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REPORT 18 OF THE BOARD OF TRUSTEES (I-25)
Published Metrics for Hospitals and Hospital Systems
(Reference Committee J)

EXECUTIVE SUMMARY

At the 2024 Interim Meeting of the House of Delegates (HOD), Policy D-215.979, "Published Metrics for Hospitals and Hospital Systems", was adopted. The policy directs our American Medical Association (AMA) to research and develop useful metrics that hospitals and hospital systems can use to improve physicians' experience, engagement, and work environment in a manner that is accessible to physicians. This report outlines the AMA's ongoing work to develop and implement metrics that enable health systems to effectively assess and enhance the physician experience, and ensure this information is accessible to physicians.

The Organizational Biopsy®, developed by the AMA in 2018, measures system-level drivers of physician burnout and organizational well-being among participating health care organizations. The tool assesses organizational culture, practice efficiency, work intentions, and support for individual resiliency. Surveying organizations receive a comprehensive summary report highlighting key performance indicators identified by the AMA, experts, and research including burnout, job satisfaction, job stress, and physicians' intent to leave or reduce clinical hours, feelings of being valued, and time spent on patient care versus administrative tasks. Additionally, AMA health system partners gain access to physician faculty support and tailored strategies to address identified issues.

Another of AMA's efforts to develop and implement metrics to improve the physician experience is the Joy in Medicine® Health System Recognition Program (The Recognition Program). The Recognition Program was developed in 2019 and provides public national recognition to health care organizations that have met a set of evidenced-based criteria for addressing physician burnout and organizational well-being. It provides a roadmap to help organizations navigate existing research and implement interventions aimed at improving organizational well-being and the physician experience. The measures included in the program's criteria include burnout, physicians' intent to leave or reduce work effort, teamwork assessments, leadership skills and its impact on direct team members, and electronic health record audit log data. The program requires that this data is shared with physicians that participate in the organizational well-being surveys.

In addition to the Organizational Biopsy and Recognition Program, the AMA also offers open access, physician-developed resources that guide physicians and practices in preventing physician burnout and improving practice efficiency through AMA STEPS Forward® toolkits, playbooks, webinars, and podcasts. The report also discusses several AMA policies and research regarding accessible hospital and hospital system metrics aimed at improving the physician experience.

Given the AMA's substantial progress in developing accessible, evidence-based metrics to assess and improve physician burnout and the overall physician experience—and its ongoing efforts to enhance and expand this work—the AMA recommends that Policy D-215.979, "Published Metrics for Hospitals and Hospital Systems", be rescinded (Rescind HOD Policy), the AMA continue to support metrics that improve the physician experience (New HOD Policy), and the remainder of the report be filed.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 18-I-25

Subject: Published Metrics for Hospitals and Hospital Systems

Presented by: David H. Aizuss, MD, Chair

Referred to: Reference Committee J

INTRODUCTION

At the 2024 Interim Meeting of the House of Delegates (HOD), Policy D-215.979, "Published Metrics for Hospitals and Hospital Systems", was adopted. The policy states:

> Our American Medical Association (AMA) will research and develop useful metrics that hospitals and hospital systems can use to improve physicians' experience, engagement, and work environment in a manner accessible to physicians, with report back to the House of Delegates no later than Annual 2026.

The underlying report (BOT 15-I-24) includes detailed information about existing publicly available metrics for hospitals and hospital systems and their potential impact on physicians and patients. The report recommended that the AMA research useful metrics that hospitals and hospital systems can use to improve physicians' experience, engagement, and work environment and thus, this report serves to provide this information to the HOD.

BACKGROUND

Recent research shows that over 45 percent of U.S. physicians experience at least one symptom of burnout.[1] Burnout and job dissatisfaction rose sharply during the first two years of the COVID-19 pandemic, prompting many physicians to consider reducing their work effort, leaving their organization, or exiting the profession entirely.[2] Nearly one-quarter of all physicians noted an intent to leave their job, and a recent study found that the annual rate of physician turnover in the United States increased between 2010 and 2018.[3,4] Time spent in the electronic health record (EHR) and managing the inbox has been associated with burnout.[5,6] Following the pandemic's onset, primary care physicians (PCPs) saw a notable rise in EHR-related workload, including time spent on orders, chart review, notes, inbox management, and after-hours work.[6] Also during this period, all physician specialties experienced an increase in time spent in the EHR, with PCPs most affected.[7] Additional challenges, such as lack of inbox coverage, have made it difficult for physicians to fully disconnect from work during vacation—or take time off at all—further contributing to burnout and increased likelihood of reducing clinical hours or leaving their current practice.[8,9]

Overall, these trends are alarming for the U.S. health care system. Nearly one billion dollars in excess patient costs are tied to physician turnover.[10] Physician burnout and turnover also risks exacerbating

existing health disparities, particularly for people living in rural areas and health systems caring for underserved communities. While many hospitals and hospital systems have begun to address the underlying system-level issues that cause burnout and turnover, much work remains to be done to address the work environment of physicians to reduce physician burnout and turnover.

Physician burnout and turnover have myriad causes and addressing these issues to reduce physician burnout (and lessen physician turnover) is a key pillar of the AMA's "You Are Why We Fight" campaign. Central to these efforts are AMA's collaborations over the past five years with more than 300 hospitals or hospital systems in measuring physician burnout and turnover, and incentivizing health systems to improve the physician experience through AMA's Organizational Biopsy and Joy in Medicine Health System Recognition Program (The Recognition Program). Currently, the AMA has developed a set of key metrics by which organizations can measure physicians' experience and work environment. These metrics are based on existing research, expert opinion, and data collected through the Organizational Biopsy. The AMA works directly with health systems to assess these metrics and make them accessible to physicians. The Recognition Program requires that organizations measure several of these key indictors and that these data are transparently shared back with physicians.

DISCUSSION

The AMA Organizational Biopsy

Overview

Since 2018, the AMA has completed research and development on metrics to support health systems in measuring the physician work environment and organizational well-being. Specifically, the AMA has worked to develop an assessment tool, the Organizational Biopsy, which provides health systems with a structured and validated survey tool to comprehensively measure organizational culture, practice efficiency, and other dimensions of the physician work environment. The Organizational Biopsy is available to all health systems, and the AMA offers a service delivery model that provides hands-on support to health systems for measurement and critical follow-up steps during the post-assessment period.

History and Background

Development of the Organizational Biopsy began in 2018 with a pilot of several health systems seeking a survey tool to measure system drivers of organizational well-being. The validated Mini-Z[11,12] is included in the Organizational Biopsy and has been a core component of the tool since its inception. Using data and feedback provided in the pilot, the AMA worked to continuously iterate on the tool to ensure actionable data that can guide health system strategies to improve the work environment of its physicians.

Importantly, the Organizational Biopsy measures system-level drivers of organizational well-being and physician burnout. While solutions that support individual resilience are an important contributor to physicians thriving, the AMA focuses primarily on the work environment, as burnout originates in systems. Organizations that survey with the AMA are provided with a comprehensive summary report and AMA health system partners gain access to AMA physician faculty to support them in follow-up steps and development strategies to address issues identified in the survey. More information about the AMA's approach to offering these metrics, data, and follow-up steps are included below.

Psychometric Evaluation

The Mini-Z is a 10-question tool adapted from the Minimizing Error Maximizing Outcome clinician survey. It was designed to assess workplace satisfaction, stress, and burnout by capturing factors including work control, value alignment with organizational leadership, teamwork, documentation time pressure, and EHR use.[13,14] In 2022, the tool was re-evaluated using new data, and the AMA conducted psychometric evaluation to re-validate it.[12]

Metrics

The Organizational Biopsy consists of over 75 questions that measure four overarching domains related to the physician experience. They include:

- Organizational culture (leadership, teamwork, trust, etc.)
- Practice efficiency (team structure, team stability, workflow design, workload control, etc.)
- Work intentions (intention to leave and/or reduce hours)
- Organizational support for individual resiliency (protected time off, work-life balance, etc.)

A complete list of the question set within the tool is available to participating organizations that contact the AMA to schedule a demonstration, access the question bank, and sign up to participate.

Key Performance Indicators

The AMA has identified six key performance indicators (KPIs) that should be used by organizations to regularly assess the state of organizational well-being. These KPIs were developed based on expert opinion, existing research, and correlations in the Organizational Biopsy data that indicated certain metrics are highly valuable in assessing the state of organizational well-being. These six indicators include:

- Burnout (as defined by the single-item Mini-Z assessment)
- Job satisfaction
- Job stress
- Work intentions (physician intent to leave the organization or reduce their clinical hours)
- Feeling valued (how valued do physicians feel by their organization?)
- Time spend (how much time are physicians spending on patient care, administrative work, etc.?)

These KPIs are published annually in the AMA national comparison report, which is provided to all health systems that have measured using the Organizational Biopsy. The national comparison report is also shared with AMA health system partners, and the AMA participates in a variety of national conferences and forums each year to share these data widely with the field and to urge organizations to adopt these key indicators.

Organizations that survey using the Organizational Biopsy receive their KPI results in their executive summary report. These KPIs are also presented to them by various data stratifications, including specialty, gender, and the number of years post-training so that organizations can more readily identify areas that may need additional support, resources, or interventions. More information about these reports can be found below.

The AMA continues to conduct research on emerging metrics to identify new metrics as they arise. This is an ongoing priority for the AMA and efforts to identify new areas for measurement and improvement based on emerging evidence will continue.

Service Delivery

When an organization collaborates with the AMA to distribute the Organizational Biopsy to their physicians, they are supported directly by a team of AMA staff to develop, draft, and distribute their survey. The AMA educates each organization on the KPIs and guides them in selecting questions from the Organizational Biopsy question bank that are actionable and based on organizational need. The service delivery team works closely with each organization to build and test their survey and provide support during the distribution of the survey, usually lasting around six weeks.

Reporting

All data collected through the Organizational Biopsy are stored in the AMA Data Lab, a dynamic and secure reporting platform that is proprietary to the AMA. The AMA offers a survey for practicing physicians and non-physician providers in addition to a resident/fellow survey. Each organization that surveys with the AMA is provided with a unique login to view a reporting dashboard that includes all their survey results, including their KPIs. Survey results are only shared in aggregate with participating organizations. AMA does not report aggregate data unless there are at least six total respondents in any aggregation. Response-level data is confidential and never shared with organizations to maintain the confidentiality of survey respondents. Names and emails are not collected in the survey. Organizations actively use this dashboard to report data back to their executive leadership teams and physicians. The dashboard is user-friendly and allows organizations to seamlessly analyze their survey results, pinpoint areas for improvement, and develop reports for internal reporting.

Organizations also receive customized executive summary reports of their data, which include aggregated findings of the KPIs and other measures included in their survey. The executive summary is paired with a virtual report-out in which AMA staff and physician faculty walk through salient findings and provide organizations with additional context for their results. The executive summary report also includes stratification of the KPIs by several demographics including specialty, gender, and number of years post-training. These initial stratifications allow the AMA to highlight specific areas and/or populations that are in greatest need of support or intervention. Organizations can further analyze their data using the Data Lab. AMA health system partners receive greater attention and support in follow-up from their Organizational Biopsy. The AMA often provides more detailed executive reports for health system partners, including specialty-specific reports and detailed statistical analysis to further inform their approaches to improving the physician work environment.

The AMA also develops an annual national comparison report for its Organizational Biopsy data. This report is developed using the previous year's data (i.e., the 2025 national comparison report includes 2024 data). This comprehensive report provides aggregate insights on the four domains of the Organizational Biopsy and the KPIs. This report also includes data stratifications to highlight specific physician segments that may have different results (e.g., specialties with the highest burnout).

Support Post-Survey

After an executive summary report and virtual report-out are completed, organizations can continue to utilize the Data Lab for any additional reporting needs. Additionally, health systems have access to AMA STEPS Forward, a resource that offers physician-developed toolkits, playbooks, podcasts, and webinars to guide physicians and practices in mitigating burnout and improving practice efficiency.

AMA health system partners are provided with in-depth support from physician faculty to support the development of well-being strategic plans, conduct workshops, and advise on the implementation of interventions. The AMA also provides additional report-outs to health system partners, including reports to executive leaders when requested.

Sharing Results with Physicians Post-Survey

The AMA encourages all organizations that use the Organizational Biopsy to share survey results with their physicians as a critical next step in their work, recognizing that making these results accessible to their physicians is critical for several reasons:

1. Builds Trust and Organizational Credibility

   Transparency signals that leadership values honesty and openness. When health systems share well-being data with physicians, it demonstrates that the organization is committed to addressing the realities of physician experience. This transparency builds credibility and helps foster a culture of trust which is essential for engagement and retention.

2. Promotes Shared Accountability

   Sharing well-being data empowers physicians to be part of the solution. When physicians are aware of trends, challenges, and progress, they can participate meaningfully in developing interventions. This can lead to more collaborative, relevant, and accepted well-being initiatives.

3. Supports Data-Driven Improvements

   Physicians, as scientifically trained professionals, respect and respond to data. Transparency allows physicians to understand the scope of issues like burnout, dissatisfaction, or workload strain. Data shared openly can guide quality improvement efforts in a targeted, measurable way.

4. Normalizes Conversations About Burnout and Well-Being

   Many physicians hesitate to speak up about well-being issues due to stigma or fear of professional consequences. Sharing aggregate data encourages open dialogue, which is crucial for reducing stigma and fostering psychological safety.

5. Enables Benchmarking and Progress Tracking

   When well-being data is shared over time, physicians can see whether interventions are making a difference. This creates a sense of momentum and accountability for ongoing improvements.

6. Enhances Engagement and Morale

   When physicians feel heard and see their feedback reflected in data and subsequent changes, morale and engagement can improve.

Information about the importance of sharing data back with physicians and making it accessible to them is included in Organizational Biopsy materials and is identified as a core part of the survey process.

The AMA typically works with health systems on an annual basis to re-measure to determine whether improvements have led to better outcomes.

The Joy in Medicine Health System Recognition Program

Launched in 2019, the Joy in Medicine Health System Recognition Program (the Recognition Program) incentivizes health systems to improve the physician experience by providing public national recognition for organizations that have met a set of evidence-informed criteria centered on addressing the primary system drivers of physician burnout and organizational well-being. Organizations self-attest through an annual application process to criteria involving bronze, silver, and gold levels of recognition. Organization must submit supporting documentation as evidence of their work. A review committee reviews each application to determine if an organization adequately meets recognition criteria requirements.

The Recognition Program provides a comprehensive roadmap to guide organizations through the existing research and interventions to improve organizational well-being—and thus, the physician experience. Measurement of various outcomes and processes are foundational to the program, as AMA asserts that this data can and should be used to understand unique organizational drivers of physician burnout within an organization and to help focus system-specific solutions.

Measures included in the Recognition Program criteria include:

- Burnout (using a validated tool)
- Intentions to leave or reduce work effort (via survey)
- Teamwork assessments (via surveys)
- Leadership skills assessments and their impact on direct team members (via surveys) and
- EHR audit log data to help illuminate the day-to-day experience of physicians and identify workload/workflow improvements.

The Recognition Program includes required criteria for health systems to share these data internally with their physicians as well as their executive leadership teams for shared decision making and increased accountability.

Specifically, the Recognition Program criteria states that to receive recognition at any level, organizations must "share survey results with the physicians that participated in the survey".[15] Organizations must attest in their application that they have done so, providing information on how, when, and where those results were made accessible to their physicians. This further incentivizes organizations, as organizations cannot receive recognition without doing so.

Organizational recognition is valid for two years. Since 2019, AMA has recognized more than 150 organizations for their efforts, and this body of work continues to gain a national spotlight in the efforts to improve physician well-being. Health system leaders have publicly noted the impact the Recognition Program has had on their efforts to improve conditions for their workforce and in providing them with a critical framework for addressing a complex issue. AMA continues to review emerging evidence and expert opinions to identify the most pressing issues related to organizational well-being and a thriving physician workforce. It is an ongoing priority to regularly evaluate our framework, seeking input from our health system partners and other stakeholders to ensure that the AMA remains the national leader in physician well-being.

AMA Research

Beginning in 2011, researchers from the AMA, Mayo Clinic, University of Colorado School of Medicine, and Stanford Medicine produced the only study to regularly measure physician burnout rates.[16] Since

then, this study series has measured the prevalence of occupational burnout, professional fulfillment, and satisfaction with work-life integration among physicians and the general U.S. working population every three years. The most recent study found that in 2023, 45.2 percent of physicians reported at least one symptom of burnout compared to 62.8 percent in 2021, 38.2 percent in 2020, 43.9 percent in 2017, 54.4 percent in 2014, and 45.5 percent in 2011. Burnout among U.S. physicians peaked in 2021 during the earlier part of the COVID-19 pandemic and improved in 2023, returning to pre-pandemic levels seen in 2017. Despite this improvement, physicians remain at increased risk for burnout compared to the general U.S. working population.[1]

The AMA also continues to advance the science on the use of EHR user audit log data to better understand EHR use and its impact on the physician experience. This research helps stakeholders identify factors that support or hinder patient care; contribute to burnout and physicians' intent to reduce clinical hours, leave their practice, or exit medicine altogether; and inform improvements in workflow efficiency and resource allocation. Using audit log data, the AMA has defined and standardized key EHR use metrics[17,18], and examined factors such as cognitive load[19], documentation[20–22], inbox management[6,7,23], after-hours work[24], and work during vacation.[8] Studies also used these metrics to analyze variations by specialty.[25,26]

Additionally, the AMA has been a leading contributor to the literature on physicians' work intentions. Its published studies have examined the relationship between physicians' work intentions and stress[27] and work overload[3] during the COVID-19 pandemic, as well as factors such as work environment[28] , work control[29], and perceived pay fairness.[30]

AMA POLICY

The AMA has several policies related to accessible hospital and hospital system metrics aimed at improving the physician experience.

The AMA will study current tools and develop metrics to measure physician professional satisfaction (Policy D-405.985, "Physician Satisfaction").

The AMA will also foster the creation of quality measures and rating systems that incorporates the satisfaction and perspective of the medical staff regarding individual hospitals (Policy D-215.988, "Capturing Physician Sentiments of Hospital Quality").

Further, the AMA promotes physician-developed guidelines for evaluating patient and physician satisfaction with plans, accreditation standards, utilization, quality and cost policies (Policy H-450.962, "National Committee for Quality Assurance").

Additionally, the AMA supports that the "Triple Aim" be expanded to the Quadruple Aim, adding the goal of improving the work-life balance of physicians and other health care providers.
The AMA will also advocate that addressing physician satisfaction count as a Clinical Practice Improvement Activity under the Merit-Based Incentive Payment System (MIPS) (Policy H-405.955, "Support for the Quadruple Aim").

The AMA also recognizes that medical students, resident physicians, and fellows face unique challenges that contribute to burnout during medical school and residency training, such as debt burden, inequitable compensation, discrimination, limited organizational or institutional support, stress, depression, suicide, childcare needs, mistreatment, long work and study hours, among others, and that such factors be included as metrics when measuring physician well-being, particularly for this population of physicians (Policy H-405.948, "Factors Causing Burnout").

CONCLUSION

The AMA has made substantial efforts to address and improve physician burnout, professional satisfaction, and workforce turnover. Such efforts have included the adoption of a variety of policies, advocacy, partnerships with professional organizations, development and dissemination of tools, research, educational resources, and hands-on support for health systems to regularly assess the state of their physician workforce.

The AMA has been tracking burnout and other key metrics nationally since 2011. At the organizational level, the AMA has worked over the past several years to develop a set of KPIs related to physician experience, burnout, and the work environment. These include: burnout, job satisfaction, job stress, feeling valued, work intentions, and overall time spent on various clinical and administrative tasks. These KPIs are published in the AMA's annual national comparison report and the AMA currently works with over 150 health systems in measuring these KPIs on an annual basis and reporting them back to their physicians. The Joy in Medicine Health System Recognition Program further incentivizes health systems to measure these KPIs and make them accessible to physicians by requiring that organizations do so to receive national recognition from the AMA.

RECOMMENDATIONS

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

1. Our American Medical Association supports the use of metrics that hospitals and hospital systems can use to improve physicians' experience, engagement, and work environment in a manner accessible to physicians (New HOD Policy)

2. That Policy D-215.979, "Published Metrics for Hospitals and Hospital Systems," be rescinded as being accomplished by this report. (Rescind HOD Policy)

Fiscal Note: Minimal

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REPORT 1 OF THE COUNCIL ON MEDICAL SERVICE (I-25)
Health Savings Account Reform
(Reference Committee J)

EXECUTIVE SUMMARY

At the 2024 Interim Meeting, the House of Delegates referred Resolution 803-I-24, "Health Care Savings Account Reform," which asked the American Medical Association (AMA) to:

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

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

An HSA pairs with an HSA-eligible high-deductible health plan (HDHP) and is a tax-advantaged way to save money for qualified medical expenses. HSAs are closely tied to United States tax code and have many guidelines and regulations they must follow as a result. In 2023, there were 36 million active HSA accounts that reported holding over $116 billion in assets. An individual can contribute to an HSA if: 1) they are not enrolled in a health plan sponsored by their spouse or parent that is not an HSA-eligible health plan; 2) they have no other health coverage (with some exceptions); 3) they are not enrolled in Medicare; and 4) they cannot be claimed as a dependent on someone else's tax return. As long as HSA funds are used for qualified medical expenses, an individual will not owe taxes on the money when it is taken out of the account. Employers can contribute to employees' HSAs, and like a 401(k) account, the money remains with the employee, even if they leave their job. Investing HSA funds is also possible and can help build a nest egg for health expenses later in life when needs may be greater.

Council on Medical Service Report 1-I-25 examines each of the proposed clauses and makes several policy recommendations to improve usability and flexibility for those who have HSAs but does not encourage or incentivize replacing other forms of health coverage with these accounts. The report recommends supporting HSA contributions from family members, employers, or other designated individuals; supporting continued contributions to HSAs by Medicare enrollees, with further study on appropriate guardrails for using those funds; amending AMA policy to include dental, vision, and hearing insurance premiums as qualified medical expenses; supporting external research and/or demonstration projects on the feasibility and tax integrity of transferring HSA funds between spouses and family members; supporting ACA premium tax credit design that allows unused or residual tax credits be placed in an HSA; amending AMA policy to support individual market bronze and silver plans being treated as HSA-qualified HDHPs; and supporting education on the use of HSAs, specifically to Medicare enrollees and those interested in bronze or silver plans on the ACA marketplace.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 1-I-25

Subject: Health Savings Account Reform

Presented by: Betty Chu, MD, MBA, Chair

Referred to: Reference Committee J

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

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

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

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

BACKGROUND

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

accounts that reported holding over $116 billion in assets. This represents a 500 percent increase since 2013.[3]

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

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

There are several advantages to an HSA:

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

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

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

becomes problematic when deductibles are too high for enrollees to afford and patients are unable to cover their costs when they need access to care.[10]

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

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

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

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

PROPOSED CHANGES TO HSAs

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

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

Contributions to the accounts of dependents, including children and spouses

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

Contributions from Medicare and Medicaid enrollees

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

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

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

Medicaid enrollees typically do not have access to qualifying HDHPs. According to Medicaid.gov, Michigan, Indiana, and Arkansas have used Section 1115 demonstration waivers to implement programs to offer HSAs for Medicaid beneficiaries. Iowa and Pennsylvania are also exploring the possibilities of using Medicaid funds to enroll beneficiaries in these plans. States that have tried these programs have ended them after their trial periods due to low enrollment, cost, and additional administrative burdens.

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

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

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

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

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

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

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

> contribution. The spouse with the family HDHP coverage must reduce their contribution amount by the contribution amount made by the spouse with self-only coverage. The spouses' combined contribution amounts cannot exceed the amount allowed for family coverage.[20]

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

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

Expansion of the role and functions of HSAs

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

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

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

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

the OBBBA, beginning on January 1, 2026, all premium tax credit recipients must repay the full amount of excess, no matter their household income.[21]

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

AMA POLICY

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

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

Policy H-165.852(7) states that legislation promoting the establishment of and use of HSAs and allowing the tax-free use of such accounts for health care expenses, including health and long-term care insurance premiums and other costs of long-term care, be strongly supported as an integral component of AMA efforts to achieve universal access and coverage and freedom of choice in health insurance. The addition of dental and vision premiums as qualified medical expenses could be considered within this policy.

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

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

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

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

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

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

DISCUSSION

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

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

The Council believes it is reasonable to support continued contributions to an HSA once an individual has reached 65 years of age and is eligible for Medicare. Many individuals live decades past eligibility for Medicare, and allowing continued contributions to an HSA can help those individuals continue to prepare for the medical costs associated with aging, especially since funds from an HSA can be used to pay for long-term care premiums. However, in order to follow the current tax laws, guardrails would need to be in place to ensure this benefit does not further strain the Medicare program and can be accessed fairly among Medicare beneficiaries, regardless of socioeconomic status. The Council believes that further study from tax experts and others is warranted to develop the specific guardrails but recommends that Medicare enrollees be allowed to continue to contribute to an HSA. Regarding Medicaid, the AMA has extensive policy outlining principles for states considering offering HSA-like accounts to their Medicaid populations. Notably, most states that have attempted to do so have ended these programs due to low use, expense, and/or associated administrative burdens.

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

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

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

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

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

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

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

RECOMMENDATIONS

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

1) That our American Medical Association (AMA) support permitting health savings account (HSA) contributions from family members, employers, or other designated individuals and not limiting HSA contributions to the owner of the high-deductible health plan, provided that annual Internal Revenue Service contribution limits are not exceeded. (New HOD Policy)

2) That our AMA support contributions to HSAs by individuals who are Medicare enrollees with support for external research and/or demonstration projects to determine how best those distributions can be spent, with special consideration for low-resource Medicare enrollees. (New HOD Policy)

3) That our AMA amend Policy H-165.852 by addition to read as follows:

HEALTH SAVINGS ACCOUNTS, H-165.852
It is the policy of the AMA that:

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

4) That our AMA supports external research and/or demonstration projects on the feasibility and tax integrity of transferring HSA funds between spouses and other family members. (New HOD Policy)

5) That our AMA supports Affordable Care Act (ACA) premium tax credits designed to allow individuals to contribute to HSAs through the application of unused or residual credit amounts. (New HOD Policy)

6) That our AMA amend Policy H-165.828 by addition and deletion to read as follows:

HEALTH INSURANCE AFFORDABILITY, H-165.828

(3) Our AMA (i) encourages the development of demonstration projects to allow individuals eligible for cost-sharing subsidies, who forego these subsidies by enrolling in a bronze plan, to have access to a health savings account (HSA) partially funded by an amount determined to be equivalent to the cost-sharing subsidy; and (ii) supports individual market bronze and silver plans being treated as HSA-qualified high-deductible health plans.
(Modify Current HOD Policy)

7) That our AMA supports education on the use of HSAs to Medicare beneficiaries and purchasers of ACA marketplace plans, including those purchasing bronze plans and how that plan compares to purchasing a silver plan with subsidies. (New HOD Policy)

8) That our AMA reaffirm Policy H-290.972, Health Savings Accounts in the Medicaid Program, which outlines several principles for states considering offering beneficiaries HSAs. (Reaffirm HOD Policy)

9) That our AMA reaffirm Policy H-165.833, Amend the Patient Protection and Affordable Care Act, which states that as part of the AMA's organizational goal of amending and improving the Affordable Care Act, the AMA will advocate to expand the use of HSAs as a means to provide health insurance. (Reaffirm HOD Policy)

10) That our AMA reaffirm Policy H-385.912, Direct Primary Care, which states that the use of a health savings account to access direct primary care (DPC) providers and/or to receive care from a direct primary care medical home constitutes and bona fide medical expense, and that particular sections of the IRS code related to qualified medical expenses should be amended to recognize the use of HSA funds for DPC and DPC medical home models as a qualified medical expense. Furthermore, H-385.912 states that the AMA will seek federal legislation or regulation to amend appropriate sections of the IRS code to specify that DPC access or DPC medical homes are not health "plans" and that the use of HSA funds to pay for DPC provider services in such setting constitutes a qualified medical expense, enabling patients to use HSAs to help pay for DPC and to enter DPC periodic-fee agreements without IRS interference or penalty. (Reaffirm HOD Policy)

Fiscal Note: Minimal

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[21] *Supra.* Item 18

Council on Medical Service Report 1-I-25
Health Savings Account Reform
Policy Appendix

Update on HSAs, HRAs, and Other Consumer-Driven Health Care Plans, D-165.954
Our AMA will: (1) educate physicians about health insurance plan practices that may impact physician billing and collection of payment from patients with Health Savings Accounts (HSAs), health reimbursement arrangements (HRAs), and other forms of consumer-driven health care; and (2) monitor and support rigorous research on the impact of HSAs and HRAs on physician practices, and on levels and appropriateness of utilization, including preventive care, costs, and account savings.
(CMS Rep. 3, I-05; Modified: CMS Rep. 1, A-15)

Health Savings Accounts for Older Americans, D-165.962
Our AMA will monitor pending regulations and take appropriate steps to ensure access to Health Savings Accounts by all Medicare eligible individuals.
(Sub. Res. 702, A-04; Reaffirmation: A-10; Reaffirmed: BOT Rep. 04, A-20)

Flexible Spending Accounts (FSAs), H-165.863
1. Along with other efforts to liberalize Health Savings Account rules, our AMA places a top priority on allowing employees to roll-over any unexpended funds in a Flexible Spending Account into a Health Savings Account.
2. Our AMA will advocate for a reasonable increase in Section 125 Flex Spending Accounts.
(Reaffirmed by Sub. Res. 125 and Sub. Res. 109, A-95; Reaffirmation: A-97; Reaffirmed: CMS Rep. 5, I-97; Reaffirmation: I-98; Reaffirmed: CMS Rep. 5, and 7, I-99; Appended by Res. 220, A-00; Reaffirmation: I-00; Res. 120, A-01; Reaffirmed: CMS Rep. 2, I-01; Reaffirmation: A-02; Reaffirmed: CMS Rep. 3, I-02; Reaffirmed: CMS Rep. 3, A-03; Reaffirmation: I-03; Reaffirmation: A-04; Consolidated: CMS Rep. 7, I-05; Appended: Res. 121, A-15; Modified: CMS Rep. 1, A-15)

Health Savings Accounts, H-165.852
It is the policy of the AMA that:
(1) high-deductible health insurance plans issued to families in conjunction with Health Savings Accounts (HSAs) be allowed to apply lower, per-person deductibles to individual family members with the permitted levels for per-person deductibles being the same as permitted levels for individual deductibles, and with the annual HSA account contribution limit being determined by the full family deductible or the dollar-limit for family policies;
(2) contributions to HSAs should be allowed to continue to be tax deductible until legislation is enacted to replace the present exclusion from employees' taxable income of employer-provided health expense coverage with tax credits for individuals and families;
(3) advocacy of HSAs continues to be incorporated prominently in its campaign for health insurance market reform;
(4) activities to educate patients about the advantages and opportunities of HSAs be enhanced;
(5) efforts by companies to develop, package, and market innovative products built around HSAs continue to be monitored and encouraged;
(6) HSAs continue to be promoted and offered to AMA physicians through its own medical insurance programs;
(7) legislation promoting the establishment and use of HSAs and allowing the tax-free use of such accounts for health care expenses, including health and long-term care insurance premiums and other costs of long-term care, be strongly supported as an integral component of AMA efforts to achieve universal access and coverage and freedom of choice in health insurance.

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

Health Savings Accounts in the Medicaid Program, H-290.972
It is the policy of our AMA that states offering Medicaid beneficiaries Health Savings Accounts (HSAs) should adhere to the following principles:
A. Make beneficiary participation voluntary;
B. Provide first-dollar coverage of preventive services regardless of whether the beneficiary has met the deductible;
C. Offer positive incentives to reward healthy behavior and offset beneficiary cost-sharing, provided that such incentives do not result in punitive cuts in standard benefits or increased cost-sharing to enrollees who are unable to achieve improvements in personal behavior affecting their health;
D. Set deductibles at 100% of account contributions, but no higher;
E. Allow payments to non-Medicaid providers by beneficiaries to count toward deductibles and out-of-pocket spending limits;
F. Allow the deductible limits for families to be the lower of either the individual or family combined deductible;
G. Ensure that enrollees are protected by standard Medicaid maximum out-of-pocket spending limits;
H. Provide outreach, information, and decision-support that is readily accessible through a variety of formats (e.g., written, telephone, online) and in multiple languages;
I. Encourage HSA enrollees to establish a medical home, in order to assure provision of preventive care services, coordination of care and continuity of care;
J. Prohibit use of HSA funds for non-medical purposes, but consider allowing HSA balances of enrollees who lose Medicaid coverage to be used to purchase private insurance, including the employee share of premium for employer-sponsored coverage;
K. Monitor the impact on utilization and beneficiary financial burden;
L. Test broadening of eligibility to include currently ineligible beneficiary groups; and
M. Ensure that physicians and other providers of health care services have access to up-to-date information verifying beneficiary enrollment and covered benefits, and are paid at point-of-service, or are allowed to use their standard billing procedures to obtain payment from the insurer or account custodian.
(CMS Rep. 1, I-06; Modified: CMS Rep. 01, A-16; Reaffirmation: A-18)

Increasing Accessibility to Incontinence Products, H-155.955
Our AMA supports increased access to incontinence products for children and adults, including the removal of sales tax, and ensuring eligibility of these products as medical expenses for Health Savings Accounts (HSAs), Health Reimbursement Arrangements (HRAs), and Flexible Spending Accounts (FSAs).
(Res. 908, I-18; Modified: Res. 231, A-22)

Health Insurance Affordability, H-165.828
1. Our American Medical Association supports modifying the eligibility criteria for premium credits and cost-sharing subsidies for those offered employer-sponsored coverage by lowering the threshold that determines whether an employee's premium contribution is affordable to the level at which premiums are capped for individuals with the highest incomes eligible for subsidized coverage in Affordable Care Act (ACA) marketplaces.
2. Our AMA supports legislation or regulation, whichever is relevant, to fix the ACA's "family glitch," thus determining the eligibility of family members of workers for premium tax credits and cost-sharing reductions based on the affordability of family employer-sponsored coverage and household income.
3. Our AMA encourages the development of demonstration projects to allow individuals eligible for cost-sharing subsidies, who forego these subsidies by enrolling in a bronze plan, to have access to a health savings account (HSA) partially funded by an amount determined to be equivalent to the cost-sharing subsidy.
4. Our AMA supports capping the tax exclusion for employment-based health insurance as a funding stream to improve health insurance affordability, including for individuals impacted by the inconsistency in affordability definitions, individuals impacted by the "family glitch," and individuals who forego cost-sharing subsidies despite being eligible.
5. Our AMA supports additional education regarding deductibles and cost-sharing at the time of health plan enrollment, including through the use of online prompts and the provision of examples of patient cost-sharing responsibilities for common procedures and services.
6. Our AMA supports efforts to ensure clear and meaningful differences between plans offered on health insurance exchanges.
7. Our AMA supports clear labeling of exchange plans that are eligible to be paired with a Health Savings Account (HSA) with information on how to set up an HSA.
8. Our AMA supports the inclusion of pregnancy as a qualifying life even for special enrollment in the health insurance marketplace.
(CMS Rep. 8, I-15; Reaffirmed in lieu of: Res. 121, A-16; Reaffirmation: A-17; Reaffirmed: CMS Rep. 09, A-19; Reaffirmed: CMS Rep. 02, A-19; Reaffirmed in lieu of: Res. 101, A-19; Reaffirmed: CMS Rep. 01, I-20; Reaffirmed: CMS Rep. 2, I-20; Modified: CMS Rep. 3, I-21; Appended: Res. 701 I-21; Reaffirmed: Res. 826, I-24)

Update on HSAs, HRAs, and Other Consumer-Driven Health Care Plans, H-165.849
1. Our AMA opposes health plan requirements that require physicians to bill patients for out-of-pocket payments and do not allow physicians to collect these payments in a more efficient manner, such as collecting at point-of-service, establishing systems of electronic transfers from a patient's account, or offering case discounts for expedited payment, particularly for patients enrolled in health savings accounts (HSAs), health reimbursement arrangements (HRAs), and other consumer-directed health care plans.
2. Our AMA will engage in a dialogue with health plan representatives (e.g., Americas Health Insurance Plans, Blue Cross and Blue Shield Association) about the increasing difficulty faced by physician practices in collecting co-payments and deductibles from patients enrolled in high-deductible health plans.
(CMS Rep. 3, I-05; Reaffirmed: CMS Rep. 1, A-15; Appended: BOT Action in response to referred for decision Res. 805, I-16; Reaffirmed: CMS Rep. 09, A-19)

Transparency of Employer Sponsored Health Insurance, H-155.961
Our AMA encourages employers to inform employees as frequently as possible, preferably with each payment period (pay stub) but at least annually, of the total cost of health insurance benefits

paid on their behalf by the employer in the form of health insurance premiums, direct payments for services and deposits into health savings accounts.
(Res. 127, A-07; Reaffirmed: CMS 01, A-17)

Direct Primary Care, H-385.912
1. Our AMA supports: (a) inclusion of Direct Primary Care as a qualified medical expense by the Internal Revenue Service; and (b) efforts to ensure that patients in Direct Primary Care practices have access to specialty care, including efforts to oppose payer policies that prevent referrals to in-network specialists.
2. AMA policy is that the use of a health savings account (HSA) to access direct primary care providers and/or to receive care from a direct primary care medical home constitutes a bona fide medical expense, and that particular sections of the IRS code related to qualified medical expenses should be amended to recognize the use of HSA funds for direct primary care and direct primary care medical home models as a qualified medical expense.
3. Our AMA will seek federal legislation or regulation, as necessary, to amend appropriate sections of the IRS code to specify that direct primary care access or direct primary care medical homes are not health "plans" and that the use of HSA funds to pay for direct primary care provider services in such settings constitutes a qualified medical expense, enabling patients to use HSAs to help pay for Direct Primary Care and to enter DPC periodic-fee agreements without IRS interference or penalty.
(Res. 103, A-16; Appended: Res. 246, A-18; Reaffirmation: A-18; Reaffirmation: I-18; Appended: Res 102, A-19)

Principles for Structuring a Health Insurance Tax Credit, H-165.865
(1) AMA support for replacement of the present exclusion from employees' taxable income of employer-provided health insurance coverage with tax credits will be guided by the following principles: (a) Tax credits should be contingent on the purchase of health insurance, so that if insurance is not purchased the credit is not provided. (b) Tax credits should be refundable. (c) The size of tax credits should be inversely related to income. (d) The size of tax credits should be large enough to ensure that health insurance is affordable for most people. (e) The size of the tax credits should be capped in any given year. (f) Tax credits should be fixed-dollar amounts for given income and family structure. (g) The size of tax credits should vary with family size to mirror the pricing structure of insurance premiums. (h) Tax credits for families should be contingent on each member of the family having health insurance. (i) Tax credits should be applicable only for the purchase of health insurance, including all components of a qualified Health Savings Account, and not for out-of-pocket health expenditures. (j) Tax credits should be advanceable for low-income persons who could not afford the monthly out-of-pocket premium costs.
(2) It is the policy of our AMA that in order to qualify for a tax credit for the purchase of individual health insurance, the health insurance purchased must provide coverage for hospital care, surgical and medical care, and catastrophic coverage of medical expenses as defined by Title 26 Section 9832 of the United States Code.
(3) Our AMA will support the use of tax credits, vouchers, premium subsidies or direct dollar subsidies, when designed in a manner consistent with AMA principles for structuring tax credits and when designed to enable individuals to purchase individually owned health insurance.
(CMS Rep. 4, A-00; CMS Rep. 5, A-00; Reaffirmation, I-00; Reaffirmation: A-02; Reaffirmation: I-03; CMS Rep. 2, A-04; Consolidated: CMS Rep. 7, I-05; Reaffirmation: A-07; Modified: CMS Rep. 8, A-08; Reaffirmed in lieu of Res. 813, I-08; Reaffirmation: A-10; Reaffirmed: CMS Rep. 9, A-11; Reaffirmation: A-11; Reaffirmed: Res. 239, A-12; Reaffirmed: CMS Rep. 9, A-14; Reaffirmed: CMS Rep. 01, A-24)

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

1. Our American Medical Association supports Value-Based Insurance Design (VBID) plans designed in accordance with the tenets of "clinical nuance," recognizing that
a. medical services may differ in the amount of health produced.
b. the clinical benefit derived from a specific service depends on the person receiving it, as well as when, where, and by whom the service is provided.
2. Our AMA supports initiatives that align provider-facing financial incentives created through payment reform and patient-facing financial incentives created through benefit design reform, to ensure that patient, provider, and payer incentives all promote the same quality care. Such initiatives may include reducing patient cost-sharing for the items and services that are tied to provider quality metrics.
3. Our AMA will develop coding guidance tools to help providers appropriately bill for zero-dollar preventive interventions and promote common understanding among health care providers, payers, patients, and health care information technology vendors regarding what will be covered at given cost-sharing levels.
4. Our AMA will develop physician educational tools that prepare physicians for conversations with their patients about the scope of preventive services provided without cost-sharing and instances where and when preventive services may result in financial obligations for the patient.
5. Our AMA will continue to support requiring private health plans to provide coverage for evidence-based preventive services without imposing cost-sharing (such as co-payments, deductibles, or coinsurance) on patients.
6. Our AMA will continue to support implementing innovative VBID programs in Medicare Advantage plans.
7. Our AMA supports legislative and regulatory flexibility to accommodate VBID that:
a. preserves health plan coverage without patient cost-sharing for evidence-based preventive services.
b. allows innovations that expand access to affordable care, including changes needed to allow High Deductible Health Plans paired with Health Savings Accounts to provide pre-deductible coverage for preventive and chronic care management services.
8. Our AMA encourages national medical specialty societies to identify services that they consider to be high-value and collaborate with payers to experiment with benefit plan designs that align patient financial incentives with utilization of high-value services.
(Joint CMS CSAPH Rep. 01, I-18; Reaffirmed: CMS Rep. 06, A-19; Reaffirmed in lieu of: Res. 101,
A-19; Reaffirmed: CMS Rep. 2, I-20; Reaffirmation: A-22)

Amend the Patient Protection and Affordable Care Act (PPACA), H-165.833
1. Our AMA continues to advocate to achieve needed reforms of the many defects of the federal Patient Protection and Affordable Care Act (PPACA) law so as to protect the primacy of the patient-physician relationship. These needed changes include but are not limited to:
- repeal of the Independent Payment Advisory Board (IPAB);
- study of the Medicare Cost/Quality Index;
- repeal of the non-physician provider non-discrimination provision;
- enactment of comprehensive medical liability reform;
- enactment of long term Medicare physician payment reform including permitting patients to privately contract with physicians not participating in the Medicare program;
- enactment of antitrust reform to permit independently practicing physicians to collectively negotiate with health insurance companies; and
- expanding the use of health savings accounts as a means to provide health insurance coverage.
2. Our AMA will vigorously work to change the PPACA to accurately represent our AMA policy.
(Res. 217, A-11; Reaffirmation: A-12; Reaffirmed: Res. 239, A-12; Reaffirmed: CMS Rep. 5, I-12; Reaffirmed: CMS Rep. 9, A-14; Reaffirmed in lieu of Res. 215, A-15; Reaffirmed: Res. 206, A-19)

REPORT 2 OF THE COUNCIL ON MEDICAL SERVICE (I-25)
Telehealth Licensure
(Reference Committee J)

EXECUTIVE SUMMARY

Telehealth falls within the Council on Medical Service's purview and has been the subject of several reports, including Council on Medical Service Report 8-Jun-21, Licensure and Telehealth, which established American Medical Association (AMA) policy supporting an exception for out-of-state physicians providing continuity of care to existing patients (Policy D-480.960), and Council on Medical Service Report 1-I-19, Established Patient Relationships and Telemedicine, which established AMA policy encouraging participation in the Interstate Medical Licensure Compact (ILMC) and supporting state efforts to expand licensure recognition across state lines (Policy D-480.964).

The Council monitors telehealth policy issues and self-initiated this updated report to assess the need for new AMA policy supporting licensure exceptions that permit physicians to provide medical care to out-of-state patients using telehealth. Existing AMA policy supports exceptions allowing interstate telehealth for continuity of care purposes, physician-to-physician consultations, and in the event of urgent or emergent circumstances. Additional AMA policy supports streamlining licensure processes and reducing licensure costs, as well as state efforts to expand licensure recognition across state lines.

Consistent with previous work on this topic, the Council adopted a balanced approach to policy development that seeks solutions for physicians and patients as well as appropriate guardrails that ensure high quality patient care. The Council continues to believe that there must be clear lines of accountability in licensure policies to protect patients, and that licensure of physicians and other health professionals should remain within the purview of each state, which is the prevailing standard. At the same time, AMA policy needs to keep pace with telehealth innovations, including those that lessen geographic barriers to care by enabling patients to access medical services not available close to home. After reviewing the literature and updated telehealth policies from the Federation of State Medical Boards, the Uniform Law Commission, and across states, the Council found that additional licensure exceptions are warranted for physicians using telehealth to prospectively screen patients for complex referrals, and physicians working on and recruiting patients for clinical trials. As with any exception, a physician must have a medical license in good standing in order to qualify. Accordingly, the Council recommends amending Policy H-480.969[1] to support exemptions from licensure requirements for physicians assessing or screening out-of-state patients for acceptance of a referral to a center for excellence or to a physician with specific expertise in the patient's condition; physicians screening out-of-state patients for acceptance into a clinical trial; and physicians conducting assessments of out-of-state patients that are required as part of a clinical trial, as long as certain conditions are met.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 2-I-25

Subject: Telehealth Licensure

Presented by: Betty Chu, MD, MBA, Chair

Referred to: Reference Committee J

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

- Council on Medical Service Report 8-Jun-21, Licensure and Telehealth, was written during the COVID-19 pandemic, when telehealth use increased dramatically. This report established American Medical Association (AMA) policy supporting an exception for out-of-state physicians providing continuity of care to an existing patient, provided that a previous in-person visit has occurred and the telehealth services are incident to an ongoing care plan or one that is being modified (Policy D-480.960). Prior to this policy being adopted, the AMA had supported narrow exceptions to state licensure requirements for physician-to-physician consultations and in the event of an urgent or emergent circumstance (Policy H-480.969).
- Council on Medical Service Report 1-I-19, Established Patient Relationships and Telemedicine, was written prior to the pandemic at a time when fewer physicians were practicing interstate telehealth. This report established new AMA policy encouraging participation in the Interstate Medical Licensure Compact (ILMC) and supporting state efforts to expand licensure recognition across state lines (Policy D-480.964).

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

BACKGROUND

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

in 2018, a figure that rose to 79 percent in 2020 before decreasing to 71 percent in 2024.[2] To support this transformation, telehealth became a core element of the AMA Recovery Plan for America's Physicians post pandemic.

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

INTERSTATE TELEHEALTH

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

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

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

Interstate Medical Licensure Compact

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

Federal/National Initiatives

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

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

State Exceptions to Licensure Requirements

Because the standards and scope of telehealth services should be consistent with related in-person care (consistent with Policy H-480.946), state licensure requirements vary by but still generally adhere to the prevailing standards, with some exceptions. In an attempt to address some of the challenges to practicing telehealth across state lines, states have adopted a variety of measures, including limited licensure exceptions for certain types of care, alternative licensure/registration processes for interstate telehealth, and cross-state licensing that allows physicians to practice in

contiguous states. An example of the latter is the agreement between DC, Maryland, and Virginia medical boards that facilitated expedited licensure reciprocity for physicians practicing in the area.[8]

According to the Federation of State Medical Boards (FSMB), all state medical boards require that physicians engaging in telehealth be licensed in the state where the patient is located or registered in the state if the state maintains a special registry for interstate telehealth. Licensure exceptions and/or consultation exceptions for telehealth services rendered across state lines are in place in 40 states plus DC and Guam.[9] To qualify for an exception, physicians must have an existing license to practice medicine in good standing. State-based licensure exceptions can be useful to physicians because they permit limited interstate telehealth work without requiring lengthy applications or licensure fees. Some of the more common state licensure exceptions include:

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

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

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

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

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

FEDERATION OF STATE MEDICAL BOARDS (FSMB) MODEL POLICY

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

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

FSMB's updated model policy permits the practice of interstate telehealth, without the need for licensure in the state where the patient is located, for the following:

- *Physician-to-physician consultations*, which permit physicians licensed in another state to consult with licensed practitioners responsible for diagnosing and treating a patient in the patient's state. Policy H-480.969 similarly supports an exception for physician-to-physician consultations.
- *Prospective patient screening for complex referrals*, which exempts physicians providing specialty assessments or consultations, such as at centers for excellence, from obtaining licenses in the state where the patient is located in order to screen a patient for acceptance of

a referral. FSMB policy specifies that, "If the out-of-state physician agrees to diagnosis, counsel, or treat the patient directly, the patient must travel to the state where the physician is licensed, or the physician must obtain a license to practice medicine in the state where the patient is located." Policy H-480.969 supports an exception for physician-to-physician consultations but does not specifically address prospective patient screening for complex referrals.

- *Episodic follow-up care for established patients*, which permits physicians to provide care while an established patient is temporarily out of the state as long as the physician has sufficient clinical information to provide care that meets the accepted standard of care. Policies D-480.960 and H-480.969 similarly support a continuity of care exception.
- *Follow-up after travel for surgical/medical treatment*, which allows follow-up care via telehealth for patients with rare or severe diagnoses or treatments who have traveled to a medical center in another state to get specialty care and need follow-up care after returning home. FSMB policy states that, "Physicians providing out-of-state care under this exception should ensure that their patients have backup plans to receive care locally if changes in their medical condition make that necessary." Policies D-480.960 and H-480.969 support continuity of care exceptions that are inclusive of follow-up care.
- *Clinical trials*, so that physicians working on clinical trials enabled by telehealth are not precluded from including patients residing in states where the physician is not licensed. FSMB policy stipulates that, "Physicians providing out-of-state care under this exception should ensure that their patients have backup plans to receive care locally if changes in their medical conditions make that necessary." A licensure exception for clinical trials work is not addressed in AMA policy.

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

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

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

AMA POLICY

The AMA has numerous telemedicine/telehealth policies as well as model state legislation. Policy D-480.960 was established by Council on Medical Service Report 8-Jun-21, Licensure and Telehealth, along with a follow-up Board of Trustees Management Report. This policy directs the AMA to work with FSMB, state medical associations, and other stakeholders to encourage states to

allow an out-of-state physician to use telehealth to provide continuity of care to an existing patient in the state without penalty if the following conditions are met:

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

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

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

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

Policy H-130.941 supports the Uniform Emergency Volunteer Health Practitioners Act. Code of Medical Ethics Opinion 1.2.12 states that physicians who provide clinical services through

telemedicine must uphold the standards of professionalism expected in in-person interactions, follow appropriate ethical guidelines of relevant specialty societies and adhere to applicable law governing the practice of telemedicine. Clinical trials are addressed by numerous policies, including Policies H-460.911, H-460.912, and H-460.965, and Code of Medical Ethics Opinion 7.1.4. The AMA has substantial scope of practice policy, including Policies D-160.995, H-270.958, and H-160.949. Principles for the supervision of nonphysician providers when telemedicine is used are outlined in Policy H-160.937.

DISCUSSION

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

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

The Council also recommends amending Policy H-480.969[1] to support an exemption from licensure requirements for physicians screening out-of-state patients for acceptance into a clinical trial, as long as the trial meets relevant federal, state, and ethical standards as well as those outlined in AMA policy. Further, the Council recommends supporting an exemption for physicians conducting assessments of out-of-state patients that are required as part of a clinical trial, provided that: 1) the trial meets certain standards; 2) assessments are not intended to replace care for the

patient outside of the context of the trial; and 3) physicians identify a physician in the patient's state in case in-person care is needed. With recommended guardrails in place, we believe these exemptions will improve the accessibility of clinical trials and increase participation. Lastly, we recommend reaffirmation of Policies D-480.960, which supports a licensure exceptions for continuity of care purposes, and D-480.964, which supports the IMLC and expanded licensure recognition across state lines.

RECOMMENDATIONS

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

1. That our AMA amend Policy H-480.969[1] by addition to read:

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

a. Exemption from such a licensure requirement for physician-to-physician consultations.

b. Exemption from such a licensure requirement for telemedicine practiced across state lines in the event of an emergent or urgent circumstance, the definition of which for the purposes of telemedicine should show substantial deference to the judgment of the attending and consulting physicians as well as to the views of the patient.

c. Allowances, by exemption or other means, for out-of-state physicians providing continuity of care to a patient, where there is an established ongoing relationship and previous in-person visits, for services incident to an ongoing care plan or one that is being modified.

d. Exemption from licensure requirements for physicians assessing or screening out-of-state patients for acceptance of a referral to a center for excellence or to a physician with specific expertise in the patient's condition.

e. Exemption from licensure requirements for physicians screening out-of-state patients for acceptance into a clinical trial that meets relevant federal, state, and ethical standards as well as those outlined in AMA policy.

f. Exemption from licensure requirements for physicians conducting assessments of out-of-state patients that are required as part of a clinical trial, provided that:

1. The trial meets relevant federal, state, and ethical standards as well as those outlined in AMA policy;
2. The assessments are not intended to establish or replace care for the patient outside of the context of the trial; and
3. Physicians planning to use telehealth identify a physician licensed in the patient's state to address in-person care needs that may arise from the clinical trial.

~~d~~g. Application requirements that are non-burdensome, issued in an expeditious manner, have fees no higher than necessary to cover the reasonable costs of administering this process, and that utilize principles of reciprocity with the licensure requirements of the state in which the physician in question practices. (Modify Current HOD Policy)

2. That our AMA reaffirm Policy D-480.960, which encourages states to allow an out-of-state physician to use telehealth to provide continuity of care to existing patients if there is a pre-existing and ongoing physician-patient relationship and a previous in-person visit, and the care is incident to an existing care plan or one that is being modified. (Reaffirm HOD Policy)

3. That our AMA reaffirm Policy D-480.964, which encourages states that are not part of the Interstate Medical Licensure Compact (IMLC) to consider joining the Compact; advocates for reduced application and state licensure(s) fees processed through the IMLC; supports state efforts to expand physician licensure recognition across state lines in accordance with the standards and safeguards outlined in AMA policy; and encourages states to pass legislation enhancing patient access to and proper regulation of telehealth services. (Reaffirm HOD Policy)

Fiscal Note: Minimal

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APPENDIX A

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

Exceptions in FSMB Policy	Relevant AMA Policy
Physician-to-physician consultation, which permits a consulting physician licensed in another state to consult with a licensed practitioner who remains responsible for diagnosing and treating the patient in the patient's state.	**Policy H-480.969** supports exemption of licensure requirements for physician-to-physician consultations.
Prospective patient screening for complex referrals, which exempts physicians providing specialty assessments or consultations, such as at centers for excellence. FSMB policy specifies that, "If the out-of-state physician agrees to diagnosis, counsel, or treat the patient directly, the patient must travel to the state where the physician is licensed, or the physician must obtain a license to practice medicine in the state where the patient is located."	**Policy H-480.969** supports exemption of physician-to-physician consultations but does not specifically address prospective patient screening for complex referrals.
Episodic follow-up care for established patients, which permits physicians to provide care while an established patient is temporarily out of the state as long as the physician has sufficient clinical information to provide care that meets the accepted standard of care. FSMB policy specifies that, "If the patient is presenting with new medical conditions, the physician may consider directing the patient to receive local care," and "physicians providing care under this exception should also be prepared to make referrals to a hospital or to a local specialist who can step in and assist …"	**Policy D-480.960** encourages states to allow an out-of-state physician to use telehealth to provide continuity of care to an existing patient in the state without penalty if: a. The physician has an active license to practice medicine in a state or US territory and has not been subjected to disciplinary action. b. There is a pre-existing and ongoing physician-patient relationship. c. The physician has had an in-person visit(s) with the patient. d. The telehealth services are incident to an existing care plan or one that is being modified. e. The physician has verified that the telehealth services are covered under the physician's medical liability insurance policy that satisfies applicable state legal requirements. f. Telehealth use complies with Health Insurance Portability and Accountability Act privacy and security rules. **Policy H-480.969** supports allowances, by exemption or other means, for out-of-state physicians providing continuity of care to a patient, where there is an established ongoing relationship and previous in-person visits, for services incident to an ongoing care plan or one that is being modified.

Follow-up after travel for surgical/medical treatment, which allows follow-up care via telehealth for patients with rare or severe diagnoses or treatments who have traveled to a medical center in another state to get specialty care and need follow-up care after returning home. FSMB policy states that, "Physicians providing out-of-state care under this exception should ensure that their patients have backup plans to receive care locally if changes in their medical condition make that necessary."	**Policies D-480.960 and H-480.969** support continuity of care exceptions but do not specifically address follow-up care after patients have traveled to another state for surgical or medical treatment.
Exceptions for clinical trials, which maintains that physicians working on clinical trials enabled by telehealth should not be precluded from including patients residing in states where the physician is not licensed. FSMB policy states that, "Physicians providing out-of-state care under this exception should ensure that their patients have backup plans to receive care locally if changes in their medical conditions make that necessary."	Not addressed in AMA policy.

REPORT 3 OF THE COUNCIL ON MEDICAL SERVICE (I-25)
Payment Models to Sustain Rural Hospitals
(Reference Committee J)

EXECUTIVE SUMMARY

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

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

Additionally, Policy D-190.969, adopted as a part of Council on Medical Service Report 6-I-23, Rural Hospital Payment Models, called for report back on recommendations for improved rural hospital payment models.

The Council reviewed information on the present state of rural hospitals and their payment systems. Currently, many rural hospitals are struggling to stay open, and the problem only seems to be increasing in magnitude. In efforts to stay open, some rural hospitals are forced to stop providing services such as obstetric/gynecologic care or chemotherapy services. Other rural hospitals are turning to private equity investment to keep their doors open. While neither of these strategies have yielded successful results, in the short term these strategies may give hospitals a few additional months or years to serve their communities. Additionally, it is projected that the newly passed legislation, One Big Beautiful Bill Act (OBBBA), will exacerbate existing challenges for rural hospitals. Specifically, the OBBBA is expected to result in rural hospitals losing approximately $137 billion dollars over 10 years. Although the bill includes a $50 billion rural health transformation fund, it is not expected to be enough to cover the overall losses. Additionally, its implementation timeline is unclear. In order to look for potential solutions for rural hospitals, the Council reviewed three existing payment models as well as one model in development. While none of these payment models provide a perfect solution or a singular answer to fixing rural hospital payment, each provides insight into what could make an alternative payment model successful. Finally, the Council intends to initiate a future report fully discussing issues impacting rural hospitals beyond payment models, such as workforce, infrastructure, federal designation(s), and supply chain.

Based on its review of alternative payment models, the Council recommends the adoption of new policy outlining minimum standards for alternative payment models for rural hospitals. Specifically, this new policy outlines that alternative payment models should include fixed cost payments, include adequate payment rates for variable services, ensure affordable patient cost-sharing, include high-quality care, and minimize administrative burdens. The Council recommends the adoption of a new policy to emphasize the importance of rural hospitals and encourage monitoring and education regarding alternative payment models. New policy is also recommended to ensure that funds allocated for rural hospitals are used for their express intent. Additionally, the Council recommends the amendment of Policy D-465.999 to update language, Policy D-465.998 to include education and advocacy around the impact of Medicare Advantage in rural hospitals, and Policy D-190.969 to remove the clause accomplished by this report. Finally, the Council recommends the reaffirmation of Policies H-465.994, H-465.982, and H-465.997, which all work to support rural hospitals beyond payment models.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 3-I-25

Subject: Payment Models to Sustain Rural Hospitals

Presented by: Betty Chu, MD, MBA, Chair

Referred to: Reference Committee J

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

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

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

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

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

BACKGROUND

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

Rural hospitals are struggling to stay open nationwide as challenges continue to grow. Recent research demonstrates that half of rural hospitals are currently operating in a deficit, up nearly seven percent over a 12-month period, the biggest jump researchers have noted while monitoring the issue.[5] In some states, the landscape is even worse, with both Kansas and Wyoming reporting

over 80 percent of rural hospitals operating in a deficit.[5] Even for the rural hospitals that are able to stay open, many are forced to stop providing vital services, like obstetric/gynecologic (OB/GYN) care and cancer care.[6] Since 2020, over 100 labor and delivery units in rural areas have closed, and the problem is getting worse; closures seven months into 2025 have almost reached the same number that closed in the entirety of 2024.[7] These closures have led to less than half, 42 percent, of rural hospitals maintaining obstetrical care. While some maintain outpatient pre/postnatal care, many are unable to continue any OB/GYN services at all, exacerbating maternity care deserts and the maternal mortality crisis facing America.[6,7] Cancer care, including screenings, treatments, and specialty care, has also faced significant closures. Between 2014 and 2022, 382 rural hospitals were forced to stop providing chemotherapy.[8,9] States like Texas, Alabama, Mississippi, and Tennessee were the hardest hit with at least 44 percent of their rural hospitals stopping chemotherapy services.[6]

Service closures are not the only strategy that rural hospitals have adopted to keep their doors open, as nearly 60 percent of rural hospitals have affiliated with larger health systems. Although such affiliations may help some rural hospitals stay financially viable, 42 percent of rural hospitals associated with health systems continue to operate in a deficit.[5] Many rural hospitals must choose between private equity investment and closure. However, the choice to accept private equity investment may still result in a closure, albeit delayed a few months or years. While this delay in closure is likely to have a positive impact on communities while the hospital remains open, in the long term the eventual closure may harm the community further due to additional debts and/or increased difficulties in reopening the hospital. Investors often focus on buying hospitals for low prices and reaping any available profit before deeming the hospital financially unviable and closing their doors, known as a "buy and bust" model. While this can prove to be quite lucrative for the investors, it puts profit above people and negatively impacts rural communities when they lose one of the few, or the only, sources of health care.[6,10] Further detail on private equity, its practices, and related AMA policy and advocacy efforts can be found in Council on Medical Service Report 11-A-19, Corporate Investors, Council on Medical Service Report 2-I-22, Corporate Practice of Medicine, and Council on Medical Service Report 3-A-25, Regulation of Corporate Investment in the Health Care Sector.

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

RURAL HOSPITAL PAYMENT

Rural hospitals face distinct challenges in that payments often do not cover the actual cost of providing services. While the mix of payers is generally the same for rural hospitals as it is for

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

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

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

These payment issues are further exacerbated when patients are not insured, a problem more commonly faced by rural hospitals, leading to substantial amounts of uncompensated care that financially struggling hospitals must absorb. Unfortunately, it has been projected that passage of

the OBBBA will likely lead to 10+ million Americans losing health insurance coverage, furthering the pressure on rural hospitals to provide uncompensated care.[20] Estimates indicate that many rural communities will face significant hikes in insurance premium costs across all payer types. Specifically, it is anticipated that in 32 states rural residents will face disproportionate hikes in their out-of-pocket premiums. It is projected that residents will experience an average 107 percent premium increase, compared to 89 percent for urban residents, in addition to the national median increase of 18 percent for private health plans. Additionally, rural residents who obtain coverage through the Affordable Care Act (ACA) Marketplace will experience 28 percent higher increases than urban residents. This is particularly problematic for rural communities, and the hospitals in these communities that provide care, as these communities rely more heavily on ACA Marketplace plans to obtain health insurance.[20] Further, it is likely that the work requirements outlined in the OBBBA will lead to additional disproportionate impacts on rural communities. It is anticipated that due to the additional challenges around available rural employment and/or increased challenges around coverage redetermination in rural communities, many rural residents who are eligible for coverage will end up losing coverage.[21] These specific concerns, paired with general OBBBA coverage losses, have the potential to lead to a significant worsening of the landscape of rural health care and increased financial stress on already vulnerable rural hospitals.

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

ALTERNATIVE RURAL HOSPITAL PAYMENT MODELS

In recent years, a number of programs and models have been proposed and/or evaluated to assess how well they support rural hospitals and improve overall community health. Many programs utilize one or more funding models, often focusing on patient-centered, standby capacity, or global payment models. Some experts suggest that a relatively simple fix would be allowing for greater

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

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

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

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

Evaluation of the MD TCOC model demonstrated initial decreases in Medicare spending, lessened hospital admissions, and a reduction in health disparities across communities served.[28] Specifically, the model saved the state of Maryland approximately $689 million in the first three years after

implementation. Evaluators found that incentives provided via global budgets created improvements in quality measures and lowered hospital admissions. Importantly, this model relies on improvements in primary care, which are essential for maintenance of many of the mentioned outcomes.[29] If this model were to be implemented in a rural setting, this reliance on primary care could be problematic should patients have difficulty accessing care. However, should rural patients be able to access primary care the outcomes from this model indicate it could be promising for rural communities.

Another model that included all-payers is the Vermont All-Payer ACO Model (VTAPM). This model differed from MD TCOC in that it utilized Accountable Care Organizations (ACOs) to incentivize broad system transformation to decrease spending and improve population health. Eight hospitals and one ACO participated in the evaluation, which yielded mixed results.[28] This model was successful in that avoidable hospitalizations were decreased as there was an increase in collaborative approaches to address chronic health and SUD diagnoses. However, there were significant challenges with scaling the value-based care model, leading to questions about the feasibility of the model on a state-wide or national scale. Additionally, many participating hospitals reported challenges with the increased administrative burden that accompanied this model. A number of rural CAHs opted out of participation, citing an inability to handle the anticipated increases in administrative burden.[30,31] Regardless of hospital setting, physicians and other providers who participated in the VTAPM reported both greater understanding and more support for value-based programs after participation.[30] While this model did highlight some of the challenges that can come with implementing new payment models, such as educational and administrative burdens, it is possible that with appropriate technical support and funding a similar program could be scaled to support rural hospitals.

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

AMA POLICY

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

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

DISCUSSION

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

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

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

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

RECOMMENDATIONS

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

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

2. That our AMA believes that rural hospitals are essential to the communities they serve. To ensure that these hospitals have adequate support to remain open and financially viable, our AMA will continue to work with interested national medical specialty societies and state medical associations to:
    a. support and monitor novel payment models for rural hospitals and encourage uniform reporting; and
    b. support educating physicians, providers, and patients on alternative payment models for rural hospitals. (New HOD Policy)

3. That our AMA supports that funds allocated for rural hospitals be used to enhance or maintain rural health care. (New HOD Policy)

4. That our AMA amend Policy D-465.999 by addition and deletion to read as follows:

    CRITICAL ACCESS HOSPITAL NECESSARY PROVIDER DESIGNATION, D-465.999

    Our AMA: (1) will call on the Centers for Medicare & Medicaid Services to support individual states in their development of rural health networks; (2) ~~opposes the elimination~~ support the reintroduction of the state-designated Critical Access Hospital (CAH) "necessary provider"

designation; and (3) will pursue steps to require the federal government to fully fund its obligations under the Medicare Rural Hospital Flexibility Program. (Modify Current HOD Policy)

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

ADDRESSING PAYMENT AND DELIVERY IN RURAL HOSPITALS, D-465.998

5. Our AMA supports educating patients and physicians on the impact of Medicare Advantage plans on rural hospitals and encourages all payers to provide adequate payment to support the financial stability of rural hospitals. (Modify Current HOD Policy)

6. That our AMA reaffirm Policy H-465.994 which outlines support for continued work with relevant and interested stakeholders to research, report, and improve rural health through strategies including telemedicine and innovative workforce strategies. (Reaffirm HOD Policy)

7. That our AMA reaffirm Policy H-465.982 which encourages states, and ensures AMA support, to support efforts related to managed care in rural settings. (Reaffirm HOD Policy)

8. That our AMA reaffirm Policy H-465.997 which outlines support for local and federal efforts to improve rural health with initiatives that are holistic and community-based. (Reaffirm HOD Policy)

9. That the second clause of Policy D-190.969 be rescinded as it is accomplished by this report. (Rescind AMA Policy)

Fiscal Note: Minimal

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

Rural Hospital Payment Models, D-190.969

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

Addressing Payment and Delivery in Rural Hospitals, D-465.998

1. Our American Medical Association will advocate that public and private payers take the following actions to ensure payment to rural hospitals is adequate and appropriate:
    a. Create a capacity payment to support the minimum fixed costs of essential services, including surge capacity, regardless of volume.
    b. Provide adequate service-based payments to cover the costs of services delivered in small communities.
    c. Adequately compensate physicians for standby and on-call time to enable very small rural hospitals to deliver quality services in a timely manner.
    d. Use only relevant quality measures for rural hospitals and set minimum volume thresholds for measures to ensure statistical reliability.
    e. Hold rural hospitals harmless from financial penalties for quality metrics that cannot be assessed due to low statistical reliability.
    f. Create voluntary monthly payments for primary care that would give physicians the flexibility to deliver services in the most effective manner with an expectation that some services will be provided via telehealth or telephone.
2. Our AMA encourages transparency among rural hospitals regarding their costs and quality outcomes.
3. Our AMA supports better coordination of care between rural hospitals and networks of providers where services are not able to be appropriately provided at a particular rural hospital.
4. Our AMA encourages employers and rural residents to choose health plans that adequately and appropriately reimburse rural hospitals and physicians. (CMS Rep. 9, A-21; Reaffirmed: CMS Rep. 6, I-23)

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

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

87; Modified: Sunset Report, I-97; Reaffirmation A-01; Reaffirmed: CMS Rep. 7, A-11; Reaffirmed: CMS Rep. 1, A-21; Reaffirmed: BOT Rep. 07, I-24)

Improving Rural Health, H-465.994

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

Rural Health, H-465.982

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

Rural Health, H-465.986

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

Rural Health, H-465.989

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

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

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

Rural Community Health Networks H-465.980

AMA policy is that development of rural community health networks be organized using the following principles: (1) Local delivery systems should be organized around the physical, mental and social needs of the community;

(2) Clinical decision-making and financial management should reside within the community health network whenever feasible with physicians retaining responsibility for a network's medical, quality and utilization management;

(3) Savings generated by community health networks should be reinvested in the local health care delivery system, rather than redirected elsewhere, since rural health systems and economies are fundamentally intertwined;

(4) Patients should retain access to the spectrum of local health services, thereby preserving patient-physician relationships and continuity of care; and

(5) Participation in rural community health networks should be voluntary, but open to all qualified rural physicians and other health care providers wishing to participate. (Sub. Res. 721, I-97; Reaffirmed: CMS Rep. 9, A-07; Reaffirmed: CMS Rep. 01, A-17)

Closing of Small Rural Hospitals, H-465.990
Our American Medical Association encourages legislation to reduce the financial constraints on small rural hospitals in order to improve access to health care. (Res. 145, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: BOT Rep. 6, A-10: Reaffirmed in lieu of Res. 807, I-13; Reaffirmed: CMS Rep. 3, A-15)

Certification of Rural Hospitals for Medicare, H-465.999
The AMA (1) urges the Secretary of HHS to reassess the regulations prescribing conditions of participation and to adopt a more realistic and humanitarian approach toward certification of small, rural area hospitals, and (2) recommends that state medical associations and state licensing and certifying agencies establish and maintain close surveillance of the certification and accreditation problems of small hospitals. (Res. 42, A-68Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CMS Rep. 4, A-08; Reaffirmed: CMS Rep. 01, A-18)

Critical Access Hospital Necessary Provider Designation, D-465.999
Our AMA: (1) will call on the Centers for Medicare & Medicaid Services to support individual states in their development of rural health networks; (2) opposes the elimination of the state-designated Critical Access Hospital (CAH) "necessary provider" designation; and (3) will pursue steps to require the federal government to fully fund its obligations under the Medicare Rural Hospital Flexibility Program. (Res. 102, A-14; Reaffirmed: CMS Rep. 01, A-24)

Enhancing Rural Physician Practices, H-465.981
1. Our American Medical Association supports legislation to extend the 10 percent Medicare payment bonus to physicians practicing in rural counties and other areas where the poverty rate exceeds a certain threshold, regardless of the areas' Health Professional Shortage Area (HPSA) status.
2. Our AMA encourages federal and state governments to make available low interest loans and other financial assistance to assist physicians with shortage area practices in defraying their costs of compliance with requirements of the Occupational Safety and Health Administration, Americans with Disabilities Act and other national or state regulatory requirements.
3. Our AMA will explore the feasibility of supporting the legislative and/or regulatory changes necessary to establish a waiver process through which shortage area practices can seek exemption from specific elements of regulatory requirements when improved access, without significant detriment to quality, will result.
4. Our AMA supports legislation that would allow shortage area physician practices to qualify as Rural Health Clinics without the need to employ one or more physician extenders.
5. Our AMA will undertake a study of structural urbanism, federal payment polices, and the impact on rural workforce disparities. (CMS Rep. 9, A-96; Reaffirmed: CMS Rep. 8, A-06; Reaffirmed: CMS Rep. 01, A-16; Appended: CME Rep. 3, I-21; Reaffirmed: BOT Rep. 11, A-23; Reaffirmed: Res. 215, I-24)

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 4-I-25

Subject: Payment for Biosimilars

Presented by: Betty Chu, MD, MBA, Chair

Referred to: Reference Committee J

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

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

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

BACKGROUND

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

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

BIOSIMILAR COVERAGE

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

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

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

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

BIOSIMILAR PAYMENT STRUCTURES

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

problematic for physicians when prescribing infused biosimilars. Importantly, although private payers are not required to utilize an ASP payment system for biologics/biosimilars, many choose to follow the lead of the Centers for Medicare & Medicaid Services (CMS) and utilize this payment structure.

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

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

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

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

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

AMA ADVOCACY AND POLICY

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

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

In addition to the aforementioned policies, the AMA has engaged in extensive state level advocacy regarding substitution of interchangeable biosimilar biologic products since 2012. The AMA has worked with dozens of state medical associations to support state amendments to pharmacy practice acts to align with new federal definitions. For example, AMA advocated in support of new laws in Indiana, Washington and Mississippi. Additionally, the AMA has undertaken robust advocacy efforts to lower drug costs for patients, especially around regulation and increasing the

transparency of PBMs. Specifically, over the past two years the AMA has written a number of letters to payers, regulators, and legislators and testified before both the House and Senate regarding regulation of PBMs. The AMA also has an ongoing grassroots campaign, TruthinRx, designed to support patients and physicians in understanding and fighting the lack of transparency through education and advocacy.

DISCUSSION

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

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

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

RECOMMENDATIONS

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

1. That our American Medical Association (AMA) supports the revision of the Average Sales Price (ASP) calculation of biologic/biosimilar drugs to more accurately represent the cost of drugs for the physician practice. (New HOD Policy)

2. That our AMA encourages public and private payers to implement comprehensive payment structures that allow for fair and timely payment for biologic/biosimilar drugs that:
    a. Maintain patient access to biologic/biosimilar drugs prescribed by their physician;
    b. Account for physician/practice administrative and acquisition costs, including but not limited to, obtaining, storing, and administering the drug;
    c. Incentivize the use of biosimilars when safe, clinically appropriate, and agreed upon by the patient and physician; and
    d. Ensure that patient out-of-pocket costs are affordable. (New HOD Policy)

3. That our AMA supports calculating the ASP for biologic/biosimilar drugs under Medicare Part B as the average price paid for a reference biologic and its interchangeable biosimilars adjusted by the market share of each product while ensuring payment is adequate to maintain the financial viability of physician practices. (New HOD Policy)

4. That our AMA reaffirm Policy H-100.940, which supports incentivizing the use of biosimilars when appropriate, eliminating acquisition costs/reimbursement disparities, and patient education. (Reaffirm HOD Policy)

5. That our AMA reaffirm Policy H-110.959, which opposes drug payment methodologies that result in physicians being paid less than cost of the drug and related clinical services. (Reaffirm HOD Policy)

6. That our AMA reaffirm Policy H-125.972, which supports the education of physicians on biosimilars and their involved processes as well as encourages data collection and evaluation by the Food & Drug Administration. (Reaffirm HOD Policy)

7. That our AMA reaffirm Policy D-110.987, which presents guidelines supportive of the regulation of pharmacy benefit managers in a manner that encourages transparency. (Reaffirm HOD Policy)

Fiscal Note: Minimal

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

Prescription Medication Price Negotiation, H-110.959
1. Our American Medical Association (AMA) supports efforts to ensure that patients have affordable access to medications.
2. Our AMA encourages all payers, both public and private, in efforts to establish a reasonable and affordable cap on patient out-of-pocket prescription drug spending in a manner that does not increase patient premiums.
3. Our AMA opposes drug payment methodologies that result in physician practices being paid at less than the cost of acquisition, inventory, storage, and administration of relevant drugs and other necessary related clinical services.

Cuts in Medicare Outpatient Infusion Services, D-330.960
1. Our AMA will actively support efforts to seek legislation to ensure that Medicare payments for drugs fully cover the physician's acquisition, inventory and carrying cost and that Medicare payments for drug administration and related services are adequate to ensure continued patient access to outpatient infusion services.
2. Our AMA will continue strong advocacy efforts working with relevant national medical specialty societies to ensure adequate physician payment for Part B drugs and patient access to biologic and pharmacologic agents. (Res. 926, I-03; Reaffirmed and Modified: CMS Rep. 3, I-08; Reaffirmation A-15; Reaffirmed: CMS Rep. 10, A-16; Reaffirmation: I-18)

Biosimilar Coverage Structures, H-100.940
1. Our American Medical Association supports the development and implementation of strategies to incentivize the use of lower cost biosimilars when safe, fiscally prudent for the patient and not financially disadvantageous to the clinical practice, clinically appropriate, and agreed upon as the best course of treatment by the patient and physician.
2. Our AMA advocates to eliminate acquisition cost and reimbursement disparities for in-office biosimilar treatment across diverse treatment locations.
3. Our AMA supports patient education regarding biosimilars and their safety and efficacy. (CMS Rep. 04, I-24)

Biosimilar Use Rates and Prevention of Pharmacy Benefit Manager Abuse, H-125.973
Our American Medical Association will encourage the Federal Trade Commission (FTC) and Department of Justice (DOJ) Antitrust Division to closely scrutinize long-term exclusive contracts signed between biologics originators and PBMs to ensure they do not impede biosimilar development and uptake. (Res. 207, A-24)

Cost Sharing Arrangements for Prescription Drugs, H-110.990
Our AMA:
1. believes that cost-sharing arrangements for prescription drugs should be designed to encourage the judicious use of health care resources, rather than simply shifting costs to patients;
2. believes that cost-sharing requirements should be based on considerations such as: unit cost of medication; availability of therapeutic alternatives; medical condition being treated; personal income; and other factors known to affect patient compliance and health outcomes;
3. supports the development and use of tools and technology that enable physicians and patients to determine the actual price and patient-specific out-of-pocket costs of

individual prescription drugs, taking into account insurance status or payer type, prior to making prescribing decisions, so that physicians and patients can work together to determine the most efficient and effective treatment for the patient's medical condition;
4. supports public and private prescription drug plans in offering patient-friendly tools and technology that allow patients to directly and securely access their individualized prescription benefit and prescription drug cost information; and
5. believes payers should not establish a higher cost-sharing requirement exclusively for prescription drugs approved for coverage under a medical exceptions process. (CMS Rep. 1, I-07; Reaffirmation A-08; Reaffirmed: CMS Rep. 1, I-12; Reaffirmed in lieu of Res. 105, A-13; Reaffirmed in lieu of: Res. 205, A-17; Reaffirmed in lieu of: Res. 207, A-17; Reaffirmed: CMS Rep. 07, A-18; Appended: CMS Rep. 2, I-21; Reaffirmed: Res. 113, A-23; Appended: CMS Rep. 01, A-23)

Pharmaceutical Costs H-110.987

1. Our American Medical Association encourages Federal Trade Commission (FTC) actions to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives.
2. Our AMA encourages Congress, the FTC and the Department of Health and Human Services to monitor and evaluate the utilization and impact of controlled distribution channels for prescription pharmaceuticals on patient access and market competition.
3. Our AMA will monitor the impact of mergers and acquisitions in the pharmaceutical industry.
4. Our AMA will continue to monitor and support an appropriate balance between incentives based on appropriate safeguards for innovation on the one hand and efforts to reduce regulatory and statutory barriers to competition as part of the patent system.
5. Our AMA encourages prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies.
6. Our AMA supports legislation to require generic drug manufacturers to pay an additional rebate to state Medicaid programs if the price of a generic drug rises faster than inflation.
7. Our AMA supports legislation to shorten the exclusivity period for biologics.
8. Our AMA will convene a task force of appropriate AMA Councils, state medical societies and national medical specialty societies to develop principles to guide advocacy and grassroots efforts aimed at addressing pharmaceutical costs and improving patient access and adherence to medically necessary prescription drug regimens.
9. Our AMA will generate an advocacy campaign to engage physicians and patients in local and national advocacy initiatives that bring attention to the rising price of prescription drugs and help to put forward solutions to make prescription drugs more affordable for all patients.
10. Our AMA supports:
    a. drug price transparency legislation that requires pharmaceutical manufacturers to provide public notice before increasing the price of any drug (generic, brand, or specialty) by 10 percent or more each year or per course of treatment and provide justification for the price increase;
    b. legislation that authorizes the Attorney General and/or the Federal Trade Commission to take legal action to address price gouging by pharmaceutical manufacturers and increase access to affordable drugs for patients; and
    c. the expedited review of generic drug applications and prioritizing review of such applications when there is a drug shortage, no available comparable generic drug, or a price increase of 10 percent or more each year or per course of treatment.

11. Our AMA advocates for policies that prohibit price gouging on prescription medications when there are no justifiable factors or data to support the price increase.
12. Our AMA will provide assistance upon request to state medical associations in support of state legislative and regulatory efforts addressing drug price and cost transparency.
13. Our AMA supports legislation to shorten the exclusivity period for FDA pharmaceutical products where manufacturers engage in anti-competitive behaviors or unwarranted price escalations.
14. Our AMA supports legislation that limits Medicare annual drug price increases to the rate of inflation. (CMS Rep. 2, I-15; Reaffirmed in lieu of: Res. 817, I-16; Appended: Res. 201, A-17; Reaffirmed in lieu of: Res. 207, A-17; Modified: Speakers Rep. 01, A-17; Appended: Alt. Res. 806, I-17; Reaffirmed: BOT Rep. 14, A-18; Appended: CMS Rep. 07, A-18; Appended: BOT Rep. 14, A-19; Reaffirmed: Res. 105, A-19; Appended: Res. 113, I-21; Reaffirmed in lieu of: Res. 810, I-22; Reaffirmed: Res. 801, I-23; Reaffirmed: Res. 801, I-23; Reaffirmed: CMS Rep. 04, I-24)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 802
(I-25)

Introduced by: Michigan

Subject: Patient Choice of Physician

Referred to: Reference Committee J

Whereas, policies imposed by insurance companies and hospital insurance plans can disrupt patient-physician relationships; and

Whereas, out-of-network services policies and penalties imposed by insurance companies and hospital insurance plans often restrict or prohibit patients from continuing long standing patient-physician relationships; and

Whereas, insurance companies and hospital insurance plans can refuse to reimburse patient-physician relationships that are out of their network even though it's the patients' preference; and

Whereas, hospital insurance managed care plans are negligent in paying out-of-network physicians any compensation; therefore be it

RESOLVED, that our American Medical Association continue its support of the patient-physician relationship and the patient's choice of physician by reaffirming existing AMA policies, "Preservation of Physician-Patient Relationships and Promotion of Continuity of Patient Care H-160.901" and "Physician Penalties for Out-of-Network Services H-180.952." (Reaffirm HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 9/3/25

RELEVANT AMA POLICY

Preservation of Physician-Patient Relationships and Promotion of Continuity of Patient Care H-160.901
Our AMA supports: (1) policies that encourage the freedom of patients to choose the health care delivery system that best suits their needs and provides them with a choice of physicians; (2) the freedom of choice of physicians to refer their patients to the physician practice or hospital that they think is most able to provide the best medical care when appropriate care is not available within a limited network of providers; and (3) policies that encourage patients to return to their established primary care provider after emergency department visits, hospitalization or specialty consultation.

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 804
(I-25)

Introduced by: New England Delegation

Subject: Medicare Advantage Filing Limit

Referred to: Reference Committee J

Whereas, the AMA currently has no policy regarding limits on filing claims for services provided to Medicare Advantage patients; and

Whereas, in the sponsors' observations, many medical practices are burdened with increased costs that threaten the financial viability of the practice; and

Whereas, the sponsors have observed that Medicare reimbursement continues to decline as practice costs increase; and

Whereas, the sponsors believe that many Medicare patients chose Medicare Advantage plans as a more affordable option; and

Whereas, the sponsors have observed that many Medicare patients are not able to provide initial or updated information about their specific type of Medicare insurance or changes made in their insurance or their primary care physician since the last time they were treated; and

Whereas, some Medicare Advantage plans require filing of claims within a relatively short, 60-day period from the time of service and deny payment for claims filed after that, but traditional Medicare allows claims to be made up to one year after date of service[1]; and

Whereas, in the sponsors' experiences, many Medicare Advantage plans require referrals, which in some cases can be challenging to obtain in a prompt manner and prior to the required filing limit deadline, especially for services already provided; therefore be it

RESOLVED, that our American Medical Association and other stakeholders advocate for and support federal efforts to ensure policy uniformity regarding claim filing time limits between Medicare Advantage plans and traditional Medicare, with a uniform time of one calendar year. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/18/25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 805
(I-25)

Introduced by: New England Delegation, American College of Lifestyle Medicine

Subject: Shared Medical Appointments

Referred to: Reference Committee J

Whereas, our American Medical Association's policy H-160-911 promotes physician education about the potential value of Shared/Group Medical Appointments (SMAs) for diagnoses that might benefit from such venues such as chronic diseases, pain, pregnancy, etc.; and

Whereas, physician shortages have led to decreased access to care for patients and less time for individual patient appointments[1]; and

Whereas, the treatment of chronic medical conditions requires significant patient education and counseling for behavior change to promote health[2]; and

Whereas, SMAs involve a cohort of patients meeting with a physician or members of a physician-led, interdisciplinary team in a group setting, allowing for extended consultation and treatment times, peer support, and comprehensive education[3]; and

Whereas, the option of individual patient appointments in a private room or shared medical appointments (SMAs) for appropriate patient cohort(s) should be made available to patients depending upon the choice of the individual patient, the cohort's comparable diagnoses and the relevant services to be provided; and

Whereas, in addition to education and counseling, participants in a SMA receive the full range of services ordinarily provided in an individual visit, including: (i) guided, experiential learning such as training on insulin pumps, injectable, asthma inhalers or in teaching kitchens; (ii) necessary physical exams; and, (iii) delivery of treatment protocols , including ordering and interpreting laboratory tests, initiating referrals, prescribing medications and related clinical; management; and

Whereas, the SMA model of care is particularly effective for managing chronic conditions such as diabetes, hypertension, and obesity, where lifestyle modifications, behavioral support, and patient education play crucial roles[4]; and

Whereas, SMAs have been shown to increase access, increase doctor-patient contact time, and increase time for consultation, treatment and patient education[5,6]; and

Whereas, the SMA model of care is the most efficient and effective means to realistically achieve (e.g.,) the USPSTF's recommended intensive counseling of at least 26 contact hours for patients with a high BMI in a 6-to-12-month period or an estimated 6 hours of contact time over 6-18 months for adults with cardiovascular risk [7]; and

Whereas, a number of State and Specialty Societies have begun to support and utilize SMAs for themselves; therefore be it

RESOLVED, that our American Medical Association recognizes Shared Medical Appointments, also known as Group Medical Visits, as an effective model of care delivery (New HOD Policy); and be it further

RESOLVED, that our AMA advocate to hospitals and health systems that they support physicians and other clinicians who desire to host Shared Medical Appointments, also known as Group Medical Visits (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate to Medicare, Medicaid, private insurers, and other appropriate indemnity organizations, for payment of in-person or telehealth Shared Medical Appointments, also known as Group Medical Visits, commensurate with standard Evaluation and Management billing codes (i.e., 99212-99215) based on Medical Decision Making criteria or the time spent in the delivery of individualized care, with individual assessments occurring either within the group setting or in private. (Directive to Take Action)

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

Received: 9/18/25

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RELEVANT AMA POLICY

Value of Group Medical Appointments H-160.911
Our American Medical Association promotes education about the potential value of group medical appointments for diagnoses that might benefit from such appointments including chronic diseases, pain, and pregnancy.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 806
(I-25)

Introduced by: Mississippi

Subject: Insurance Coverage for Colonoscopy Preparation Cost

Referred to: Reference Committee J

Whereas, colorectal cancer is the second leading cause of cancer-related deaths in the United States, and regular colonoscopy screenings are proven to reduce mortality by early detection of pre-cancerous growths; and

Whereas, the Affordable Care Act (ACA) mandates coverage for preventative screenings, including colonoscopies, without patient cost-sharing to promote public health and reduce the financial burden of preventative care; and

Whereas, despite this coverage requirement, many insurance providers do not fully cover the costs of colonoscopy preparation materials (colon preps), which are essential to the efficacy of the screening; and

Whereas, the cost of colon prep kits can be a significant barrier for patients, potentially discouraging them from undergoing this lifesaving procedure and thereby undermining the ACA's goal of expanding access to preventative care; and

Whereas, financial barriers to colon prep coverage disproportionately impact low-income and underserved populations, exacerbating health inequities and contributing to lower screening rates and worse health outcomes in these communities; and

Whereas, closing this coverage gap aligns with public health goals and supports a more equitable healthcare system by ensuring that all patients have access to comprehensive, cost-free preventative care; therefore be it

RESOLVED, that our American Medical Association advocates for a federal mandate to include full coverage of colonoscopy preparation costs as part of the Affordable Care Act's preventative care requirements, ensuring that all Americans have access to necessary, cost-free preventative measures for colorectal cancer. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/22/25

RELEVANT AMA POLICY

H-185.960 Support for the Inclusion of the Benefit for Screening for Colorectal Cancer in All Health Plans

1. Our American Medical Association supports health plan coverage for the full range of colorectal cancer screening tests.
2. Our AMA will advocate through legislation and/or regulation, as appropriate for adequate payment and the elimination of cost-sharing in all health plans for the full range of colorectal cancer screening and all associated costs, including colonoscopy that includes a “diagnostic” intervention (i.e. the removal of a polyp or biopsy of a mass), as defined by Medicare. To further this goal, the AMA will develop a coding guide to promote common understanding among health care providers, payers, health care information technology vendors, and patients.
3. Our AMA will seek to eliminate cost-sharing in all health plans for “follow-on” colonoscopies performed for colorectal cancer screening and all associated costs, defined as when other alternative screening tests (i.e., stool- or blood-based tests) are found to be positive.
4. Our AMA will seek to classify follow-up, follow-on, or surveillance colonoscopy after an original screening colonoscopy that required polyp removal as a screening service under the Affordable Care Act preventive services benefit and will seek to eliminate patient cost sharing in all health plans under such circumstances. [Res. 726, I-04 Reaffirmation I-07 Reaffirmed: CMS Rep. 01, A-17 Reaffirmed: Res. 123, A-17 Appended: CMS/CSAPH Joint Rep. 01, A-18 Modified: Res. 106, A-24]

H-330.877 Improving the Prevention of Colon Cancer by Insuring the Waiver of the Co-Payment in all Cases

1. Our AMA supports requiring Medicare to waive the coinsurance for colorectal screening tests, including therapeutic intervention(s) required during the procedure.
2. Our AMA will continue to support Medicare coverage for colorectal cancer screenings consistent with ACA-compliant plan coverage requirements. [Res. 123, A-17 Appended: CMS/CSAPH Joint Rep. 01, A-18]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 807
(I-25)

Introduced by: Mississippi

Subject: Protecting Hospitals and Patients from Inappropriate Denials of Inpatient Admissions

Referred to: Reference Committee J

Whereas, oftentimes insurance companies require a peer to peer or review process for hospital admissions; and

Whereas, if a physician assesses a patient as an appropriate full admission, the peer to peer physician often denies “full admission” status; and

Whereas, if full admission status is denied, the insurance companies do not allow the patient to be reverted to “observation status,” which results in no payment to the hospital and a significant debt for the patient; therefore be it

RESOLVED, that our American Medical Association assert that if an insurance company denies “full admission” status for a patient being hospitalized, that the insurance company must provide the ability to revert the status to observation so the hospital and patient are protected from total denial. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 9/22/25

RELEVANT AMA POLICY

H-160.944 Defining “Observation Care”

1. The AMA will work with third party payers to establish a uniform definition of "observation care," including the following: (a) The patient should be designated as under "observation care" if the physician's intent for hospital stay is less than 24 hours. If the physician's intent and expectation is for a hospital stay of greater than 24 hours, then the stay should be considered inpatient. The use of 24 hours as a threshold for observation is a guideline. It is not unusual for observation to extend to a few hours beyond 24 hours or for patients to be admitted to inpatient status before 24 hours. (b) Patients classified as under "observation care" require hospital level-of-care. (c) The patient should be registered as under "observation care" after initial physician evaluation of the patient's signs and symptoms and appropriate testing. Post day surgical patients should be registered as under "observation care" if, after a normal recovery period, they continue to require hospital level-of-care as determined by a physician.

2. The AMA will establish policy on "observation care" and develop model legislation to ensure that: (a) After initial approval of inpatient admission by insurers, there should be no retrospective reassignment to "observation care" status by insurers unless the original information given to insurers is incorrect. (b) Insurers should provide 60 days prior notice to providers of changes to "observation care" criteria or the application of those criteria with opportunity for comment. There should be no implementation of criteria or changes without first following these protocols. (c) Insurers' "observation care" policies should include

an administrative appeal process to deal with all utilization and technical denials within a 60 day time frame for final resolution. An expedited appeal process should be available for patients in the admission process, allowing for a decision within 24 hours. (d) Insurers and HMOs should provide clearly written educational materials on "observation care" to subscribers highlighting differences between inpatient and "observation care" benefits and patient appeal procedures.

3. Our AMA will work with all appropriate governmental and non-governmental organizations to assure that both patients and physicians are treated fairly in the process of delineating the hospital admission status of patients, and to ensure that the process is transparent and administratively simple. [Res. 808, I-95 Reaffirmed: CMS Rep. 7, A-05 Reaffirmed: BOT Action in response to referred for decision Res. 715, I-07 Reaffirmed: BOT Rep. 32, A-09 Appended: Res. 808, I-11 Reaffirmed: CMS Rep. 4, A-14 Reaffirmed: CMS Rep. 01, A-24]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 808
(I-25)

Introduced by: Organized Medical Staff Section

Subject: No Prior Authorization for Inexpensive Medications

Referred to: Reference Committee J

Whereas, a key element of American Medical Association principles is to enhance access to medical care; and

Whereas, the process known as prior authorization or preauthorization (PA) was devised for the stated purpose of restraining excessive medical care costs; and

Whereas, over time, prior authorization has increasingly been imposed on a wide spectrum of pharmaceutical and procedural medical care, including those of lower nominal cost; and

Whereas, prior authorization applied without the justification of real cost-containment can result in adverse health consequences via delay or denial of service; and

Whereas, efforts to restrain excessively intrusive prior authorization have failed to curtail such abuses by attempting to eliminate prior authorization entirely; and

Whereas, a strategy of eliminating truly nuisance application of prior authorization may be more successful; and

Whereas, a formula for determining what constitutes low cost should be devised, such as a ceiling equal to the quarterly cost of health insurance; and

Whereas, existing AMA policy already states that, “our American Medical Association advocates that low-cost noninvasive procedures that meet existing standard Medicare guidelines should not require prior authorization,” thus establishing that there should be a cost floor on the application of that process; therefore be it

RESOLVED, that our American Medical Association identify through the Council on Medical Services or other professional content experts a cost threshold below which medical services and medications should not require prior authorization (Directive to Take Action); and be it further

RESOLVED, that our American Medical Association advocate that low-cost medications and procedures should not require prior authorization. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/22/25

RELEVANT AMA POLICY

Insurer Accountability When Prior Authorization Harms Patients D-320.974

1. Our American Medical Association advocates for increased legal accountability of insurers and other payers when delay or denial of prior authorization leads to patient harm, including but not limited to the prohibition of mandatory pre-dispute arbitration regarding prior authorization determinations and limitation on class action clauses in beneficiary contracts.
2. Our American Medical Association advocates that low-cost noninvasive procedures that meet existing standard Medicare guidelines should not require prior authorization.
3. Our AMA supports that physicians be allowed to bill insurance companies for all full time employee hours required to obtain prior authorization.
4. Our AMA supports that patients be allowed to sue insurance carriers which preclude any and all clauses in signed contracts should there be an adverse outcome as a result of an inordinate delay in care.

Citation: Res. 711, A-24

Approaches to Increase Payer Accountability H-320.968

Our AMA supports the development of legislative initiatives to assure that payers provide their insureds with information enabling them to make informed decisions about choice of plan, and to assure that payers take responsibility when patients are harmed due to the administrative requirements of the plan. Such initiatives should provide for disclosure requirements, the conduct of review, and payer accountability.

1. Disclosure Requirements. Our American Medical Association supports the development of model draft state and federal legislation to require disclosure in a clear and concise standard format by health benefit plans to prospective enrollees of information on:
    a. Coverage provisions, benefits, and exclusions.
    b. Prior authorization or other review requirements, including claims review, which may affect the provision or coverage of services.
    c. Plan financial arrangements or contractual provisions that would limit the services offered, restrict referral or treatment options, or negatively affect the physician's fiduciary responsibility to their patient.
    d. Medical expense ratios.
    e. Cost of health insurance policy premiums. (Ref. Cmt. G, Rec. 2, A-96; Reaffirmation A-97)
2. Conduct of Review. Our AMA supports the development of additional draft state and federal legislation to:
    a. Require private review entities and payers to disclose to physicians on request the screening criteria, weighting elements and computer algorithms utilized in the review process, and how they were developed.
    b. Require that any physician who recommends a denial as to the medical necessity of services on behalf of a review entity be of the same specialty as the practitioner who provided the services under review.
    c. Require every organization that reviews or contracts for review of the medical necessity of services to establish a procedure whereby a physician claimant has an opportunity to appeal a claim denied for lack of medical necessity to a medical consultant or peer review group which is independent of the organization conducting or contracting for the initial review.
    d. Require that any physician who makes judgments or recommendations regarding the necessity or appropriateness of services or site of service be licensed to practice medicine in the same jurisdiction as the practitioner who is proposing the service or whose services are being reviewed.
    e. Require that review entities respond within 48 hours to patient or physician requests for prior authorization, and that they have personnel available by telephone the same business day who are qualified to respond to other concerns or questions regarding

medical necessity of services, including determinations about the certification of continued length of stay.

f. Require that any payer instituting prior authorization requirements as a condition for plan coverage provide enrollees subject to such requirements with consent forms for release of medical information for utilization review purposes, to be executed by the enrollee at the time services requiring such prior authorization are recommended or proposed by the physician.

g. Require that payers compensate physicians for those efforts involved in complying with utilization review requirements that are more costly, complex and time consuming than the completion of standard health insurance claim forms. Compensation should be provided in situations such as obtaining preadmission certification, second opinions on elective surgery, and certification for extended length of stay.

3. Accountability. Our AMA believes that draft federal and state legislation should also be developed to impose similar liability on health benefit plans for any harm to enrollees resulting from failure to disclose prior to enrollment the information on plan provisions and operation specified under Section 1 (a)-(d) above.

Citation: Issued: BOT Rep. M, I-90; Reaffirmed: Res. 716, A-95; Reaffirmed: CMS Rep. 4, A-95; Reaffirmed: I-96; Reaffirmed: Rules and Cred. Cmt, I-97; Reaffirmed: CMS Rep. 13; I-98; Reaffirmed: I-98; Reaffirmed:A-99; Reaffirmation: I-99; Reaffirmed: A-00; Reaffirmed in lieu of: Res. 839, I-08; Reaffirmed: A-09; Reaffirmed: Sub. Res. 728, A-10; Modified: CMS Rep. 4, I-10; Reaffirmed: A-11; Reaffirmed in lieu of Res. 108, A-12; Reaffirmed: Res. 709, A-12; Reaffirmed; CMS Rep. 07, A-16; Reaffirmed in lieu of: Res. 242, A-17; Reaffirmed in lieu of: Res. 106, A-17; Reaffirmed: A-17; Reaffirmed: A-18; Reaffirmed: A-19; Reaffirmed: Res. 206, I-20; Reaffirmed: A-22; Modified: Speakers Rep. 02, I-24

Promoting Accountability in Prior Authorization D-285.960

1. Our American Medical Association will advocate that peer-to-peer (P2P) prior authorization (PA) determinations must be made and actionable at the end of the P2P discussion notwithstanding mitigating circumstances, which would allow for a determination within 24 hours of the P2P discussion.
2. Our AMA will advocate that the reviewing P2P physician must have the clinical expertise to treat the medical condition or disease under review and have knowledge of the current, evidence-based clinical guidelines and novel treatments.
3. Our AMA will advocate that P2P PA reviewers follow evidence-based guidelines consistent with national medical specialty society guidelines where available and applicable.
4. Our AMA will continue to advocate for a reduction in the overall volume of health plans' PA requirements and urge temporary suspension of all PA requirements and the extension of existing approvals during a declared public health emergency.
5. Our AMA will advocate that health plans must undertake every effort to accommodate the physician's schedule when requiring peer-to-peer prior authorization conversations.
6. Our AMA will advocate that health plans must not require prior authorization on any medically necessary surgical or other invasive procedure related or incidental to the original procedure if it is furnished during the course of an operation or procedure that was already approved or did not require prior authorization.

Citation: CMS Rep. 4, A-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 809
(I-25)

Introduced by: Organized Medical Staff Section

Subject: Ensuring Patient Safety and Physician Oversight in the Integration of Hospital Inpatient Virtual Nursing

Referred to: Reference Committee J

Whereas, inpatient hospital virtual nursing is a healthcare model that uses technology to provide nursing care remotely to patients admitted to a hospital; and

Whereas, virtual nursing in the inpatient setting involves experienced registered nurses working remotely—often from a centralized command center—to support bedside nurses and patients via video, audio, and digital tools; and

Whereas, virtual nursing can transform healthcare delivery by addressing long-standing challenges such as nursing shortages, burnout, and capacity issues in hospitals; virtual nursing has potential to alleviate the stress on direct-care staff but also can provide significant operational and financial benefits to healthcare organizations; and

Whereas, virtual nurses handle paperwork, patient education, and discharge planning to reduce the workload on bedside nurses as admission and discharge support; and

Whereas, virtual nursing can assist in ongoing patient monitoring, such as vital sign reviews and safety checks and provide information, answer questions, and check on patient well-being; and

Whereas, virtual nurses can be useful in patient and family education and communication; and

Whereas, there is currently no national policy or governance structure in place to guide the development and adoption of inpatient virtual nursing besides state nursing boards; and

Whereas, the Centers for Medicare & Medicaid Services does not yet have comprehensive guidelines just for inpatient virtual nursing, preferring to defer to state regulations and accrediting bodies; and

Whereas, current AMA policy H-225.957, “Positions for Strengthening the Physician-Hospital Relationship states, “the organized medical staff and the hospital governing body are responsible for the provision of quality care, providing a safe environment for patients, staff, and visitors, and working continuously to improve patient care rendered and for patient safety vested with the organized medical staff; and responsibility of the organized medical staff and the hospital governing body for the proper performance of their respective obligations;” and

Whereas, the deployment of virtual nursing models without adequate input from medical staff may lead to fragmentation of care, unclear clinical responsibilities, and diminished physician oversight; and

Whereas, the thoughtful integration of virtual nursing requires collaboration among physicians, nurses, hospital leadership, and technology developers to ensure that innovations support—not replace—physician-led high-quality, patient-centered care; therefore be it

RESOLVED, that our American Medical Association undertake a comprehensive study of hospital inpatient virtual nursing, including an assessment of its benefits and risks for patient safety and an analysis of guidelines for credentialing, privileging, and documentation standards and any policy gaps related to oversight by the Centers for Medicare & Medicaid Services and The Joint Commission (Directive to Take Action); and be it further

RESOLVED, that our AMA recognizes that organized medical staffs, as leaders in hospital medicine who have a duty to protect patient safety within their institutions, should work collaboratively to ensure physician-led, high-quality, patient-centered care in the integration of inpatient virtual nursing, (New HOD Policy)

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

Received: 9/22/25

REFERENCES

1. 'More than just technology': How virtual nursing models are shaping care delivery innovation. Beckers Hospital Review. Accessed: May 13, 2025. 'More than just technology': How virtual nursing models are shaping care delivery innovation - Becker's Hospital Review | Healthcare News & Analysis
2. TeledocHealth. Inpatient virtual nursing fundamentals, uses, and benefits: Mitigate the nursing shortage and enhance patient care with inpatient virtual nursing. Accessed: May 13, 2025. https://www.teladochealth.com/content/dam/tdh-www/us/en/documents/white-paper/Virtual_Nursing_White_Paper_Teladoc_Health.pdf
3. Sellinger T. Breaking down indemnification clauses. Physician's Weekly. January 23, 2025. Accessed March 9, 2025. https://www.physiciansweekly.com/qa-breaking-down-indemnification-clauses/.

RELEVANT AMA POLICY

Principles for Strengthening the Physician-Hospital Relationship H-225.957

The following twelve principles are our American Medical Association policy:
PRINCIPLES FOR STRENGTHENING THE PHYSICIAN-HOSPITAL RELATIONSHIP

1. The organized medical staff and the hospital governing body are responsible for the provision of quality care, providing a safe environment for patients, staff and visitors, protection from interruption of delivery of care, and working continuously to improve patient care and health outcomes—including but not limited to the development, selection, and implementation of augmented intelligence—with the primary responsibility for the quality of care rendered and for patient safety vested with the organized medical staff. These activities depend on mutual accountability, interdependence, and responsibility of the organized medical staff and the hospital governing body for the proper performance of their respective obligations.
2. The organized medical staff, a self-governing organization of professionals, possessing special expertise, knowledge and training, discharges certain inherent professional responsibilities by virtue of its authority to regulate the professional practice and standards of its members, and assumes primary responsibility for many functions, including but not limited to: the determination of organized medical staff membership; performance of credentialing, privileging and other peer review; and timely oversight of clinical quality and patient safety.
3. The leaders of the organized medical staff, with input from the hospital governing body and senior hospital managers, develop goals to address the healthcare needs of the community and are involved in hospital strategic planning as described in the medical staff bylaws.
4. Ongoing, timely and effective communication, by and between the hospital governing body and the organized medical staff, is critical to a constructive working relationship between the organized medical staff and the hospital governing body.

5. The organized medical staff bylaws are a binding, mutually enforceable agreement between the organized medical staff and the hospital governing body. The organized medical staff and hospital bylaws, rules and regulations should be aligned, current with all applicable law and accreditation body requirements and not conflict with one another. The hospital bylaws, policies and other governing documents do not conflict with the organized medical staff bylaws, rules, regulations and policies, nor with the organized medical staff's autonomy and authority to self govern, as that authority is set forth in the governing documents of the organized medical staff. The organized medical staff, and the hospital governing body/administration, shall, respectively, comply with the bylaws, rules, regulations, policies and procedures of one another. Neither party is authorized to, nor shall unilaterally amend the bylaws, rules, regulations, policies or procedures of the other.
6. The organized medical staff has inherent rights of self governance, which include but are not limited to:
    a. Initiating, developing and adopting organized medical staff bylaws, rules and regulations, and amendments thereto, subject to the approval of the hospital governing body, which approval shall not be unreasonably withheld. The organized medical staff bylaws shall be adopted or amended only by a vote of the voting membership of the medical staff.
    b. Identifying in the medical staff bylaws those categories of medical staff members that have voting rights.
    c. Identifying the indications for automatic or summary suspension, or termination or reduction of privileges or membership in the organized medical staff bylaws, restricting the use of summary suspension strictly for patient safety and never for purposes of punishment, retaliation or strategic advantage in a peer review matter. No summary suspension, termination or reduction of privileges can be imposed without organized medical staff action as authorized in the medical staff bylaws and under the law.
    d. Identifying a fair hearing and appeals process, including that hearing committees shall be composed of peers, and identifying the composition of an impartial appeals committee. These processes, contained within the organized medical staff bylaws, are adopted by the organized medical staff and approved by the hospital governing board, which approval cannot be unreasonably withheld nor unilaterally amended or altered by the hospital governing board or administration. The voting members of the organized medical staff decide any proposed changes.
    e. Establishing within the medical staff bylaws:
        1. The qualifications for holding office.
        2. The procedures for electing and removing its organized medical staff officers and all organized medical staff members elected to serve as voting members of the Medical Executive Committee.
        3. The qualifications for election and/or appointment to committees, department and other leadership positions.
    f. Assessing and maintaining sole control over the access and use of organized medical staff dues and assessments, and utilizing organized medical staff funds as appropriate for the purposes of the organized medical staff.
    g. Retaining and being represented by legal counsel at the option and expense of the organized medical staff.
    h. Establishing in the organized medical staff bylaws, the structure of the organized medical staff, the duties and prerogatives of organized medical staff categories, and criteria and standards for organized medical staff membership application, reapplication credentialing and criteria and processing for privileging. The standards and criteria for membership, credentialing and privileging shall be based only on quality of care criteria related to clinical qualifications and professional responsibilities, and not on economic credentialing, conflicts of interest or other non-clinical credentialing factors.
    i. Establishing in the organized medical staff bylaws, rules and regulations, clinical criteria and standards to oversee and manage quality assurance, utilization review and other organized medical staff activities, and engaging in all activities necessary and proper to implement those bylaw provisions including, but not limited to, periodic meetings of the organized medical staff and its committees and departments and review and analysis of patient medical records.

   j. The right to define and delegate clearly specific authority to an elected Medical Executive Committee to act on behalf of the organized medical staff. In addition, the organized medical staff defines indications and mechanisms for delegation of authority to the Medical Executive Committee and the removal of this authority. These matters are specified in the organized medical staff bylaws.
   k. Identifying within the organized medical staff bylaws a process for election and removal of elected Medical Executive Committee members.
   l. Defining within the organized medical staff bylaws the election process and the qualifications, roles and responsibilities of clinical department chairs. The Medical Executive Committee must appoint any clinical chair that is not otherwise elected by the vote of the general medical staff.
   m. Enforcing the organized medical staff bylaws, regulations and policies and procedures.
   n. Establishing in medical staff bylaws, medical staff involvement in contracting relationships, including exclusive contracting, medical directorships and all hospital-based physician contracts, that affect the functioning of the medical staff.
7. Organized medical staff bylaws are a binding, mutually enforceable agreement between the organized medical staff and the hospital governing body, as well as between those two entities and the individual members of the organized medical staff.
8. The self-governing organized medical staff determines the resources and financial support it requires to effectively discharge its responsibilities. The organized medical staff works with the hospital governing board to develop a budget to satisfy those requirements and related administrative activities, which the hospital shall fund, based upon the financial resources available to the hospital.
9. The organized medical staff has elected appropriate medical staff member representation to attend hospital governing board meetings, with rights of voice and vote, to ensure appropriate organized medical staff input into hospital governance. These members should be elected only after full disclosure to the medical staff of any personal and financial interests that may have a bearing on their representation of the medical staff at such meetings. The members of the organized medical staff define the process of election and removal of these representatives.
10. Individual members of the organized medical staff, if they meet the established criteria that are applicable to hospital governing body members, are eligible for full membership on the hospital governing body. Conflict of interest policies developed for members of the organized medical staff who serve on the hospital's governing body are to apply equally to all individuals serving on the hospital governing body.
11. Well-defined disclosure and conflict of interest policies are developed by the organized medical staff which relate exclusively to their functions as officers of the organized medical staff, as members and chairs of any medical staff committee, as chairs of departments and services, and as members who participate in conducting peer review or who serve in any other positions of leadership of the medical staff.
12. Areas of dispute and concern, arising between the organized medical staff and the hospital governing body, are addressed by well-defined processes in which the organized medical staff and hospital governing body are equally represented. These processes are determined by agreement between the organized medical staff and the hospital governing body.

Citation: Res. 828, I-07; Reaffiremd in lieu of Res. 730, A-09; Modified: Res. 820, I-09; Reaffirmed: Res. 725, A-10; Reaffirmed: A-12; Reaffirmed: CMS Rep. 6, I-13; Reaffirmed: CMS Rep. 5, A-21; Modified: Res. 024, A-24

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 811
(I-25)

Introduced by: Florida, South Carolina, Tennessee, Oklahoma

Subject: Non-Medical Switching

Referred to: Reference Committee J

Whereas, non-medical switching is defined as the practice of changing a patient's medication for reasons other than clinical efficacy or safety, typically due to formulary or cost considerations imposed by pharmacy benefit managers (PBMs) or health insurers; and

Whereas, non-medical switching often disrupts stable treatment regimens and can lead to adverse clinical outcomes, including increased side effects, reduced therapeutic effectiveness, and diminished medication adherence; and

Whereas, studies have shown that patients subject to non-medical switching may experience increased healthcare utilization, including more physician visits, emergency department use, and hospitalizations; and

Whereas, physicians, as licensed medical professionals, are in the best position to determine the appropriate medication regimen based on a patient's individual medical history and clinical condition; and

Whereas, PBM-driven formulary changes often occur with minimal notice and no requirement for physician consent or medical justification; and

Whereas, the AMA has longstanding policies opposing undue interference in the physician-patient relationship and supporting transparency in PBM practices; and

Whereas, a number of states have introduced or passed legislation to limit or ban non-medical switching, affirming a growing national concern about this practice; therefore be it

RESOLVED, that our American Medical Association opposes the practice of non-medical switching by pharmacy benefit managers and health insurers, except when clinically justified and approved by the prescribing physician (New HOD Policy); and be it further

RESOLVED, that our American Medical Association study and report back at I-26 on the clinical and economic impact of non-medical switching on patient outcomes, medication adherence, and overall healthcare utilization, and disseminate these findings to policymakers and the public. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/24/25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 812
(I-25)

Introduced by: American Academy of Physical Medicine and Rehabilitation

Subject: Discontinue Review Choice Demonstration Project for Inpatient Rehabilitation Hospital Admissions

Referred to: Reference Committee J

Whereas, Inpatient Rehabilitation Facility (IRF) care is an important part of all health care systems, providing intensive inpatient rehabilitation to patients who sustain major injuries or illnesses, such as stroke, traumatic brain injuries, limb amputation, hip fractures, major neurological impairments, or spinal cord injuries; and

Whereas, a CMS demonstration project called the Inpatient Rehabilitation Facility Review Choice Demonstration (IRF RCD) is currently burdening inpatient rehabilitation physicians and hospitals while failing to meet its goal of identifying any fraud, waste, or abuse; and

Whereas, under the IRF RCD, 100% pre-claim or post-payment review of all IRF patient admissions was implemented by CMS through contractors as a pilot project in Alabama in 2023 and Pennsylvania in 2024 with the stated objective of eliminating fraud, waste, and abuse[1]; and

Whereas, CMS plans to expand the IRF RCD to Texas and California[1]; and

Whereas, this project will continue to expand to nearly half of the IRFs in the country if fully implemented[1]; and

Whereas, there have been high affirmation rates to date in the first two states subject to the IRF RCD with no evidence of fraud, waste, and abuse; and

Whereas, this 100% review is an additional burden on physicians, IRFs, and staff without findings of major problems; and

Whereas, this demonstration project may institute additional barriers to access for some patients, even though their treating physicians believe IRF care is reasonable and necessary; and

Whereas, this demonstration project is expensive for CMS to implement and this money could better be used to improve other areas of the Medicare program, including physician payment; and

Whereas, this project institutes significant expenses on IRFs in the program, who must dedicate staff time and resources to the administrative needs of the demonstration; and

Whereas, a stated focus of this Administration and CMS is to remove unnecessary provider burden, and avoid duplicative regulations; and

Whereas, the IRF stakeholder community is aligned on the position that the IRF RCD should not be expanded to Texas or California and should be discontinued as soon as possible[2,3,4,5,6] therefore be it

RESOLVED, that our American Medical Association oppose CMS's expansion of the Inpatient Rehabilitation Facility Review Choice Demonstration Project and advocate that the project be immediately discontinued. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/26/25

REFERENCES

1. 9/3/2021 Federal Register Notice on Proposal to Implement IRF RCD: Federal Register: Agency Information Collection Activities: Submission for OMB Review; Comment Request
2. 7/28/25 AAPM&R Comments to CMS in response to IRF RCD Request for Information: aapmr-comments_irf-rcd-july-28-2025.pdf
3. 7/28/25 American Medical Rehabilitation Providers Association (AMRPA) Comments to CMS in response to IRF RCD Request for Information: RCD Comment Letter Procedural Argument (D1189450).DOCX
4. 6/10/25 Coalition to Preserve Rehabilitation Comments in response to FY 2026 IRF PPS Proposed Rule: CPR Comments re: FY 2026 IRF PPS Proposed Rule (Final Draft) (D1181187).DOCX
5. 8/11/23 Joint Stakeholder Letter to CMS Requesting an Immediate Delay to Implementation of the IRF RCD: irf-stakeholder-letter-re-rcd-delay-8.11.2023-final.pdf
6. 10/8/21 AAPM&R Comments on Proposed IRF RCD: aapm-r-comments-on-proposed-review-choice-demonstration-for-inpatient-rehabilitation-facility-services.pdf

RELEVANT AMA POLICY

H-330.921 Medicare Prepayment and Postpayment Audits

1. AMA policy is that with respect to prepayment and postpayment audits by the Medicare program, the following principles guide AMA advocacy efforts:
(a) The confidential medical record should be preserved as an instrument of clinical care, with strong confidentiality protections and, we oppose its use as an accounting document;
(b) CMS should discontinue random prepayment audits of E&M services;
(c) In lieu of prepayment audits, CMS should use focused medical review of outliers based on reviews of patterns of services, using an independent medical peer review process, where physicians practicing in the same specialty, review their peers;
(d) No financial or legal penalties should be assessed based on one level of disagreement in E&M code assignment; and
(e) CMS must stop the practice of requiring physicians to repay alleged Medicare overpayments before an actual appeal is rejected or a final administrative decision or a court order is rendered. Legislative relief will be sought if advocacy with CMS is not successful in this regard.
2. Our AMA advocates that all government recovery programs contain complete physician access to any data mining criteria and programs, that there is same-specialty/same-subspecialty physician review prior to denial of claims, and that any denial of claims be based on medical necessity review as determined by that same-specialty/same-subspecialty physician reviewer, and will explore options for increased reimbursement of physician costs related to government audits, including remedies available through the Equal Access to Justice Act.
3. Our AMA supports the enactment of federal legislation or regulation that requires fairness in the practice of conducting physicians' post-payment audits as contained in paragraph 1 above, and which would include the following:
(a) The requirement for such audits to be reviewed by a physician board certified within the same specialty prior to any requirement for repayment by the audited physician
(b) The requirement for the repayment to be placed in escrow until the appeals process is complete
(c) The removal of any incentives that are based upon a percentage of recovery for contracted government auditors
(d) The establishment of a mechanism for recovery of a practice's legal fees incurred for unsuccessful audits

(e) The full disclosure of contract terms with audit contractors
(f) The elimination or improvement of the extrapolation formula
(g) The payment for costly documentation requests
(h) Imposition of penalties on auditors for inaccurate findings, and
(i) Incentivizing the auditors to perform more physician education.
4. Our AMA will formally request that Medicare employ rules for prepayment and postpayment audits that are at least as protective as the Recovery Audit Contractor (RAC) rules for physicians, and that our AMA continue to advocate for reforms to the audit process, including giving great weight to the treating physician's determination of medical necessity.
5. Our AMA will propose to Medicare that there be a mechanism by which prepayment and postpayment audit denials can be resolved via the telephone or other electronic communications.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 813
(I-25)

Introduced by: New York

Subject: Increased Regulation of For-Profit Healthcare Insurance

Referred to: Reference Committee J

Whereas, health insurance companies operating as for-profit entities prioritize shareholder profits over patient care, leading to higher administrative costs, increased premiums, and reduced funding for direct patient services; and

Whereas, for-profit health insurers often deny coverage for necessary medical treatments to minimize costs, creating barriers to timely and equitable healthcare access; and

Whereas, for-profit health insurers have created vertically-integrated systems that bypass regulations to increase profits with an overall increase in healthcare costs; and

Whereas, MSSNY has previously passed many resolutions directed at reining in health insurance company abuses without effective change; therefore be it

RESOLVED, that our American Medical Association promote public awareness of the harms of for-profit vertical integration of health insurance systems (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for a comprehensive review by the legislature of current regulations and increased regulatory oversight and increased resources for the monitoring of State Medicaid and Managed Medicare for-profit health plans, including vertical integration. (Directive to Take Action)

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

Received: 9/26/25

REFERENCES

EXISTING MSSNY POLICY:

- 120.897 Reducing Prior Authorization Burden and Separate Payment When Not Part of a Patient Encounter
- 120.898 Prior Authorization Reform
- 120.903 Bypassing Surprise Bill Good Faith Negotiation
- 120.913 Qualified Physicians on Preauthorization Phone Lines
- 120.914 Difficulty Obtaining Pre-Op Information for Insurers
- 120.915 Insurers' Procedures Regarding Termination and Resignations
- 120.916 Contract Non Renewals by Third Party Insurers: Problems With the Insurers' Notification Process
- 120.922 Insurers Withhold Key Financial Information from Out-ofNetwork Physicians
- 120.925 Peer-to-Peer Reviews by Insurers
- 120.926 Private Insurers and Managed Care Organizations Pre–Authorization/Pre–Certification Protocols
- 120.931 NYS Private Payer Medical Necessity Guidelines
- 120.935 Non-Experimental Status Determined by Centers for Medicare and Medicaid Services

• 120.939 Physician-Directed Medication Access
• 120.949 Health Insurance Policies for Small Groups
• 120.986 Non-Assignability Clauses in Health Insurance Contracts
• 120.999 Health Insurer Abuses
• 165.834 Payment for Pre-Authorized/Pre-Certified Procedures
• 165.835 Regulation Against Insurance Company Denials Following Insurer Peer-toPeer Prior Authorization
• 165.840 Insurers and Vertical Integration
• 165.842 Request for Action on MSSNY Policy
• 165.933 Managed Care Organization Downcoding,
• 165.847 Pharmacy Benefit Managers Interfering with the Progress and Continuity of Treatment
• 165.848 Medicare Advantage Insurer Abuses
• 165.850: Insurers' Use of Offsets with Refund Demands
• 165.855 Identification of Insurance Plans by Payer ID
• 165.869 Participating Provider Lists
• 165.876 Ownership of Managed Care Organizations
• 165.897 MCOs Use of Pre-Payment Claim Reviews to Circumvent the New York State Prompt Payment Law
• 165.918 Time Limit for Retrospective Denials
• 165.937 Full Adoption of the National Specialty Societies' Practice Parameter Guidelines by Third-Party Insurer

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 814
(I-25)

Introduced by: New York

Subject: Mandate for Insurance Companies to Assist in the Transition of Patients to Alternative Participating Physicians Upon Contract Termination

Referred to: Reference Committee J

Whereas, patients rely on their physicians to manage and coordinate their medical care, and changes in the physician network can significantly disrupt their continuity of care; and

Whereas, physicians may elect to terminate participation in a particular insurance plan or network due to changes in payment policy or irreconcilable differences in contract terms; and

Whereas, when a physician notifies an insurer of their intent to terminate participation in a specific insurance plan, it can create confusion and hardship for patients who may be forced to find a new physician on short notice, often with limited options; and

Whereas, the transition to a new physician can result in gaps in care, delays in treatment, and increased patient distress, particularly for individuals with complex or ongoing medical needs; and

Whereas, many patients, especially those with chronic conditions, may require ongoing management from specialists and may need assistance navigating the process of finding an in-network physician that can effectively take over their care; and

Whereas, it frequently becomes the responsibility and burden of the physician to assist the patient in locating and securing a new in-network physician; and

Whereas, it is in the best interest of both patients and insurers to ensure that patients can continue to receive timely, high-quality care without unnecessary disruption, and that insurers play an active role in facilitating this transition; and

Whereas, current regulations do not require insurers to directly assist in the transition of care when a physician exits the network, leaving patients to navigate these challenges on their own or the physician burdened to provide these services; therefore be it

RESOLVED, that our American Medical Association advocate through legislation or regulations that private and public health insurers be mandated on the event of a treating physician terminating participation with that insurer to provide assistance to affected patients in transitioning to other in-network physicians, including providing a list of alternative participating physicians who can continue to provide care to the patient (Directive to Take Action); and be it further

RESOLVED, that our American Medical Association advocate through legislation or regulations that private and public health insurers be mandated to provide resources to ensure continuity of care for patients who are mid-treatment or require ongoing care with the exiting physician

without penalties to the physician, including offering extended benefits or out-of-network coverage when necessary (Directive to Take Action); and be it further

RESOLVED, that our American Medical Association advocate through legislation or regulations that private and public health insurers be mandated to provide an online payment policy tool that has a uniform interface that works across all insurers and physicians, ensuring consistent and streamlined access to coverage information for physicians and patients. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/26/25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 815
(I-25)

Introduced by: New York

Subject: Mandating Health Insurers to Provide a Real-Time Online Tool for Coverage and Payment Policies, Integrated into Electronic Health Records (EHRs)

Referred to: Reference Committee J

Whereas, Physicians and patients frequently experience delays and difficulties in determining the coverage and payment policies for medical procedures under various health insurance plans, leading to inefficiencies and potential financial burdens for patients; and

Whereas, the ability to accurately and quickly ascertain coverage information is essential for informed decision-making by both healthcare providers and patients, ensuring timely access to necessary medical services; and

Whereas, current systems for determining insurance coverage and payment policies are often opaque, inconsistent, and cumbersome, causing unnecessary administrative burdens on healthcare providers, including staff time and resources; and

Whereas, a real-time, online tool that provides immediate, clear, and comprehensive coverage and payment policy information for medical procedures would streamline the process, reduce administrative inefficiencies, and enhance transparency in insurance practices; and

Whereas, this tool should be available to physicians at the time a procedure is suggested, allowing providers to receive real-time, accurate coverage and payment policy information for the proposed procedure, enabling them to make informed decisions and discuss coverage options with patients before proceeding; and

Whereas, for maximum efficiency, the real-time online tool should be a uniform interface that works across all insurers and healthcare providers, ensuring consistency, ease of use, and integration into existing workflows; and

Whereas, the integration of this tool directly into Electronic Health Records (EHRs) would enable seamless, real-time access to coverage and payment policy information within the physician's existing clinical workflow, enhancing usability and reducing administrative burden; therefore be it

RESOLVED, that our American Medical Association shall advocate for legislation or regulations requiring all health insurers in every State to provide a real-time online tool for physicians and patients to determine coverage and payment policies for medical procedures, treatments, and services at the time of suggested procedures (Directive to Take Action); and be it further

RESOLVED, that our AMA advocates that the online payment policy tool must include detailed, accurate, and up-to-date information regarding covered services, co-pays, deductibles, and payment policies for specific procedures, and that this tool be binding on the insurers for the purposes of determining payment for claims (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate that the online payment policy tool must be a uniform interface that works across all insurers and physicians, ensuring consistent and streamlined access to coverage information for physicians and patients. (Directive to Take Action)

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

Received: 9/26/25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 816
(I-25)

Introduced by: New York

Subject: Prohibit Arbitrary Time Limits on Preauthorizations

Referred to: Reference Committee J

Whereas, patients are increasingly having access to care delayed or denied by insurance companies as health insurers report yearly increases in revenue, suggesting that the majority of denials are financially motivated; and

Whereas, reducing added insurer administrative hurdles such as having to repeat the preauthorization process due to an expired preauthorization is paramount to preventing further moral injury to already overburdened, increasingly underpaid physicians; and

Whereas, arbitrary time limits on preauthorizations for diagnostic and therapeutic interventions are one of the many tools used to delay and deny access to care, harming patients; and

Whereas, there is no accepted scientific medical rationale for placing time limits on access to care published in peer-reviewed medical literature; and

Whereas, when, for a variety of reasons medical and nonmedical, completing preauthorized care within the arbitrary insurance time frame isn't possible; therefore be it

RESOLVED, that our American Medical Association advocate for changes in State legislation and Division of Financial Services policy to prohibit health insurers in any State, including Medicaid plans, from establishing time limits on duration of preauthorization for care of less than one year (Directive to Take Action); and be it further

RESOLVED, that our AMA seek similar changes in Federal legislation and policies to prohibit Medicare Advantage, Medicaid, and Employee Retirement Income Securement Act of 1974 (ERISA) plans from establishing time limits on preauthorizations for care of less than one year. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/26/25

REFERENCES

EXSISTING MSSNY POLICY

1. 120.893 Fifteen Month Lab Orders
   MSSNY will advocate for legislation and/or regulation for all insurances to allow any standing laboratory order to be valid for up to 15 months before a new order is required. MSSNY will submit a resolution to the AMA seeking action by the Centers for Medicare/Medicaid Services (CMS) to allow standing laboratory orders to be active for 15 months. (HOD 2021-101)
2. 120.906 Grandfathering of Medications that have been Prescribed for Over 1 Year MSSNY will advocate that a physician be able to ensure continued insurer authorization for a particular medication that a patient has been using for over one year by noting on the e-prescription that the patient is stabilized on that medication. (HOD 2019-68)
3. 120.907 Nuisance Prior Authorizations Prior authorizations for medication must have a sound clinical justification which would be available upon request from the Pharmacy Benefit Manager and which would include, but not be limited to, promotion of adherence to guidelines, promotion of generic alternatives, and prevention of adverse reactions. MSSNY will advocate with the NYS Department of Health and NYS Department of Financial Services to prevent health insurers from imposing prior authorizations without appropriate clinical justification and to instruct Medicaid managed care contractors to approve prior authorizations for a minimum of one year. (HOD 2019-61)
4. 120.912 Reducing the Rate of Precertification Requirements In an effort to improve patient care and reduce the unnecessary burden regarding precertification requirements for physicians, MSSNY will continue and expand its efforts to force health insurers to reduce the level of required pre-certifications and preauthorizations physicians must obtain prior to rendering care. (HOD 2018-264)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 817
(I-25)

Introduced by: New York

Subject: Prohibiting Insurers from Denying Payment for Procedures Based on Site of Service

Referred to: Reference Committee J

Whereas, physicians, healthcare providers, and patients rely on insurance reimbursement to ensure that medically necessary procedures and treatments are covered, regardless of where the procedure is performed; and

Whereas, insurers may deny payment for procedures based solely on the site of service, despite the medical necessity of the service; and

Whereas, these site-of-service denials create significant barriers to timely care, cause unnecessary delays, and place a financial burden on both patients and providers, ultimately compromising patient outcomes and the quality of care; and

Whereas, there has been an expansion of the ability to perform more extensive procedures in the physician's office, frequently motivated by the self-same health insurers that are denying care; and

Whereas, the cost of performing the same procedure may vary significantly depending on the site of service, with higher costs often associated with hospital-based procedures, which can result in increased healthcare expenditures without improving the quality of care; and

Whereas, treating physicians should have the autonomy to determine the most appropriate site of service for their patients based on clinical considerations, not based on the cost-benefit analysis imposed by insurers; and

Whereas, such practices may disproportionately affect certain patient populations, including those in rural or underserved areas, where alternative sites of care may not be easily accessible; therefore be it

RESOLVED, that our American Medical Association advocates for legislation or regulation that prohibit insurers in all States from denying payment for a procedure based on the site of service in which it was performed, provided that the procedure is medically necessary. (Directive to Take Action)

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

Received: 9/26/25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 818
(I-25)

Introduced by: New York

Subject: Universal Out-of-Network Benefits

Referred to: Reference Committee J

Whereas, private Health Insurers have deliberately used their regional monopoly powers to push unacceptably low rates on physicians, thus creating artificially narrow networks; and

Whereas, such practice creates the appearance of physician shortages and lack of access to physicians in a reasonable time, all to the sole benefit and profit of insurers; and

Whereas, state laws that require insurers to allow patients to seek an out-of-network physician when appropriate will always be entirely inadequate because insurers will always determine that a patient doesn't need an out-of-network physician; and

Whereas, the now frequent need to wait months to see a physician would largely resolve if patients all had out-of-network benefits and could see any practicing physician; and

Whereas, many states are now taking the absurd step of trying to allow nurses and physician assistants to practice medicine independently because there aren't enough in-network doctors available to care for patients; and

Whereas, the practice of creating and restricting networks has coincided with a massive increase in overall healthcare costs, not a saving; and

Whereas, the single and only beneficiary of insurance policies that offer no out-of-network benefits are the insurance companies themselves, to no clear public advantage; therefore be it

RESOLVED, that our American Medical Association will advocate for federal and state laws that requires all private insurers to offer health insurance plans with out-of-network benefits. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/26/25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 819
(I-25)

Introduced by: New York

Subject: Update the status of Virtual Credit card policy, EFT fees, and lack of Enforcement of Administrative Simplification Requirements by CMS

Referred to: Reference Committee J

Whereas, our American Medical Association adopted policies CMS Administrative Requirements D-190.970, Virtual Credit Card Payments H-190.955, Amend Virtual Credit Card and Electronic Funds Transfer Fee Policy D-190.968; and

Whereas, despite the efforts of the American Medical Association and other groups, the sneaky practices and associated costs of virtual credit cards and EFT fees have not abated; and

Whereas, these possible violations of the HIPAA administrative simplification requirements have not been remedied; and

Whereas, enforcement of these laws preventing imposition of costs for EFT requires continued vigilance by the AMA, medical societies and physicians across the country; therefore be it

RESOLVED, that our American Medical Association report at the Annual 2027 Meeting on the progress of implementation of AMA Policies D-190.970, H-190.955, and D-190.968. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/26/25

RELEVANT AMA POLICY

CMS Administrative Requirements D-190.970
Our AMA will: (1) forcefully advocate that the Centers for Medicare and Medicaid Services (CMS) investigate all valid allegations of HIPPPA Administrative simplification requirements thoroughly and offers transparency in its processes and decisions as required by the Administrative Procedure Act (APA);

(2) forcefully advocate that the CMS resolve all complaints related to the non-compliant payment methods including opt-out virtual credit cards, charging processing fees for electronic claims and other illegal electronic funds transfer (EFT) fees; (3) communicate its strong disapproval of the failure by the CMS Office of Burden Reduction to effectively enforce the HIPAA administrative simplification requirements as required by the law and its failure to impose financial penalties for non-compliance by health plans; and (4) through legislation, regulation or other appropriate means, advocate for the prohibition of health insurers charging physicians and other providers to process claims and make payment.

Amend Virtual Credit Card and Electronic Funds Transfer Fee Policy D-190.968

1. Our American Medical Association will advocate for legislation or regulation that would prohibit the use of virtual credit cards (VCCs) for electronic health care payments.

2. Our AMA will advocate on behalf of physicians and plainly state that it is not advisable or beneficial for medical practices to get paid by VCCs.

3. Our AMA will engage in legislative and regulatory advocacy efforts to address the growing and excessive electronic funds transfer (EFT) add-on service fees charged by payers when paying physicians, including advocacy efforts directed at: (a) the issuance of Centers for Medicare & Medicaid Services (CMS) regulatory guidance affirming physicians' right to choose and receive timely basic EFT payments without paying for additional services, (b) CMS enforcement activities related to this issue, and (c) physician access to a timely no fee EFT option as an alternative to VCCs.

Virtual Credit Card Payments H-190.955

Our American Medical Association will educate its members about the use of virtual credit cards by third party payers, including the costs of accepting virtual credit card payments from third party payers, the beneficiaries of the administrative fees paid by the physician practice inherent in accepting such payments and the lower cost alternative of electronic funds transfer via the Automated Clearing House.

2. Our AMA will advocate for advance disclosure by third-party payers of transaction fees associated with virtual credit cards and any rebates or other incentives awarded to payers for utilizing virtual credit cards.

3. Our AMA supports transparency, fairness, and provider choice in payers' use of virtual credit card payments, including: advanced physician consent to acceptance of this form of payment; disclosure of transaction fees; clear information about how the provider can opt out of this payment method at any time; and prohibition of payer contracts requiring acceptance of virtual credit card payments for network inclusion.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 821
(I-25)

Introduced by: Oklahoma, American Society of Retina Specialists, American Society of Cataract and Refractive Surgery

Subject: Improving Access to Emergency Ophthalmologic Surgical Care

Referred to: Reference Committee J

Whereas, AMA Code of Medical Ethics, 11.1.4 Financial Barriers to Health Care Access, states "Health care is a fundamental human good because it affects our opportunity to pursue life goals, reduces our pain and suffering, helps prevent premature loss of life, and provides information needed to plan for our lives;" and

Whereas, AMA Code of Medical Ethics 11.1.4 also states "as professionals, physicians individually and collectively have an ethical responsibility to ensure that all persons have access to needed care;" and

Whereas, enhancing access to ophthalmologic surgical services is expected to reduce the incidence of permanent vision loss by enabling timely surgical management for urgent conditions such as acute retinal detachment, traumatic open globe injuries, endophthalmitis, and intraocular foreign bodies; and

Whereas, acute retinal detachment is the leading vision-threatening condition that requires prompt surgical treatment to prevent permanent loss of vision; [1] and

Whereas, delayed treatment of retinal detachment, particularly involving the macula, significantly worsens visual prognosis and increases the risk of irreversible blindness; [2–5] and

Whereas, access to emergency vitreoretinal surgical services faces significant restrictions across the United States due to insufficient facility reimbursement, resulting in hospital retina service closures and ambulatory surgery centers reducing retina block time or eliminating services entirely, while also constraining surgical room availability during nights and weekends; [6-11] and

Whereas, hospital privileging for vitreoretinal surgical services including retinal detachment (RD) surgery is hindered by institutional barriers—low reimbursement, resource and staffing limitations, and infrastructure demands—such that the decision to grant and sustain privileges often reflects hospital capacity and financial feasibility as much as surgeon expertise, ultimately restricting timely access to this procedure; and

Whereas, according to American Society of Retina Specialists' 2025 Preferences and Trends (PAT) survey, more than 70% of 889 respondents reported experiencing challenges with adequate operating room (OR) availability or access, particularly for emergent cases such as retinal detachment repair; [7] and

Whereas, some patients are forced to travel significant distances experiencing delays in care; [8] and

Whereas, inequities in access to timely retinal detachment surgery disproportionately affect underserved populations, including Medicaid beneficiaries, the uninsured, and residents of rural communities; [6-9] and

Whereas, payer-imposed barriers such as prior authorization and inadequate Medicaid and Medicare coverage further delay time-sensitive surgical care; and

Whereas, untreated or delayed treatment of retinal detachment not only results in blindness but also increases long-term societal costs through disability claims, Medicare and Medicaid expenditures, and loss of patient independence and productivity; and

Whereas, improving systems of care, reimbursement incentives, privileging standards, and payer rules, could enhance timely access to surgical management and prevent avoidable vision loss; [6-9] therefore be it

RESOLVED, that our American Medical Association supports policies aimed at enhancing access to emergency ophthalmic care—including vitreoretinal surgical services and traumatic open globe injuries— through initiatives such as improved operating room availability, facility reimbursement reforms, and changes to hospital privileging that exclude economic criteria to facilitate timely surgical care (New HOD Policy); and be it further

RESOLVED, that our AMA advocates to reduce payer barriers, including prior authorization and inadequate Medicaid and Medicare reimbursement, that hinder access to surgical ophthalmologic emergency care including vitreoretinal surgery and traumatic open globe injuries (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for reducing geographic and socioeconomic barriers to timely ophthalmologic emergency care—including both surgical vitreoretinal services and traumatic open globe injuries—in alignment with AMA health equity policies, with emphasis on rural and underserved communities. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/26/25

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 822
(I-25)

Introduced by: Medical Student Section

Subject: Improving Home or Community-Based Services Waiver Waiting List Management

Referred to: HOD Reference Committee J

Whereas, individuals with permanent disabilities are often unable to meet their Activities of Daily Living without long-term caregivers that deliver home or community-based services (HCBS); and

Whereas, in 2024, individuals waited an average of 40 months to receive HCBS, and as of 2024, over 700,000 individuals, primarily with intellectual and developmental disabilities (I/DD), remain on HCBS waiting lists across the United States[1,2]; and

Whereas, waiting list management for HCBS waivers differs between states, with some states maintaining waiting lists for enrolled individuals for whom services are not currently available (due to workforce shortages or waiver caps) while other states maintain waiting lists of individuals who have yet to be screened for eligibility[1]; and

Whereas, automatic eligibility screening ensures that only qualified applicants are placed on a waiting list, increasing efficiency and ensuring that individuals who need services the most receive them in a timely manner[3]; and

Whereas, people with I/DD residing in states that do not automatically screen for eligibility wait longer for services than people with I/DD residing in states that do automatically screen (70 months versus 43 months, on average)[1]; and

Whereas, over half of people (428,000) on HCBS waiting lists live in the eight states that do not screen people for eligibility prior to adding them to the list[2]; and

Whereas, Texas reports some individuals have been on their HCBS waiting lists for over 15 years, with 1,469 (3.5%) of those screened for eligibility in 2024 found to be deceased[4]; and

Whereas, Ohio developed a new waiting list assessment in 2019, which removed ineligible people from the list who did not meet waiver criteria, providing them with other Medicaid state resources where applicable, and cutting the waiting list from 69,000 to 2,000 people[1,3]; and
Whereas, states' implementation of eligibility screening for HCBS waivers was associated with increased HCBS enrollment, and promoted need-based access to HCBS; and

Whereas, increasing access to HCBS waivers has been shown to improve cost efficiency for states in delivering long-term services and supports, particularly for individuals with I/DD, with

states that enroll more people into HCBS programs achieving lower per-person Medicaid spending compared to those who rely on institutional care[5]; therefore be it

RESOLVED, that our American Medical Association support automatic eligibility screening for home or community-based services (HCBS) waivers. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Date Received: 09/30/2025

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RELEVANT AMA POLICY

H-280.945 Financing of Long-Term Services and Supports
Our American Medical Association supports policies and incentives that standardize and simplify private Long Term Care Insurance (LTCI) to achieve increased coverage and improved affordability for all Americans.
Our AMA supports adding transferable and portable LTCI coverage as part of workplace automatic enrollment with an opt-out provision potentially available to both current employees and retirees.
Our AMA supports allowing employer-based retirement savings to be used for LTCI premiums and LTSS expenses, including supporting penalty-free withdrawals from retirement savings accounts for purchase of private LTCI.
Our AMA supports innovations in LTCI product design, including the insurance of home and community-based services, and the marketing of long-term care products with health insurance, life insurance, and annuities.
Our AMA supports permitting Medigap plans to offer a limited LTSS benefit as an optional supplemental benefit or as separate insurance policy.
Our AMA supports Medicare Advantage plans offering LTSS in their benefit packages.
Our AMA supports permitting Medigap and Medicare Advantage plans to offer a respite care benefit as an optional benefit.
Our AMA supports a back-end public catastrophic long-term care insurance program.
Our AMA supports incentivizing states to expand the availability of and access to home and community-based services; and
Our AMA supports better integration of health and social services and supports, including the Program of All-Inclusive Care for the Elderly. [CMS Rep. 05, A-18 Reaffirmation: I-18 Reaffirmed: CMS Rep. 10, A-19 Reaffirmed: CMS Rep. 4, I-21 Reaffirmed: A-23 Modified: Res. 815, I-23]

H-280.944 Financing of Home and Community-Based Services
Our American Medical Association supports federal funding for payment rates that promote access and greater utilization of home and community-based services (HCBS).
Our AMA supports policies that help train, retain, and develop an adequate HCBS workforce.

Our AMA supports efforts to simplify state plan amendments and Medicaid waivers to allow additional state flexibility to offer HCBS.
Our AMA supports that Medicaid's Money Follows the Person demonstration program be extended or made permanent.
Our AMA supports cross-agency and federal-state strategies that can help improve coordination among HCBS programs and streamline funding and the provision of services.
Our AMA supports HCBS programs tracking protocols and outcomes to make meaningful comparisons across states and identify best practices.
Our AMA supports that the Centers for Medicare and Medicaid Services and private insurers extend flexibility to implement innovative programs including but not limited to hospital at home programs. [CMS Rep. 4, I-21 Reaffirmed: A-23 Copyright]

H-290.982 Transforming Medicaid and Long-Term Care and Improving Access to Care for the Uninsured
Our American Medical Association urges that Medicaid reform not be undertaken in isolation, but rather in conjunction with broader health insurance reform, in order to ensure that the delivery and financing of care results in appropriate access and level of services for low-income patients.
Our AMA encourages physicians to participate in efforts to enroll children in adequately funded Medicaid and State Children's Health Insurance Programs using the mechanism of "presumptive eligibility," whereby a child presumed to be eligible may be enrolled for coverage of the initial physician visit, whether or not the child is subsequently found to be, in fact, eligible.
Our AMA encourages states to ensure that within their Medicaid programs there is a pluralistic approach to health care financing delivery including a choice of primary care case management, partial capitation models, fee-for-service, medical savings accounts, benefit payment schedules and other approaches.
Our AMA calls for states to create mechanisms for traditional Medicaid providers to continue to participate in Medicaid managed care and in State Children's Health Insurance Programs.
Our AMA calls for states to streamline the enrollment process within their Medicaid programs and State Children's Health Insurance Programs by, for example, allowing mail-in applications, developing shorter application forms, coordinating their Medicaid and welfare (TANF) application processes, and placing eligibility workers in locations where potential beneficiaries work, go to school, attend day care, play, pray, and receive medical care.
Our AMA urges states to administer their Medicaid and SCHIP programs through a single state agency.
Our AMA strongly urges states to undertake, and encourages state medical associations, county medical societies, specialty societies, and individual physicians to take part in, educational and outreach activities aimed at Medicaid-eligible and SCHIP-eligible children. Such efforts should be designed to ensure that children do not go without needed and available services for which they are eligible due to administrative barriers or lack of understanding of the programs.
Our AMA supports requiring states to reinvest savings achieved in Medicaid programs into expanding coverage for uninsured individuals, particularly children. Mechanisms for expanding coverage may include additional funding for the SCHIP earmarked to enroll children to higher percentages of the poverty level; Medicaid expansions; providing premium subsidies or a buy-in option for individuals in families with income between their state's Medicaid income eligibility level and a specified percentage of the poverty level; providing some form of refundable, advanceable tax credits inversely related to income; providing vouchers for recipients to use to choose their own health plans; using Medicaid funds to purchase private health insurance coverage; or expansion of Maternal and Child Health Programs. Such expansions must be implemented to coordinate with the Medicaid and SCHIP programs in order to achieve a seamless health care delivery system, and be sufficiently funded to provide incentive for families to obtain adequate insurance coverage for their children.
Our AMA advocates consideration of various funding options for expanding coverage including, but not limited to: increases in sales tax on tobacco products; funds made available through for-profit conversions of health plans and/or facilities; and the application of prospective payment or other cost or utilization management techniques to hospital outpatient services, nursing home services, and home health care services.
Our AMA calls for CMS to develop better measurement, monitoring, and accountability systems and indices within the Medicaid program in order to assess the effectiveness of the program, particularly

under managed care, in meeting the needs of patients. Such standards and measures should be linked to health outcomes and access to care.
Our AMA supports innovative methods of increasing physician participation in the Medicaid program and thereby increasing access, such as plans of deferred compensation for Medicaid providers. Such plans allow individual physicians (with an individual Medicaid number) to tax defer a specified percentage of their Medicaid income.
Our AMA supports increasing public and private investments in home and community-based care, such as adult day care, assisted living facilities, congregate living facilities, social health maintenance organizations, and respite care.
Our AMA supports allowing states to use long-term care eligibility criteria which distinguish between persons who can be served in a home or community-based setting and those who can only be served safely and cost-effectively in a nursing facility. Such criteria should include measures of functional impairment which take into account impairments caused by cognitive and mental disorders and measures of medically related long-term care needs.
Our AMA supports buy-ins for home and community-based care for persons with incomes and assets above Medicaid eligibility limits; and providing grants to states to develop new long-term care infrastructures and to encourage expansion of long-term care financing to middle-income families who need assistance.
Our AMA supports efforts to assess the needs of individuals with intellectual disabilities and, as appropriate, shift them from institutional care in the direction of community living.
Our AMA supports case management and disease management approaches to the coordination of care, in the managed care and the fee-for-service environments.
Our AMA urges CMS to require states to use its simplified four-page combination Medicaid / Children's Health Insurance Program (CHIP) application form for enrollment in these programs, unless states can indicate they have a comparable or simpler form.
Our AMA urges CMS to ensure that Medicaid and CHIP outreach efforts are appropriately sensitive to cultural and language diversities in state or localities with large uninsured ethnic populations.
To prevent a delay in care, our AMA supports favoring the treating physician’s judgment if the reviewing physician is not available. [BOT Rep. 31, I-97 Reaffirmed by CMS Rep. 2, A-98 Reaffirmation A-99 and Reaffirmed: Res. 104, A-99Appended: CMS Rep 2, A-99 Reaffirmation A-00 Appended: CMS Rep. 6, A-01 Reaffirmation A-02 Modified: CMS Rep. 8, A-03 Reaffirmed: CMS Rep. 1, A-05Reaffirmation A-05 Reaffirmation A-07Modified: CMS Rep. 8, A-08 Reaffirmation A-11 Modified: CMS Rep. 3, I-11 Reaffirmed: CMS Rep. 02, A-19 Reaffirmed: CMS Rep. 3, I-21 Reaffirmation: A-22 Reaffirmed: CMS Rep. 3, A-22 Modified: Res. 803, I-23 Appended: Res. 804, I-23]

H-210.994 Home Health Care
Our AMA (1) reaffirms its support of home health care as an alternative to hospital, nursing home, or institutional care;
(2) encourages physicians to take a more active role in the provision of home health care;
(3) supports modifications in Medicare regulations for home health care, so that those regulations include appropriate standardized definitions and instructions to fiscal intermediaries;
(4) supports improving patient accessibility to home health services by seeking modifications in the Medicare regulations to provide coverage for the care of homebound patients by qualified individuals working under the supervision of the patient's attending physician; and
(5) supports continued monitoring of the adequacy of the home health care system to meet the accessibility needs of homebound patients. [BOT Rep. EE, A-87 Reaffirmed by Res. 122, A-97 Reaffirmed: Sunset Report, I-97 Reaffirmed by Res. 129, A-98 Reaffirmed: CMS Rep. 4, A-08 Reaffirmed: CMS Rep. 01, A-18]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 823
(I-25)

Introduced by:	American College of Rheumatology, Association for Clinical Oncology, American Academy of Dermatology, American Society of Anesthesiologists, American Gastroenterological Association, American College of Physicians, American Association for Geriatric Psychiatry, American Society for Gastrointestinal Endoscopy, American Society of Nuclear Cardiology, Society for Cardiovascular Magnetic Resonance
Subject:	Accountability in the Use of Augmented Intelligence for Prior Authorization
Referred to:	Reference Committee J

Whereas, despite its potential to streamline the healthcare system, the use of AI (artificial intelligence/augmented intelligence) in prior authorization processes can lead to increased denials of necessary care, potentially causing harm and delays in treatment. For example, a 2024 Senate report noted that denial rates for post-acute care can be as much as 16 times higher than overall rates; and

Whereas, there is no standardized framework for using AI in prior authorization processes across the healthcare industry, which leads to inconsistencies in how AI tools are applied and the quality of their outputs; and

Whereas, over 60% of providers are concerned that health plans' use of AI is increasing prior authorization denials; and

Whereas, patients, particularly from vulnerable populations, face barriers to accessing care when AI algorithms deny treatments based on predefined rules that do not account for individual patient needs; and

Whereas, ai-driven prior authorization models lack transparency, thereby burdening providers who need to understand why a particular prior authorization request was denied or approved; and

Whereas, the lack of accountability in AI-driven prior authorization processes makes it difficult to hold payers or AI platform developers accountable for errors and incorrect or unethical decisions; and

Whereas, nearly half of providers believe payers' use of AI in prior authorization processes should be a top focus for regulatory action; and

Whereas, when there is interruption in therapies, there is the risk of formation of drug antibodies or loss of the drug's effectiveness; therefore be it

RESOLVED, that our American Medical Association will amend policy D-480.956, "Use of Augmented Intelligence for Prior Authorization," by addition and deletion to read as follows:

Our American Medical Association will work with stakeholders ~~advocates~~ to advocate for legislative and/or regulatory action for greater regulatory oversight ~~of~~ related to the use of augmented intelligence for review of patient claims and prior authorization requests, including whether insurers and/or contracted third parties are using a thorough and fair process that:

1. is based on accurate and up-to-date clinical criteria derived from national medical specialty societies' evidence-based guidelines and peer-reviewed clinical literature.
2. includes reviews by doctors and other health care professionals who are not incentivized to deny care and with expertise for the service under review.
3. ~~requires such reviews include human examination of patient records prior to a care denial~~
3. provides for transparency and accountability over the use of augmented intelligence for all medical service denials, to include a direct review of patient records by a qualified clinician.
4. requires direct review of the patient record by a qualified clinician of all medications flagged for denial by augmented intelligence platforms that were previously approved by payers.
5. provides robust appeals processes and guardrails to prevent algorithmic discrimination and ensure equitable access to care.

(Modify Current HOD Policy); and be it further

RESOLVED, that our AMA will report on actions taken by the 2026 Annual Meeting of the AMA House of Delegates. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/29/25

REFERENCES

1. U.S. Senate Permanent Subcommittee on Investigations 2024.10.17 PSI Majority Staff Report on Medicare Advantage
2. AMA prior authorization (PA) physician survey | AMA
3. AMA Augmented Intelligence Research | AMA

RELEVANT AMA POLICY

Use of Augmented Intelligence for Prior Authorization D-480.956
Our American Medical Association advocates for greater regulatory oversight of the use of augmented intelligence for review of patient claims and prior authorization requests, including whether insurers are using a thorough and fair process that: 1) is based on accurate and up-to-date clinical criteria derived from national medical specialty society guidelines and peer reviewed clinical literature, 2) includes reviews by doctors and other health care professionals who are not incentivized to deny care and with expertise for the service under review, and 3) requires such reviews include human examination of patient records prior to a care denial.
Policy Timeline
Res. 721, A-23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 824
(I-25)

Introduced by: New Jersey

Subject: Equitable Payment and Increased Access for In-Office Pediatric Lead Screening and Testing

Referred to: Reference Committee J

Whereas, early detection of lead exposure through screening and testing at 12 and 24 months and other age-appropriate times is a public health priority to prevent severe neurological and developmental harm for children; and

Whereas, a preventative lead service for children is mandated under the Medicaid Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) guidelines; and

Whereas, due to inadequate payment and lack of reimbursement by insurance plans not accounting for supplies, staff training, resources, and time taken in performing the service, many pediatric practices are forced to discontinue in-office lead services and refer patients to external labs contributing to a significant number of unfulfilled test orders; and

Whereas, barriers such as transportation challenges, time constraints, language barriers, and care coordination issues, especially for children with Medicaid, often prevent families from completing the referrals, leading to unfulfilled scripts and increased public health risks; and

Whereas, physicians are penalized for unfulfilled lab scripts that impact practice performance metrics, despite completing their responsibility by ordering the necessary tests; and

Whereas, equitable payment for in-office lead screening and testing, whether through a capillary blood test or a venous blood test, would promote in-office services and increase screening rates among vulnerable populations; therefore be it

RESOLVED, that our American Medical Association advocate for all public and private payers for equitable payment rates for in-office pediatric lead screening and testing to cover time, supplies, training, and administrative costs, including both point-of-care and other methods (Directive to Take Action); and be it further

RESOLVED, that our AMA support federal and state policies to reduce barriers to improve access to lead screening and testing by incentivizing completion of such services in physician offices (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for increased accountability among insurers to ensure that physicians do not face inappropriate disciplinary action, or decreased financial incentives or other payment, due to lab orders for lead screening that go unfulfilled for reasons outside the physician’s control. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/30/25

RELEVANT AMA POLICY

Reducing Lead Poisoning H-60.924

1. Our American Medical Association:
    a. supports regulations and policies designed to protect young children from exposure to lead;
    b. urges the Centers for Disease Control and Prevention to give priority to examining the current weight of scientific evidence regarding the range of adverse health effects associated with blood lead concentrations below the current "level of concern" in order to provide appropriate guidance for physicians and public health policy, and encourage the identification of exposure pathways for children who have low blood lead concentrations, as well as effective and innovative strategies to reduce overall childhood lead exposure;
    c. encourages physicians and public health departments to screen children based on current recommendations and guidelines and to report all children with elevated blood levels to the appropriate health department in their state or community in order to fully assess the burden of lead exposure in children. In some cases this will be done by the physician, and in other communities by the laboratories;
    d. promotes community awareness of the hazard of lead-based paints; and
    e. urges paint removal product manufacturers to print precautions about the removal of lead paint to be included with their products where and when sold.
2. Our AMA will call on the United States government to establish national goals to: (a) ensure that no child has a blood lead level >5 µg/dL (>50 ppb) by 2021, and (b) eliminate lead exposures to pregnant people and children, so that by 2030, no child would have a blood lead level >1 µg/dL (10 ppb).
3. Our AMA will call on the United States government in all its agencies to pursue the following strategies to achieve these goals:
    a. adopt health-based standards and action levels for lead that rely on the most up-to-date scientific knowledge to prevent and reduce human exposure to lead, and assure prompt implementation of the strongest available measures to protect pregnant people and children from lead toxicity and neurodevelopmental impairment;
    b. identify and remediate current and potential new sources of lead exposure (in dust, air, soil, water and consumer products) to protect children before they are exposed;
    c. continue targeted screening of children to identify those who already have elevated blood lead levels for case management, as well as educational and other services;
    d. eliminate new sources of lead introduced or released into the environment, which may entail banning or phasing out all remaining uses of lead in products (aviation gas, cosmetics, wheel weights, industrial paints, batteries, lubricants, and other sources), and the export of products containing lead, and setting more protective limits on emissions from battery recyclers and other sources of lead emissions;
    e. provide a dedicated funding stream to enhance the resources available to identify and eliminate sources of lead exposure, and provide educational, social and clinical services to mitigate the harms of lead toxicity, particularly to protect and improve the lives of children in communities that are disproportionately exposed to lead; and
    f. establish an independent expert advisory committee to develop a long-term national strategy, including recommendations for funding and implementation, to achieve the national goal of eliminating lead toxicity in pregnant people and children, defined as blood lead levels above 1 µg/dL (10 ppb).
4. Our AMA supports requiring an environmental assessment of dwellings, residential buildings, or child care facilities following the notification that a child occupant or frequent inhabitant has a confirmed elevated blood lead level, to determine the potential source of lead poisoning, including testing the water supply.
5. Our AMA advocates for accessible testing of domestic water supplies, prioritizing testing for lead in potable water used by pregnant people, newborns and young children, and with the provision of accessible water filters in homes found to have elevated lead levels in potable water.
6. Our AMA supports increased funding for lead pipe replacement and other steps to eliminate lead from public and private drinking water supplies.

7. Our AMA promotes community awareness and education campaigns on the causes and risks of lead in drinking water and steps that can be taken to eliminate these risks.
8. Our AMA supports the development and use of searchable registries of housing units known to have unresolved lead in the drinking water due to lead connectors to water mains or other sources of lead in the drinking water in cities with significant public lead exposure.
9. Our AMA urges healthcare providers to increase screening for lead exposure, particularly in areas known to have lead pipes, and particularly in underserved areas.
10. Our AMA calls for research into innovative and cost-effective methods for elimination of lead in public and private water supplies and lead from lead pipe connectors to such water supplies. CCB/CLRPD Rep. 3, A-14 Appended: Res. 926, I-16 Appended: Res. 412, A-17 Modified: Res. 432, A-24 Modified: Speakers Rep. 02, I-24

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 825
(I-25)

Introduced by: New Jersey

Subject: Ensuring Coverage for In-Office Point-of-Care (POC) Testing in Outpatient Medical Practices

Referred to: Reference Committee J

Whereas, timely diagnosis of common respiratory infections such as influenza, COVID-19, and RSV is essential to ensure appropriate treatment, reduce complications, and limit transmission in vulnerable populations; and

Whereas, in-office POC testing allows for immediate clinical decision-making during the visit, improving patient outcomes, reducing emergency room visits, and unnecessary prescriptions or follow-up visits; and

Whereas, payers have intermittent coverage for in-office molecular POC testing, at times requiring that specimen samples be sent to external laboratories leading to delayed diagnoses and reduction of appropriate, high-quality, timely care; and

Whereas, limited payer coverage for in-office molecular POC testing leads to increased urgent care usage where POC testing may be offered, breaking continuity of care of the medical home and increasing cost to the healthcare system; therefore be it

RESOLVED, that our American Medical Association advocate for all public and private payers to provide coverage and adequate payment for basic POC testing, when performed in physician offices and urgent care settings (Directive to Take Action); and be it further

RESOLVED, that the AMA advocates for the recognition of physician offices as the appropriate setting for POC testing to ensure timely and equitable access to diagnostic services for their patients. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/30/25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 826
(I-25)

Introduced by: New Jersey

Subject: Increase National Immunization Rates by Advocating for Equitable Vaccine Payments

Referred to: Reference Committee J

Whereas, Whereas, increasing immunization rates nationally is an essential public health need to avoid debilitating and life-threatening diseases for children and adults; and

Whereas, the current payment structure for vaccinations fails to reflect the acquisition cost and of administration of vaccines especially to children including clinical staff time, technical skill, administration effort, medical supplies, medical equipment, storage costs, and malpractice cost; and

Whereas, the periodic increase in the price of the immunization by the manufacturers may not reflect the update in the insurance provider database in a timely manner and continue to reimburse at the lower price; and

Whereas, the American Academy of Pediatrics (AAP) recommends that payment for vaccines be set at no less than 125% of the CDC-published private sector vaccine price to reflect the actual costs of acquisition and administration of the vaccine for the medical practices; and

Whereas, many practices are forced to limit or stop offering vaccinations due to out-of-pocket costs and financial strain, which reduces access and contributes to declining immunization rates, particularly in underserved and rural populations; therefore be it

RESOLVED, that our American Medical Association supports the establishment of national standards for immunization payment rates that ensure physicians are reimbursed at no less than 125% of the CDC private sector vaccine price. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 9/30/25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 827
(I-25)

Introduced by:	Association for Clinical Oncology, American College of Rheumatology, American Society for Radiation Oncology, California Medical Association
Subject:	Opposition to Prior Authorization in Medicare Fee-for-Service, Burdensome Administrative Requirements
Referred to:	Reference Committee J

Whereas, prior authorization (PA) and other utilization management programs are recognized by our American Medical Association (AMA) as among the most burdensome administrative processes in medicine, diverting physician and staff time and resources away from direct patient care; and

Whereas, data from AMA physician surveys demonstrate that on average, practices complete 39 PA requests per physician, per week, requiring spending an average of 12-13 hours per week on related administrative tasks; this administrative burden contributes significantly to physician burnout and practice closures, particularly among independent and smaller practices that lack the resources to manage excessive paperwork; and

Whereas, surveyed physicians report that the PA process often delays necessary care, negatively impacts clinical outcomes, and leads to patients abandoning a recommended course of treatment, resulting in worsening health conditions and increased costs to the health care system; and despite this high administrative burden, a significant number of PA requests are ultimately approved, indicating that the process is an ineffective and inefficient tool for fraud, waste, and abuse prevention; and

Whereas, the Centers for Medicare & Medicaid Services (CMS) has acknowledged the harms of PA and has worked with our AMA to reform the process in Medicare Advantage plans, making the expansion of PA into the Medicare Fee-for-Service (FFS) inconsistent with CMS' goals, and the Wasteful and Inappropriate Service Reduction Model, which would implement a technology-enabled (including augmented intelligence/artificial intelligence) PA and pre-payment review system in Medicare FFS, represents a direct expansion of these harmful policies; and

Whereas, our AMA has long-standing policies in place to reform PA, including a commitment to advocating for alternatives to PA and for legislation that ensures decisions are made by clinically appropriate peer reviewers; therefore be it

RESOLVED, that our American Medical Association opposes the use of prior authorization (PA) and pre-payment review in Medicare Fee-for-Service (FFS), including the proposed Wasteful and Inappropriate Service Reduction (WISeR) Model which would implement a technology-enabled review system (including augmented intelligence/artificial intelligence) (New HOD Policy); and be it further

RESOLVED, that our AMA will advocate against the implementation of the WISeR Model and any similar programs that impose new PA requirements in Medicare FFS, while continuing its efforts to educate Congress, the Centers for Medicare & Medicaid Services, and the public on

the harms of PA to both patients and physicians, leveraging data from its own surveys and the experiences of its members (Directive to Take Action); and be it further

RESOLVED, that our AMA will continue to advocate for a legislative and regulatory framework that streamlines administrative processes, prioritizes patient access to timely care, and replaces burdensome PA with clinically-sound alternatives, such as the adoption of "gold card" programs for high-performing providers and the greater use of evidence-based clinical guidelines. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/30/25

REFERENCES

1. CMS Testing Technology-Enabled Prior Authorization and Pre-Payment Review to Reduce Medicare Fraud, Waste, Abuse - ASCO
2. Fixing prior auth: Nearly 40 prior authorizations a week is way too many | AMA
3. 2025 ASCO Position Statement: The Use of Artificial Intelligence in Prior Authorization
4. 2022 ASCO Position Statement: Prior Authorization
5. CMS Launches New Model to Target Wasteful, Inappropriate Services in Original Medicare

RELEVANT AMA POLICY

Use of Augmented Intelligence for Prior Authorization D-480.956
Our American Medical Association advocates for greater regulatory oversight of the use of augmented intelligence for review of patient claims and prior authorization requests, including whether insurers are using a thorough and fair process that:

1. is based on accurate and up-to-date clinical criteria derived from national medical specialty society guidelines and peer reviewed clinical literature.
2. includes reviews by doctors and other health care professionals who are not incentivized to deny care and with expertise for the service under review.
3. requires such reviews include human examination of patient records prior to a care denial.

Prior Authorization and Utilization Management Reform H-320.939

1. Our American Medical Association will continue its widespread prior authorization (PA) advocacy and outreach, including promotion and/or adoption of the Prior Authorization and Utilization Management Reform Principles, AMA model legislation, Prior Authorization Physician Survey and other PA research, and the AMA Prior Authorization Toolkit, which is aimed at reducing PA administrative burdens and improving patient access to care.
2. Our AMA will oppose health plan determinations on physician appeals based solely on medical coding and advocate for such decisions to be based on the direct review of a physician of the same medical specialty/subspecialty as the prescribing/ordering physician.
3. Our AMA supports efforts to track and quantify the impact of health plans' prior authorization and utilization management processes on patient access to necessary care and patient clinical outcomes, including the extent to which these processes contribute to patient harm.
4. Our AMA will advocate for health plans to minimize the burden on patients, physicians, and medical centers when updates must be made to previously approved and/or pending prior authorization requests.

Prior Authorization Reform D-320.982
Our American Medical Association will explore emerging technologies to automate the prior authorization process for medical services and evaluate their efficiency and scalability, while advocating for reduction in the overall volume of prior authorization requirements to ensure timely access to medically necessary care for patients and reduce practice administrative burdens.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 828
(I-25)

Introduced by: California, Arizona, Hawaii, Idaho, Montana, New Mexico, Washington, Association for Clinical Oncology

Subject: Creating a Public Scorecard on Insurer Delays in Care and Payment Caused by Prior Authorization

Referred to: Reference Committee J

Whereas, private and public insurers often impose inappropriate prior authorization that delays medically necessary care to patients and payment delays to physicians; and

Whereas, an AMA survey shows that 93% of physicians report care delays or disruptions associated with prior authorization, 91% say prior authorization has a negative effect on their patients' clinical outcomes, and physician office staff spend the equivalent of two days per week on burdensome prior authorization requests instead of spending time with patients; and

Whereas, an HHS Office of Inspector General (OIG) investigation found that Medicare Advantage plans inappropriately deny necessary care for tens of thousands of patients every year; and

Whereas, these delays are a significant source of frustration for patients and providers, with evidence showing that they contribute to adverse clinical outcomes and disrupt the physician-patient relationship; and

Whereas, publicizing data about delays in care authorization and related claims payment can inform patients and employers about insurer performance and encourage insurers to improve their practices; and

Whereas, the AMA has previously published scorecards regarding insurer payment delays, successfully promoting accountability and improvements in insurer practices; and

Whereas, the Centers for Medicare and Medicaid Services (CMS) recently adopted regulations requiring Medicare Advantage plans to respond to physician requests for prior authorization within certain timeframes and for plans to publicly report on the CMS website the number of services subject to prior authorization, the number of services approved, denied and overturned on appeal, and the timeframes; therefore be it

RESOLVED, that our American Medical Association continue to lead the advocacy effort and assist state medical associations with the implementation of timely, non-aggregated public reporting by private and public plans that engage in prior authorization related to the services subject to prior authorization, the number of services approved, denied and overturned on appeal, and the timeframes for responding to requests for authorization and paying physician claims (Directive to Take Action); and be it further

RESOLVED, that our AMA work with interested organizations in the development and publication of public and private plan scorecards related to prior authorization approvals,

denials, appeals, and the timeframes for responding to requests for authorization and processing physician payments to better inform patients, physicians, and purchasers of insurance. (Directive to Take Action)

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

Received: 9/30/25

RELEVANT AMA POLICY

Prior Authorization Costs, AMA Update to CMS D-320.976
Our American Medical Association will continue to conduct research on the costs associated with prior authorization by utilizing our AMA and other data sources.
[Res. 720, A-23]

Mitigating the Impact of Excessive Prior Authorization Processes D-320.971
1. Our AMA will actively and urgently generate a prior authorization database collecting and analyzing data including metrics reflecting denial rates, care delays, impact on patient care, and associated cost adversely affecting patients and physicians across major healthcare insurers.
2. Our AMA will strengthen and expand the existing public awareness campaign including but not limited to social media, print media, and editorials to highlight the negative impacts of abusive and obstructive prior-authorization requirements on patient care, and educate physicians AND patients on their rights and available resources.
[Res 704, A-25]

Fair Reimbursement for Administrative Burdens D-320.978
1. Our AMA will continue its strong state and federal legislative advocacy efforts to promote legislation that streamlines the prior authorization process and reduces the overall volume of prior authorizations for physician practices.
2. Our AMA will continue partnering with patient advocacy groups in prior authorization reform efforts to reduce patient harms, including care delays, treatment abandonment, and negative clinical outcomes.
3. Our AMA will oppose inappropriate payer policies and procedures that deny or delay medically necessary drugs and medical services.

[Res. 701, A-22 Modified: CMS Rep. 04, A-25]

Insurer Accountability When Prior Authorization Harms Patients D-320-974
1. Our American Medical Association advocates for increased legal accountability of insurers and other payers when delay or denial of prior authorization leads to patient harm, including but not limited to the prohibition of mandatory pre-dispute arbitration regarding prior authorization determinations and limitation on class action clauses in beneficiary contracts.
2. Our American Medical Association advocates that low-cost noninvasive procedures that meet existing standard Medicare guidelines should not require prior authorization.
3. Our AMA supports that physicians be allowed to bill insurance companies for all full time employee hours required to obtain prior authorization.
4. Our AMA supports that patients be allowed to sue insurance carriers which preclude any and all clauses in signed contracts should there be an adverse outcome as a result of an inordinate delay in care.

[Res. 711, A-24]

Prior Authorization, Utilization Management Reform H-320.939

1. Our American Medical Association will continue its widespread prior authorization (PA) advocacy and outreach, including promotion and/or adoption of the Prior Authorization and Utilization Management Reform Principles, AMA model legislation, Prior Authorization Physician Survey and other PA research, and the AMA Prior Authorization Toolkit, which is aimed at reducing PA administrative burdens and improving patient access to care.
2. Our AMA will oppose health plan determinations on physician appeals based solely on medical coding and advocate for such decisions to be based on the direct review of a physician of the same medical specialty/subspecialty as the prescribing/ordering physician.
3. Our AMA supports efforts to track and quantify the impact of health plans' prior authorization and utilization management processes on patient access to necessary care and patient clinical outcomes, including the extent to which these processes contribute to patient harm.
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[CMS Rep. 08, A-17 Reaffirmation: I-17 Reaffirmed: Res. 711, A-18 Appended: Res. 812, I-18 Reaffirmed in lieu of: Res. 713, A-19 Reaffirmed: CMS Rep. 05, A-19 Reaffirmed: Res. 811, I-19 Reaffirmed: CMS Rep. 4, A-21 Appended: CMS Rep. 5, A-21 Reaffirmation: A-22]

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[Res. 727, A-22 CEJA Rep. 01, A-23]

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Our AMA supports the development of legislative initiatives to assure that payers provide their insureds with information enabling them to make informed decisions about choice of plan, and to assure that payers take responsibility when patients are harmed due to the administrative requirements of the plan. Such initiatives should provide for disclosure requirements, the conduct of review, and payer accountability.

1. Disclosure Requirements. Our American Medical Association supports the development of model draft state and federal legislation to require disclosure in a clear and concise standard format by health benefit plans to prospective enrollees of information on:
    a. Coverage provisions, benefits, and exclusions.
    b. Prior authorization or other review requirements, including claims review, which may affect the provision or coverage of services.
    c. Plan financial arrangements or contractual provisions that would limit the services offered, restrict referral or treatment options, or negatively affect the physician's fiduciary responsibility to their patient.
    d. Medical expense ratios.
    e. Cost of health insurance policy premiums. (Ref. Cmt. G, Rec. 2, A-96; Reaffirmation A-97)
2. Conduct of Review. Our AMA supports the development of additional draft state and federal legislation to:
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    b. Require that any physician who recommends a denial as to the medical necessity of services on behalf of a review entity be of the same specialty as the practitioner who provided the services under review.
    c. Require every organization that reviews or contracts for review of the medical necessity of services to establish a procedure whereby a physician claimant has an opportunity to appeal a claim denied for lack of medical necessity to a medical consultant or peer

review group which is independent of the organization conducting or contracting for the initial review.

d. Require that any physician who makes judgments or recommendations regarding the necessity or appropriateness of services or site of service be licensed to practice medicine in the same jurisdiction as the practitioner who is proposing the service or whose services are being reviewed.
e. Require that review entities respond within 48 hours to patient or physician requests for prior authorization, and that they have personnel available by telephone the same business day who are qualified to respond to other concerns or questions regarding medical necessity of services, including determinations about the certification of continued length of stay.
f. Require that any payer instituting prior authorization requirements as a condition for plan coverage provide enrollees subject to such requirements with consent forms for release of medical information for utilization review purposes, to be executed by the enrollee at the time services requiring such prior authorization are recommended or proposed by the physician.
g. Require that payers compensate physicians for those efforts involved in complying with utilization review requirements that are more costly, complex and time consuming than the completion of standard health insurance claim forms. Compensation should be provided in situations such as obtaining preadmission certification, second opinions on elective surgery, and certification for extended length of stay.

3. Accountability. Our AMA believes that draft federal and state legislation should also be developed to impose similar liability on health benefit plans for any harm to enrollees resulting from failure to disclose prior to enrollment the information on plan provisions and operation specified under Section 1 (a)-(d) above.

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 829
(I-25)

Introduced by:	California, Arizona, Hawaii, Idaho, Montana, New Mexico, Washington
Subject:	Publicize Insurer Financial Gains from Delayed Care and Payment Caused by Prior Authorization
Referred to:	Reference Committee J

Whereas, some Medicare Advantage and commercial plans may financially benefit from delays in authorizing care and processing claims by earning interest or withholding funds while patients and physicians wait for care or payment; and

Whereas, these delays can lead to patient harm, including worsened clinical outcomes, prolonged suffering, and unnecessary hospitalizations, while contributing to administrative burdens for physicians; and

Whereas, AMA survey data shows that 93% of physicians report care delays or disruptions associated with prior authorization; and

Whereas, New York Times Opinion interviewed more than 50 doctors and patients and their experiences suggest that "…insurance companies often weaponize prior authorization in order to control doctors and inflate their own profits;" and

Whereas, New York Times Opinion reported that the U.S. spends about $35 billion a year on the administrative costs of prior authorization and these resources could be devoted to patient care; and

Whereas, in 2019 a federal court found that the largest commercial insurer in the U.S. was abrogating the entire point of health insurance by systemically denying medically necessary behavioral health services for financial reasons; and

Whereas, an HHS Office of Inspector General (OIG) investigation of Medicare Advantage plans reports "widespread and persistent problems related to denials of care and payment."

Whereas, as the evidence continues to grow that some Medicare Advantage (MA) and commercial insurers routinely delay and deny care through excessive and inappropriate use of prior authorization, a recent survey revealed that enrollees in MA plans are more likely than Traditional Medicare enrollees to report delays in receiving care due to prior authorization practices; and

Whereas, a recent report by the Medicare Payment Advisory Commission (MedPAC) uncovered that Medicare Advantage is projected to cost taxpayers $88 billion more in 2024 than the government spent on Traditional Medicare; and

Whereas, increased transparency about the financial gains of delayed care authorization and claims processing can empower patients, physicians, employers, and policymakers to demand accountability and reform; therefore be it

RESOLVED, that our American Medical Association support efforts to investigate and publicize the financial benefit and profit to commercial insurers, and Medicare and Medicaid health plans that inappropriately use prior authorization to unnecessarily delay care for patients and payments to physicians. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 9/30/25

RELEVANT AMA POLICY

Prior Authorization Costs, AMA Update to CMS D-320.976
Our American Medical Association will continue to conduct research on the costs associated with prior authorization by utilizing our AMA and other data sources.
[Res. 720, A-23]

Mitigating the Impact of Excessive Prior Authorization Processes D-320.971

1. Our AMA will actively and urgently generate a prior authorization database collecting and analyzing data including metrics reflecting denial rates, care delays, impact on patient care, and associated cost adversely affecting patients and physicians across major healthcare insurers.
2. Our AMA will strengthen and expand the existing public awareness campaign including but not limited to social media, print media, and editorials to highlight the negative impacts of abusive and obstructive prior-authorization requirements on patient care, and educate physicians AND patients on their rights and available resources.
[Res 704, A-25]

Fair Reimbursement for Administrative Burdens D-320.978
1. Our AMA will continue its strong state and federal legislative advocacy efforts to promote legislation that streamlines the prior authorization process and reduces the overall volume of prior authorizations for physician practices.
2. Our AMA will continue partnering with patient advocacy groups in prior authorization reform efforts to reduce patient harms, including care delays, treatment abandonment, and negative clinical outcomes.
3. Our AMA will oppose inappropriate payer policies and procedures that deny or delay medically necessary drugs and medical services.

[Res. 701, A-22 Modified: CMS Rep. 04, A-25]

Insurer Accountability When Prior Authorization Harms Patients D-320-974
1. Our American Medical Association advocates for increased legal accountability of insurers and other payers when delay or denial of prior authorization leads to patient harm, including but not limited to the prohibition of mandatory pre-dispute arbitration regarding prior authorization determinations and limitation on class action clauses in beneficiary contracts.
2. Our American Medical Association advocates that low-cost noninvasive procedures that meet existing standard Medicare guidelines should not require prior authorization.
3. Our AMA supports that physicians be allowed to bill insurance companies for all full time employee hours required to obtain prior authorization.
4. Our AMA supports that patients be allowed to sue insurance carriers which preclude any and all clauses in signed contracts should there be an adverse outcome as a result of an inordinate delay in care. [Res. 711, A-24]

Prior Authorization, Utilization Management Reform H-320.939
1. Our American Medical Association will continue its widespread prior authorization (PA) advocacy and outreach, including promotion and/or adoption of the Prior Authorization and Utilization Management Reform Principles, AMA model legislation, Prior Authorization Physician Survey and

other PA research, and the AMA Prior Authorization Toolkit, which is aimed at reducing PA administrative burdens and improving patient access to care.
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