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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.

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:

- 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.

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.

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.

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)

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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.

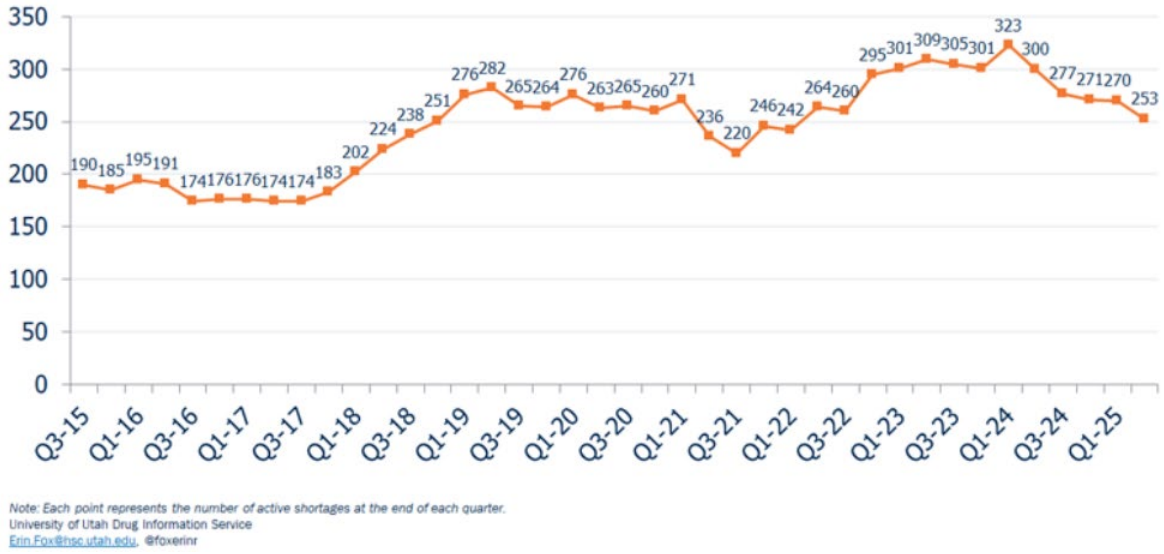
10. Our AMA supports:
    a. drug price transparency legislation that requires pharmaceutical manufacturers to provide public notice before increasing the price of any drug (generic, brand, or specialty) by 10% or more each year or per course of treatment and provide justification for the price increase;
    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

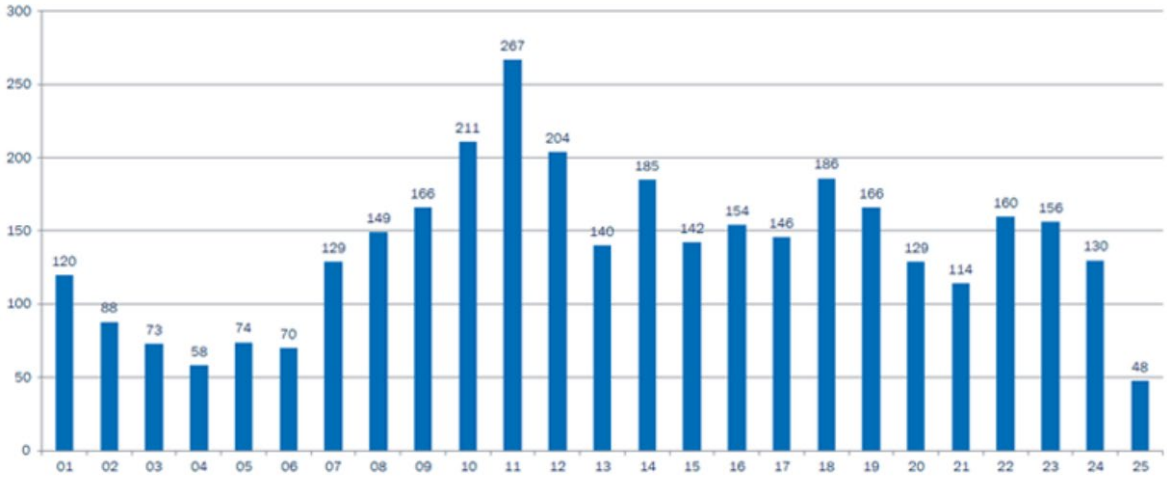
Appendix 1

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]

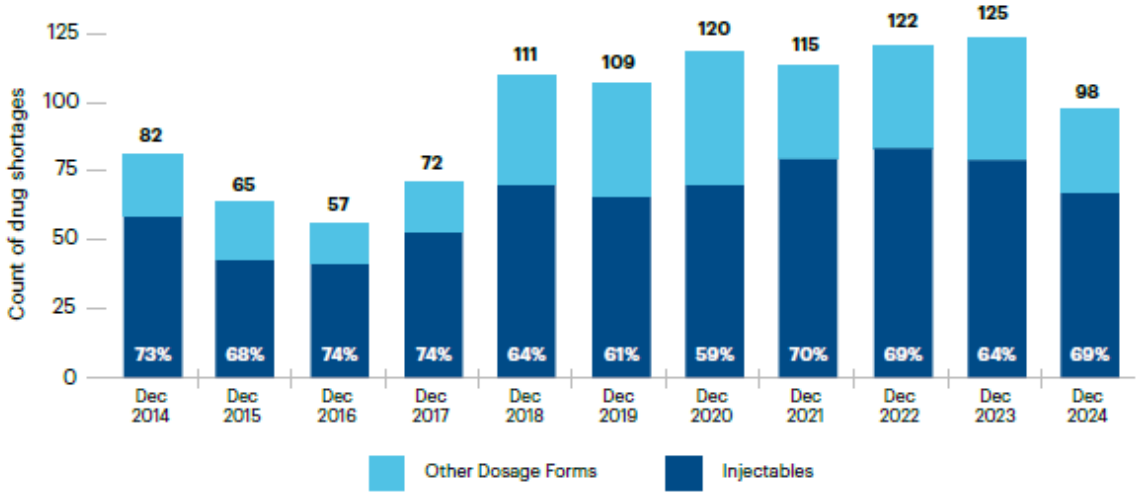


Figure 4. National New Drug Shortages by Year: January 2001 to June 2025, % Injectable[7,8]

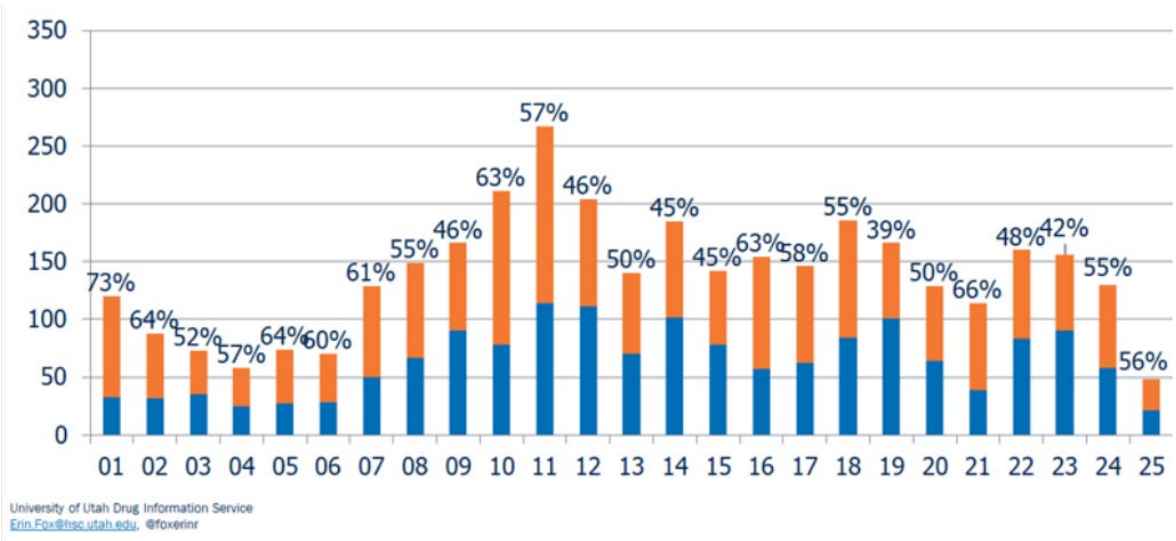


Figure 5. National Active Drug Shortages: Top 5 Drug Classes[7,8]

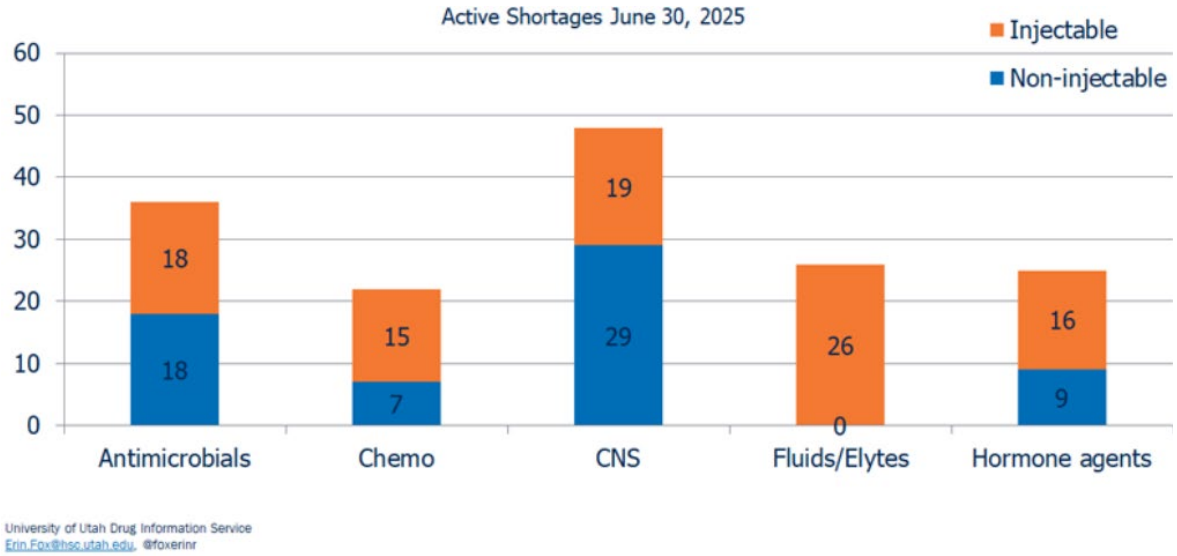


Figure 6. Common Drug Classes in Short Supply: 5 Year Trend[7,8]

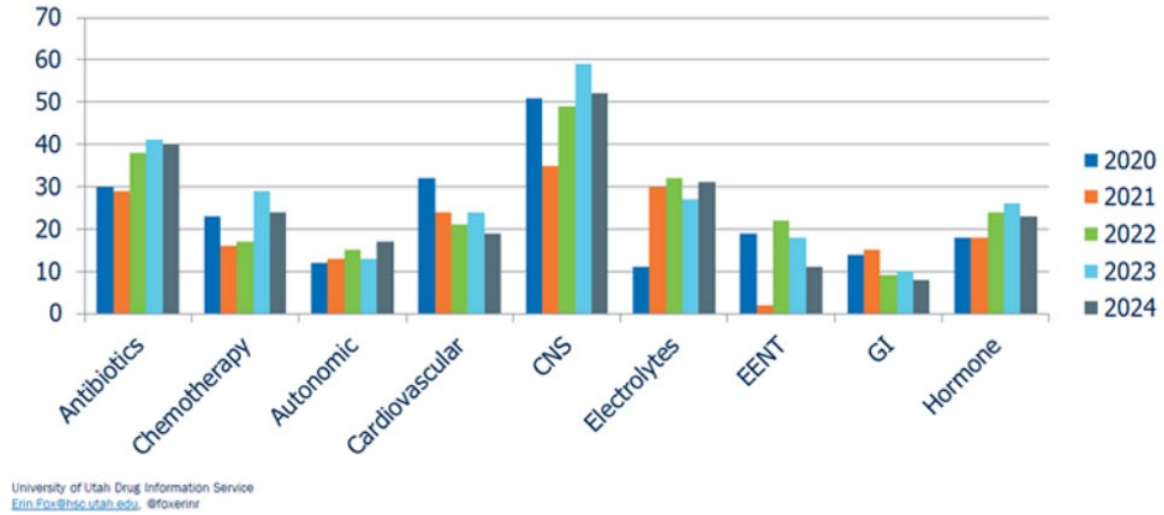


Figure 7. Average Duration of Drug Shortages by Year (USP/CDER)[6,9]

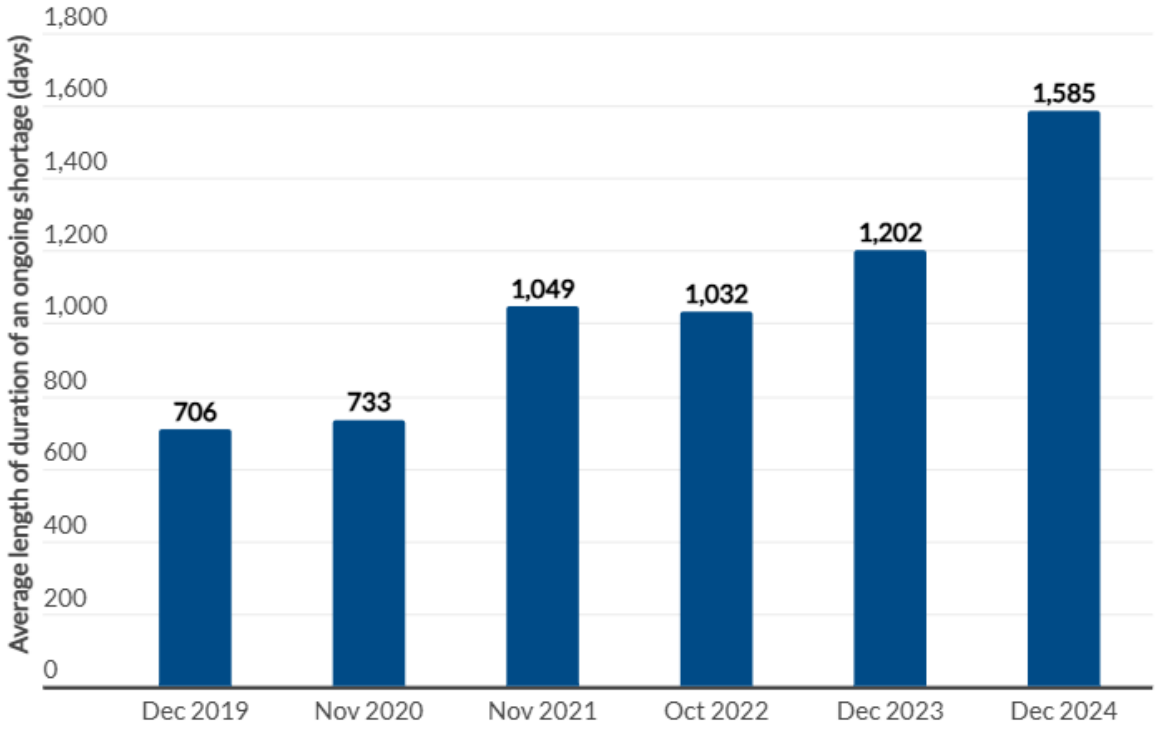


Figure 8. Reasons for Drug Shortages as Reported by Manufacturers During UUDIS Investigation 2023 and 2024[7,8]

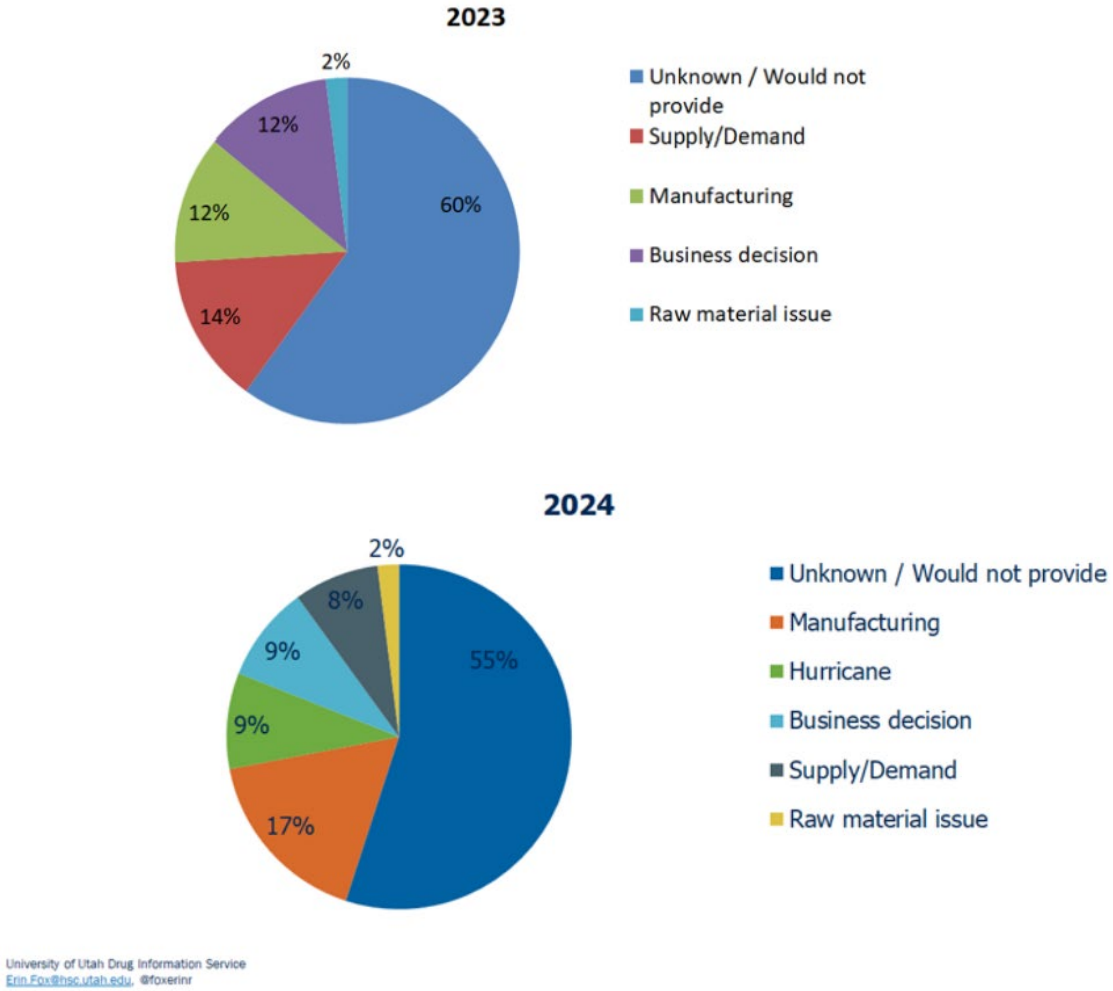
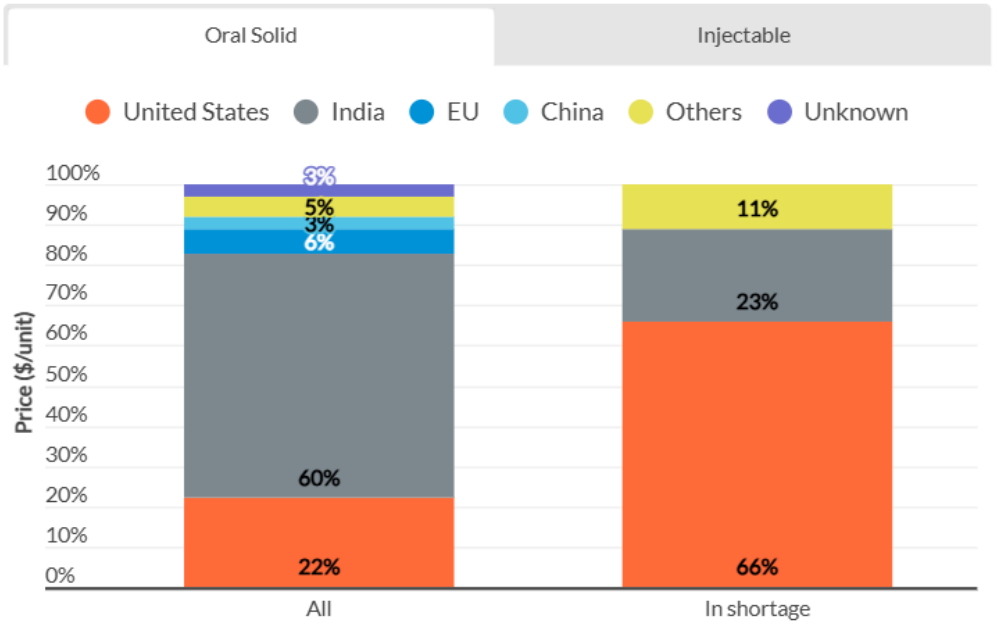


Figure 9. Geographic Distribution of Manufacturing for Oral Solid (A) and Injectable Products (B) for All and In Shortage

A: Oral Solid Products



B: Injectable Products

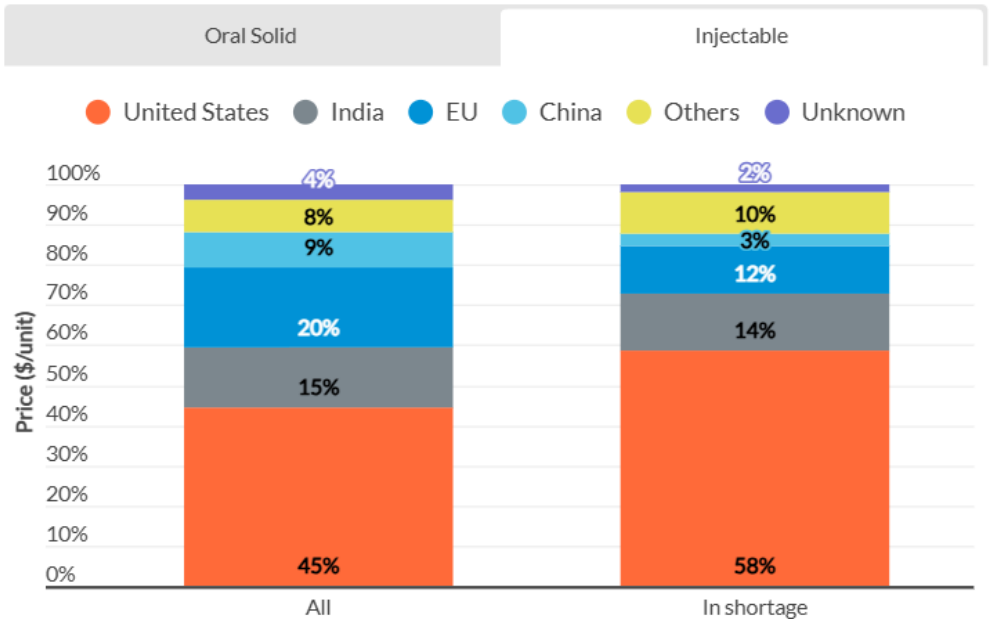
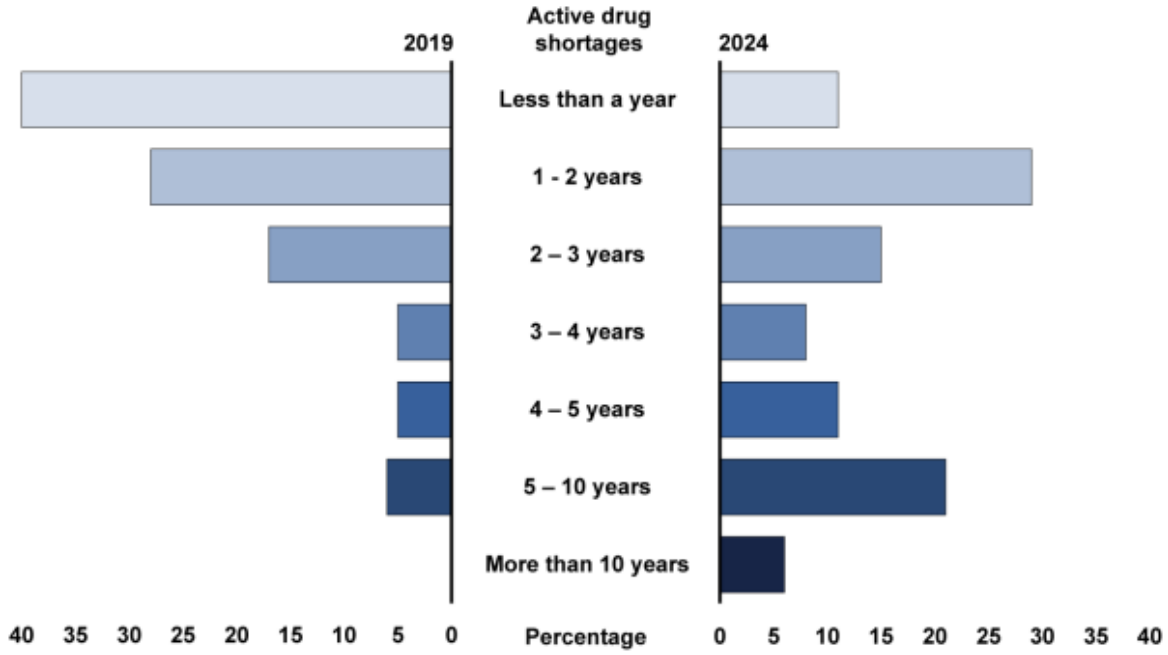


Figure 10. Drug Shortage Duration from December 2019 versus July 2024[19]



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

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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.