cove_Fact-Sheet-MAY2025-Final.pdf

13. US Food and Drug Administration. Hurricane Helene: Baxter's manufacturing recovery in North Carolina. 2024. Accessed July 24, 2025. https://www.fda.gov/drugs/updates-2024-hurricane-season/hurricane-helene-baxters-manufacturing-recovery-north-carolina

14. *HHS Informational Briefing on IV Fluid Conservation Best Practices*.; 2024. Accessed July 24, 2025. https://www.youtube.com/watch?v=dFL8xnDFcg0

15. Harpine M, Bai S, Baker R. Normal saline storage practices. *Hosp Pharm*. 2015;50(2):93. doi:10.1310/hpj5002-93

16. Rogin A, Zahn H. Hospitals nationwide grapple with IV fluid shortage caused by Hurricane Helene. Published online December 14, 2024. Accessed July 24, 2025. https://www.pbs.org/newshour/show/hospitals-nationwide-grapple-with-iv-fluid-shortage-caused-by-hurricane-helene

17. Vizient, Inc. *Beyond the Shortage: The Hidden Cost of Drug Supply Chain Disruptions*.; 2025. Accessed July 16, 2025. https://vizientinc-delivery.sitecorecontenthub.cloud/api/public/content/0fed86e17e654732ba642464400e713f?v=323b8a49

18. Hoelting K, Brummel G. Drug shortage stewardship: A novel solution for an old problem. *Am J Health-Syst Pharm AJHP Off J Am Soc Health-Syst Pharm*. 2025;82(7):e398-e402. doi:10.1093/ajhp/zxae289

19. US Government Accountability Office. Report to Congressional Addressees: Drug Shortages - HHS Should Implement a Mechanism to Coordinate Its Activities. Published online April 2025. Accessed July 2, 2025. https://www.gao.gov/assets/gao-25-107110.pdf

20. The Drug Shortage Landscape: Data, Disruptions, and the Drive for Solutions. Published online June 4, 2025. Accessed July 8, 2025. https://www.ashp.org/professional-development/ashp-podcasts/hot-topics-in-pharmacy-practice/2025/the-drug-shortage-landscape-data-disruptions-and-the-drive-for-solutions?utm_campaign=Drug-Shortages-1-00-1321-52000&utm_medium=email&_hsenc=p2ANqtz-8Tt_XUI47Njc3nStHjg3hG_ZOBgXkiLalf3N-m-paTDdjw3PUkMtsRrceqGqN6K8BoFp4AO0qxjogcoA0gnrQkeVBFAwKBJn1tDbnBidC4f10IdcA&_hsmi=364833637&utm_content=364833637&utm_source=hs_email&loginreturnUrl=SSOCheckOnly

21. US Pharmacopeia. USP Medicine Supply Map. Published online December 2024. Accessed July 21, 2025. https://www.usp.org/supply-chain/medicine-supply-map

22. US Department of Commerce. *Notice of Request for Public Comments on Section 232 National Security Investigation of Imports of Pharmaceuticals and Pharmaceutical Ingredients*.(2025). Accessed July 22, 2025. https://public-inspection.federalregister.gov/2025-06587.pdf

23. Osman M. Commerce Says Pharmaceutical Tariffs Coming In 'Next Month Or Two,' Launched Import Probe April 1. April 14, 2024. Accessed July 20, 2025. https://insidehealthpolicy.com/daily-news/commerce-says-pharmaceutical-tariffs-coming-next-month-or-two-launched-import-probe-april

24. Durkee A. Trump Floats 200% Tariffs on Pharmaceuticals. July 8, 2025. Accessed July 17, 2025. https://www.forbes.com/sites/alisondurkee/2025/07/08/trump-floats-200-tariffs-on-pharmaceuticals/

25. Osman M. AstraZeneca Bets Big On U.S. As Researchers Warn Of Talent Exodus. July 22, 2025. Accessed July 22, 2025. https://insidehealthpolicy.com/daily-news/astrazeneca-bets-big-us-researchers-warn-talent-exodus?utm_medium=ihpbn

26. Pharmaceutical Research and Manufacturers of America (PhRMA). Letter to US Department of Commerce on National Security Investigation of Imports of Pharmaceuticals and Pharmaceutical Ingredients. Published online May 6, 2025. Accessed July 22, 2025. https://cdn.aglty.io/phrma/global/resources/import/pdfs/PhRMA%20Section%20232%20Comments%20(XRIN%200694-XC120).pdf

27. Osman M. PhRMA Warns Tariffs Won't Boost U.S. Drug Manufacturing, Cites Global Trade Benefits. May 7, 2024. Accessed July 20, 2025. https://insidehealthpolicy.com/daily-news/phrma-warns-tariffs-won-t-boost-us-drug-manufacturing-cites-global-trade-benefits

28. Kansteiner F. Drugmakers, trade groups and others voice concerns with pharma-specific tariffs. May 29, 2025. Accessed July 21, 2025. https://www.fiercepharma.com/pharma/governments-trade-groups-and-drugmakers-strike-back-against-trump-tariff-threat-232

29. Sullivan SD, Grueger J, Sullivan AP, Ramsey SD. The consequences of pharmaceutical tariffs in the United States. *J Manag Care Spec Pharm*. 2025;31(6):533-536. doi:10.18553/jmcp.2025.25090

30. Socal MP, Dada M, Dai T. Prescription for made in America? Tariffs and U.S. drug manufacturing. *Health Aff Sch*. 2025;3(7):qxaf122. doi:10.1093/haschl/qxaf122

31. Eli Lilly and Company. Lilly plans to more than double U.S. manufacturing investment since 2020 exceeding $50 billion. February 26, 2025. Accessed July 22, 2025. https://investor.lilly.com/news-releases/news-release-details/lilly-plans-more-double-us-manufacturing-investment-2020

32. Slabodkin G. AbbVie plans $10B investment in US manufacturing over the next decade. April 28, 2025. Accessed July 22, 2025. https://www.pharmamanufacturing.com/all-articles/article/55286102/abbvie-plans-10b-investment-in-us-manufacturing-over-the-next-decade

33. The White House. Implementing The President's "Department of Government Efficiency" Workforce Optimization Initiative. February 11, 2025. Accessed July 24, 2025. https://www.whitehouse.gov/presidential-actions/2025/02/implementing-the-presidents-department-of-government-efficiency-workforce-optimization-initiative/

34. Vought R, Ezell C. Memorandum regarding Guidance on Agency RIF and Reorganization Plans Requested by Implementing The President's "Department of Government Efficiency" Workforce Optimization Initiative. Published online February 26, 2025. Accessed July 25, 2025. https://www.opm.gov/policy-data-oversight/latest-memos/guidance-on-agency-rif-and-reorganization-plans-requested-by-implementing-the-president-s-department-of-government-efficiency-workforce-optimization-initiative.pdf

35. Biscotti L. FDA Job Cuts Spark Food Safety Debate. May 6, 2025. Accessed July 20, 2025. https://www.forbes.com/sites/louisbiscotti/2025/05/06/fda-job-cuts-spark-food-safety-debate/

36. Lawrence L. Inside the staff exodus and tanking morale that threaten Makary's FDA. July 7, 2025. Accessed July 8, 2025. https://www.statnews.com/2025/07/07/fda-job-cuts-morale-low-staff-anxious-impact-of-new-leadership-makary-prasad-rfk-jr/

37. US Government Accountability Office. Report to Congressional Committees: Drug Safety - FDA Should Implement Strategies to Retain Its Inspection Workforce. Published online November 2024. Accessed July 24, 2025. https://www.gao.gov/assets/gao-25-106775.pdf

38. Lupkin S. How FDA cuts could make the food and drug supply less safe. April 18, 2025. Accessed July 15, 2025. https://www.npr.org/sections/shots-health-news/2025/04/18/nx-s1-5364544/fda-inspections-layoffs-food-and-drug-supply-less-safe

39. U.S. Food and Drug Administration. FDA Drug Shortages Database. Published online 2024. Accessed October 17, 2024. https://dps.fda.gov/drugshortages

40. Karins J. Senate Approps Report Calls Out FDA Staffing, Science, User Fee Concerns. July 11, 2025. Accessed July 18, 2025. https://insidehealthpolicy.com/daily-news/senate-approps-report-calls-out-fda-staffing-science-user-fee-concerns?utm_medium=mh

41. Karins J. Biotech Companies Tell Cassidy FDA RIF Leaves Agency Overwhelmed. May 2, 2025. Accessed July 22, 2025. https://insidehealthpolicy.com/daily-news/biotech-companies-tell-cassidy-fda-rif-leaves-agency-overwhelmed

42. Makary MA, Prasad V. Priorities for a New FDA. *JAMA*. 2025;334(7):565-566. doi:10.1001/jama.2025.10116

43. Jewett C. F.D.A. to Use A.I. in Drug Approvals to 'Radically Increase Efficiency.' *N Y Times*. Published online June 10, 2025. Accessed August 20, 2025. https://www.nytimes.com/2025/06/10/health/fda-drug-approvals-artificial-intelligence.html

44. US Pharmacopeia. The Drug Shortage Task Force: Ensuring patients have access to the therapies they need. 2025. Accessed July 16, 2025. https://www.usp.org/supply-chain/drug-shortage-task-force

45. Madara J. Letter to the Federal Trade Commission Regarding Lack of Competition and Contracting Practices that May be Contributing to Drug Shortages. Published online May 30, 2024. Accessed July 16, 2025. https://searchlf.ama-assn.org/letter/documentDownload?uri=/unstructured/binary/letter/LETTERS/lfftc.zip/2024-5-30-Letter-to-Khan-re-FTC-Drug-Shortages-v3.pdf

46. Madara J. Letter to Senate Finanace Committee Regarding Drug Shortages. Published online June 6, 2024. Accessed July 16, 2025. https://searchlf.ama-assn.org/letter/documentDownload?uri=/unstructured/binary/letter/LETTERS/lfcmts.zip/2024-6-6-Letter-to-Wyden-and-Crapo-re-Drug-Shortages-v2.pdf

47. Madara J. Letter to US Department of Health and Human Services on Drug Shortage Impact from Hurrican Helene. Published online October 10, 2024. Accessed July 16, 2025. https://searchlf.ama-assn.org/letter/documentDownload?uri=/unstructured/binary/letter/LETTERS/lfhhs.zip/2024-10-10-Letter-to-Becerra-re-Hurricane-Drug-Shortages-v2.pdf

48. Madara J. Letter to the Centers for Medicare and Medicaid Services on $2 Drug List Model. Published online December 9, 2024. Accessed July 16, 2025. https://searchlf.ama-assn.org/letter/documentDownload?uri=/unstructured/binary/letter/LETTERS/lfcmt.zip/2024-12-9-Letter-to-Brooks-LaSure-re-CMS-$2-Drug-Model-v2.pdf

REPORT OF THE SPEAKERS

Speakers' Report 3-I-25

Subject: Speaker Recorded Interviews for AMA Elections

Presented by: Lisa Bohman Egbert, MD, Speaker and John H. Armstrong, MD, Vice Speaker

---

The American Medical Association policy G-610.090, "AMA Election Rules and Guiding Principles," encourages your Speakers to continue recorded virtual interviews of announced candidates in contested races, to be posted on the AMA website.

In accordance with this guidance, your Speakers have recorded and posted virtual candidate interviews for the last three election cycles. These recorded interviews require significant staff resources to schedule, record, produce and post the videos. In addition, the candidates as well as your Speakers spend time preparing for and recording them. Candidates in contested elections also participate in a number of virtual interviews with official interviewing groups that require further availability away from their already busy schedules.

In assessing the effectiveness of conducting these videos, data was collected from the 2024 and 2025 election cycles which shows that utilization rates of the candidates' videos were low. Total unique viewers of all candidate recorded videos in 2024 was 751 with the most viewed individual candidate video getting 75. In 2025, there were 854 unique viewers with only 106 unique viewers for the most viewed individual candidate. It should be noted that the majority of officer candidate videos were viewed by roughly 60 individuals while most council candidate videos were viewed by roughly 35 individuals. In 2025, the most viewed candidate video was seen by less than 15 percent of delegates with most of the videos seen by less than 5 percent of delegates. This assumes that each unique viewer was a voting delegate, which is an unlikely assumption as these videos were publicly available.

CONCLUSION

Given the low viewership over the past two election cycles and the resources required to produce them, Speaker recorded virtual interviews of announced candidates will no longer be continued.

© 2025 American Medical Association. All rights reserved.