

DISCLAIMER

The following is a preliminary report of actions taken by the House of Delegates at its 2025 Interim Meeting and should not be considered final. Only the Official Proceedings of the House of Delegates reflect official policy of the Association.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (I-25)

Final Report of Reference Committee B

Sara Coffey, DO, Chair

RECOMMENDED FOR ADOPTION

- 1
- 2
- 3 1. Board of Trustees Report 02 — Laser Surgery
- 4 2. Board of Trustees Report 03 — Stark Law Self-Referral Ban
- 5 3. Board of Trustees Report 07 — Codification of the Chevron Deference Doctrine
- 6 4. Board of Trustees Report 15 — Evidence-Based Medicine, Public Health
- 7 Infrastructure and Biomedical Research Report
- 8 5. Board of Trustees Report 16 — Preservation of Medicaid
- 9 6. Board of Trustees Report 22 — Physician Assistant and Nurse Practitioner
- 10 Movement Between Specialties
- 11 7. Resolution 202 — Deepfake Technology and Harm to Physicians and Patients
- 12 8. Resolution 204 — Addressing Anti-Physician Contractual Provisions
- 13 9. Resolution 210 — PBM Divestiture and Transparency
- 14 10. Resolution 212 — Acknowledging Flexibility on Buprenorphine Mono-product
- 15 Use for Opioid Use Disorder
- 16 11. Resolution 218 — Amend AMA Policy D-160.921 on Sensitive Locations to
- 17 Protected Areas
- 18 12. Resolution 226 — Transparency with the Term “Emergency Department”
- 19 13. Resolution 228 — Support Permanent Funding and Expansion of Native
- 20 Hawaiian Healthcare
- 21 14. Resolution 230 — Banning Non-compete Agreements in States
- 22 15. Resolution 236 — Deceptive Advertising in Accredited Allied Health Professional,
- 23 Non-Physician Graduate Programs
- 24

RECOMMENDED FOR ADOPTION AS AMENDED

- 25
- 26
- 27 16. Board of Trustees Report 01 — Calling for a Multifaceted Approach to the Illicit
- 28 Fentanyl Crisis
- 29 17. Board of Trustees Report 04 — American Medical Association (AMA) Efforts on
- 30 Addressing and Reducing Patient Boarding in Emergency Departments (EDs)
- 31 18. Board of Trustees Report 06 — Information Blocking Rule
- 32 19. Board of Trustees Report 12 — Support For Doula Care Programs
- 33 20. Board of Trustees Report 13 — Antidiscrimination Protections for LGBTQ+ Youth
- 34 in Foster Care
- 35 21. Resolution 201 — Model State Legislation incorporating Medical Malpractice Tort
- 36 Reform Based on Utah H.B. 503 (2025)

- 1 22. Resolution 206 — Restore Funding to U.S. Agency for International Development
- 2 (USAID)
- 3 23. Resolution 207 — Support for a Federal Tax Incentive for Volunteer Community
- 4 Preceptors
- 5 24. Resolution 215 — Extending the Medicaid Work Requirement Exemption up to
- 6 12 Months Postpartum
- 7 25. Resolution 224 — Recoupment by CMS Recovery and Audit Contractors
- 8 (RAC)—Due Process
- 9 26. Resolution 227 — Call for Immediate and Aggressive Action by the AMA to
- 10 Reverse Medicaid Cuts Impacting Seniors
- 11 27. Resolution 229 — Protection of Medicaid Beneficiaries' Private Health
- 12 Information from Immigration Enforcement
- 13 28. Resolution 231 — Ensuring Equitable and Timely Medical Licensure for
- 14 Physicians Providing Abortion and Gender-Affirming Care
- 15 29. Resolution 232 — Safeguarding Access to IVF Amid Restorative Reproductive
- 16 Medicine Legislation
- 17 30. Resolution 233 — Renewing Mental Health Infrastructure in the School System
- 18 31. Resolution 234 — Study on Impact of Inflation Reduction Act on Oncology, Other
- 19 Physician Practices
- 20 32. Resolution 235 — Ensuring Medical Liability Insurance Transparency and
- 21 Continuity
- 22 33. Resolution 238 — Oppose Unfair Hospital Privilege Decision Based on Insurance
- 23 Plan Participation
- 24

25 **RECOMMENDED FOR ADOPTION IN LIEU OF**

- 26
- 27 34. Resolution 203 — Restore and Enhance Federal Loan Programs for Medical
- 28 Education
- 29 Resolution 217 — Protecting Access to Public Service Loan Forgiveness (PSLF),
- 30 Income-Driven Repayment (IDR), and Direct Plus Loans for Graduate or
- 31 Professional Students (Grad PLUS Loans)
- 32 35. Resolution 213 — Pathways to U. S. Permanent Residency for H-1B Physicians
- 33 Resolution 214 — Physician Visa Protection and Pathway to Serve Underserved
- 34 Communities
- 35 36. Resolution 216 — Ensuring Timely J-1 Visa Processing to Protect IMG
- 36 Participation in Residency Programs
- 37

38 **RECOMMENDED FOR REFERRAL**

- 39
- 40 37. Resolution 205 — Restoring Balance Billing and Allowing Copay Forgiveness to
- 41 Preserve Independent Practice and Improve Access to Care
- 42 38. Resolution 209 — Support for Legislative Changes Allowing Partial Medicare
- 43 Opt-Out for Physicians
- 44 39. Resolution 211 — Access to, and Retention of, Electronic Medical Records
- 45 40. Resolution 220 — Medicare Should not Unfairly Penalize Physicians
- 46 Resolution 223 — Halt the Rollout of New Payment Models by the Center for
- 47 Medicare & Medicaid Innovation (CMMI) — A New Administration Offers an
- 48 Opportunity
- 49 41. Resolution 221 — Not-for-Profit Status

- 1 42. Resolution 225 — Federal Legislation to Prohibit the Corporate Practice of
- 2 Medicine
- 3

4 **RECOMMENDATION FOR REAFFIRMATION IN LIEU OF**

- 5
- 6 43. Resolution 208 — Centralization of Medicare Provider Data Sources
- 7 44. Resolution 219 — Addressing the Harms and Misleading Nature of Medicare
- 8 Advantage Plans
- 9 45. Resolution 222 — Tackling Administrative Waste—Let Us Be Part of the Solution
- 10 to Putting Our Health System on a Sustainable Path
- 11 46. Resolution 237 — Protecting and Improving Rural Health

DRAFT

RECOMMENDED FOR ADOPTION**(1) BOARD OF TRUSTEES REPORT 02 — LASER SURGERY****RECOMMENDATION:**

Your Reference Committee recommends that Board of Trustees Report 02 be adopted, and the remainder of the Report be filed.

HOD ACTION: Board of Trustees Report 02 adopted and remainder of Report filed.

ADOPTED LANGUAGE:**Laser Surgery H-475.989**

1. Our American Medical Association **adopts** the policy that laser surgery should be performed only by individuals licensed physicians (defined as individuals who have a Doctor of Medicine, Doctor of Osteopathic Medicine, or a recognized equivalent physician degree and who would be eligible for an Accreditation Council for Graduate Medical Education (ACGME) residency) who meet appropriate professional standards, or by those categories of practitioners who are appropriately trained, credentialed, and currently licensed by the state to perform surgical services, and are working under the direct supervision of a physician who possesses appropriate training and privileges in performance of the procedure being supervised. (Modify Current HOD Policy)
2. Our AMA encourages state medical associations to support state legislation and rulemaking in support of this policy.

Addressing Surgery Performed by Optometrists H-475.980

1. Our AMA will support legislation prohibiting optometrists from performing surgical procedures as defined by AMA Policies H-475.983, "Definition of Surgery," and H-475.989, "Laser Surgery". (Modify Current HOD Policy)
2. Our AMA encourages state medical associations to support state legislation and rulemaking prohibiting optometrists from performing surgical procedures as defined by AMA Policies H-475.983, "Definition of Surgery," and H-475.989, "Laser Surgery". (Modify Current HOD Policy)

The Board of Trustees recommends that the following be adopted in lieu of Resolution 210-I-24 and the remainder of the report be filed.

1. That our American Medical Association (AMA) amend Policy H-475.989, "Laser Surgery," to read:

- 1 1. Our American Medical Association adopts the policy that laser surgery should be
2 performed only by individuals licensed physicians (defined as individuals who have a
3 Doctor of Medicine, Doctor of Osteopathic Medicine, or a recognized equivalent
4 physician degree and who would be eligible for an Accreditation Council for Graduate
5 Medical Education (ACGME) residency) to practice medicine and surgery who meet
6 appropriate professional standards, or by those categories of practitioners who are
7 appropriately trained, credentialed, and currently licensed by the state to perform
8 surgical services, and are working under the direct supervision of a physician who
9 possesses appropriate training and privileges in performance of the procedure being
10 supervised. currently licensed by the state to perform surgical services. (Modify
11 Current HOD Policy)
12
13 2. That our AMA amend Policy H-475.980, "Addressing Surgery Performed by
14 Optometrists," to read:
15
16 1. Our AMA will support legislation prohibiting optometrists from performing surgical
17 procedures as defined by AMA Policies H-475.983, "Definition of Surgery," and H-
18 475.989 H-475.988, "Laser Surgery". (Modify Current HOD Policy)
19 2. Our AMA encourages state medical associations to support state legislation and
20 rulemaking prohibiting optometrists from performing surgical procedures as defined by
21 AMA Policies H-475.983, "Definition of Surgery," and H-475.989H-475.988, "Laser
22 Surgery". (Modify Current HOD Policy)
23

24 Overwhelming supportive testimony was received for Board of Trustees Report 02.
25 Testimony commended the Board for its thoughtful, comprehensive approach in this
26 Report and for reaffirming our AMA's long-standing position that surgery — including laser
27 procedures — is the practice of medicine. Further supportive testimony noted that the
28 Report addressed a major scope of practice issue and highlighted that the correct training
29 and experience are always necessary for the safety and protection of our patients.
30 Testimony appreciated the recognition that, when appropriate, safe delegation of laser
31 procedures requires direct supervision of well-trained non-physicians. Therefore, your
32 Reference Committee recommends that Board of Trustees Report 02 be adopted, and the
33 remainder of the Report be filed.
34

35 (2) BOARD OF TRUSTEES REPORT 03 — STARK LAW
36 SELF-REFERRAL BAN

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38 RECOMMENDATION:

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40 Your Reference Committee recommends that Board of
41 Trustees Report 03 be adopted, and the remainder of the
42 Report be filed.
43

44
45 **HOD ACTION: Board of Trustees Report 03 adopted and**
46 **remainder of Report filed.**
47

1 The Board of Trustees recommends that the following be adopted in lieu of Resolution
2 227-I-23 and BOT 03-I-24 and the remainder of the report be filed:

- 3
- 4 1. That our American Medical Association (AMA) recognizes the substantial impact of
5 the Stark law's unequal restrictions on independent physicians, contributing to the
6 growing trend of hospital consolidation, which has led to negative consequences of
7 restricted access to care and inflated costs. (New HOD Policy)
- 8 2. That our AMA supports comprehensive Stark law reform aimed at rectifying the
9 disparities that disadvantage independent physician practices while preserving the
10 intent of AMA Code of Ethics Policy 9.6.9, "Physician Self-Referral." (New HOD Policy)
- 11 3. That our AMA supports equitable and balanced Stark law reform that fosters fair
12 competition, incentivizes innovation, and facilitates the delivery of high-quality, patient-
13 centered care. (New HOD Policy)
- 14

15 Supportive testimony was received for Board of Trustees Report 03. Testimony noted that
16 the Report did a nice job of explaining the competing interests in this space and working
17 to create a balanced approach for independent physician practices, which have a
18 disadvantage to large hospital systems within this context currently. Further supportive
19 testimony noted appreciation for the Board's balanced perspective in this Report. Though
20 an amendment was offered, the majority of the testimony supported adoption of the Report
21 as written. Therefore, your Reference Committee recommends that Board of Trustees
22 Report 03 be adopted, and the remainder of the Report be filed.

23

24 (3) BOARD OF TRUSTEES REPORT 07 — CODIFICATION
25 OF THE CHEVRON DEFERENCE DOCTRINE

26

27 RECOMMENDATION:

28

29 Your Reference Committee recommends that Board of
30 Trustees Report 07 be adopted, and the remainder of the
31 Report be filed.

32

33

34 **HOD ACTION: Board of Trustees Report 07 adopted and**
35 **remainder of Report filed.**

36

37

38 The Board of Trustees recommends that resolution 228-I-24 not be adopted and that the
39 remainder of the report be filed.

40

41 Supportive testimony was received for Board of Trustees Report 07. Testimony noted that
42 while the *Loper Bright* decision eliminated the presumption of implicit deference, it
43 preserved Congress' authority to delegate interpretive responsibility to the Administration
44 explicitly where appropriate. Our AMA's policy favors statutory clarity and evidence-based
45 rulemaking over blanket judicial deference, ensuring that courts retain an independent
46 interpretive role while still giving due weight to agency expertise. Further testimony stated
47 that codifying Chevron could undermine this balance, potentially granting agencies
48 excessive interpretive authority without sufficient Congressional or judicial oversight.
49 Additional testimony noted that, as stated in the Report, the Administrative Procedure Act

1 is a robust framework that allows agencies to do their work while complying with due
2 process and democratic principles when implementing new regulations. Supportive
3 testimony noted that, in alignment with the information in the Report, our AMA works to
4 protect physician and patient interests by ensuring agencies do not exercise unchecked
5 power to interpret laws, while still valuing their specialized scientific and medical expertise.
6 Though an amendment was offered, the majority of the testimony supported adoption of
7 the Report as written. Therefore, your Reference Committee recommends that Board of
8 Trustees Report 07 be adopted, and the remainder of the Report be filed.

9
10 (4) BOARD OF TRUSTEES REPORT 15 — EVIDENCE-
11 BASED MEDICINE, PUBLIC HEALTH
12 INFRASTRUCTURE AND BIOMEDICAL RESEARCH
13 REPORT

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15 RECOMMENDATION:

16
17 Your Reference Committee recommends that Board of
18 Trustees Report 15 be adopted, and the remainder of the
19 Report be filed.

21
22 **HOD ACTION: Board of Trustees Report 15 adopted and**
23 **remainder of Report filed.**

24
25 **ADOPTED LANGUAGE:**

26
27 **Protecting Evidence-Based Medicine, Public Health Infrastructure and Biomedical**
28 **Research D-440.905**

- 29
30 1. **Our AMA affirms that protecting science, clinical integrity, and the patient-**
31 **physician relationship is central to the organization's mission.**
32 2. **Our AMA assertively and publicly leads the House of Medicine in collective,**
33 **sustained advocacy for federal and state policies, proposals, and actions**
34 **that safeguard public health infrastructure, advance biomedical research,**
35 **improve vaccine confidence, and maintain the integrity of evidence-based**
36 **medicine and decision-making processes.**

38
39 The Board of Trustees recommends the following and the remainder of the report be filed.

- 40
41 1. The third item of Policy D-440.905 be rescinded as having been accomplished by this
42 report.

43
44 Supportive testimony was received for Board of Trustees Report 15. Testimony praised
45 the Report for its comprehensive summary of recent federal and state actions relating to
46 evidence-based medicine, public health infrastructure, and biomedical research, and our
47 AMA's response to such actions. Testimony emphasized the important role of our AMA in
48 this space and urged continued work in these areas. Testimony also encouraged
49 continued collaboration with, and education of, the House of Delegates on public health

1 initiatives and outcomes. Testimony from representatives of the Board of Trustees
2 indicated that the issues covered by Board of Trustees Report 15 are of ongoing concern
3 and that the Board of Trustees will continue to provide regular updates to the House of
4 Delegates on our AMA's advocacy in these areas. Additionally, your Reference Committee
5 would note that the Board of Trustees is always willing to provide updates upon request.
6 Therefore, your Reference Committee recommends that Board of Trustees Report 15 be
7 adopted, and the remainder of the Report be filed.

8
9 (5) BOARD OF TRUSTEES REPORT 16 — PRESERVATION
10 OF MEDICAID

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12 RECOMMENDATION:

13
14 Your Reference Committee recommends that Board of
15 Trustees Report 16 be adopted, and the remainder of the
16 Report be filed.

18
19 **HOD ACTION: Board of Trustees Report 16 adopted and**
20 **remainder of Report filed.**

21
22 **ADOPTED LANGUAGE:**

23
24 **Preservation of Medicaid H-290.951**

- 25
26 **1. Our American Medical Association elevates Medicaid to an urgent and top**
27 **legislative advocacy priority alongside Medicare payment reform,**
28 **specifically advocating for maintaining and expanding Medicaid coverage,**
29 **access, federal funding, and eligibility.**
30 **2. Our AMA strongly opposes federal and state efforts to restrict eligibility,**
31 **coverage, access, and funding for Medicaid and the Children's Health**
32 **Insurance Program (CHIP).**

34
35 The Board of Trustees recommends the following and that the remainder of the report be
36 filed.

37
38 The first item of Policy H-290-951, "Preservation of Medicaid" be amended by deletion as
39 follows.

- 40
41 **1. Our American Medical Association elevates Medicaid to an urgent and top legislative**
42 **advocacy priority alongside Medicare payment reform, specifically advocating for**
43 **maintaining and expanding Medicaid coverage, access, federal funding, and eligibility;**
44 **and request report back on the Board of Trustees' actions at I-25. (Modify Current**
45 **Policy)**

46
47 Testimony was overwhelmingly supportive of Board of Trustees Report 16. There was
48 substantial testimony about the negative impacts threatened by the cuts to Medicaid
49 included in Public Law 119-21 (the "One Big Beautiful Bill Act") and multiple testifiers

1 expressed appreciation for our AMA's advocacy efforts, such as the launching of a
2 dedicated [webpage](#) with resources and informational materials on the Medicaid cuts, and
3 agreed with the elevation of Medicaid to a top advocacy priority (see the discussion of
4 Resolution 227, below, for more information on our AMA's recent advocacy work on the
5 Medicaid cuts). No comments were received in opposition to the Report. Therefore, your
6 Reference Committee recommends that Board of Trustees Report 16 be adopted, and the
7 remainder of the Report be filed.

DRAFT

1 (6) BOARD OF TRUSTEES REPORT 22 — PHYSICIAN
2 ASSISTANT AND NURSE PRACTITIONER MOVEMENT
3 BETWEEN SPECIALTIES
4

5 RECOMMENDATION:
6

7 Your Reference Committee recommends that Board of
8 Trustees Report 22 be adopted, and the remainder of the
9 Report be filed.
10

11 **HOD ACTION: Board of Trustees Report 22 adopted and**
12 **remainder of Report filed.**
13

14 **ADOPTED LANGUAGE:**
15

16
17 **Physician Assistant and Nurse Practitioner Movement Between Specialties H-**
18 **35.960**
19

- 20 1. Our American Medical Association encourages hospitals and other health
21 care entities employing nurse practitioners and physician assistants to
22 ensure that the practitioner's certification aligns with the specialty in which
23 they will practice.
- 24 2. Our AMA will continue educating policymakers and lawmakers on the
25 education, training, and certification of nurse practitioners and physician
26 assistants, including the concept of specialty switching.
- 27 3. Our AMA will continue to support research into the cost and quality of
28 primary care delivered by nurse practitioners and physician assistants.
- 29 4. Our AMA will continue to support research into the distribution and impact
30 of nurse practitioners and physician assistants on primary care in
31 underserved areas.
- 32 5. Our AMA will continue to support expansion of access to physicians in
33 under resourced areas.
- 34 6. Our AMA will continue to support workforce research, including surveys by
35 state medical and nursing boards, that specifically focus on gathering
36 information on nurse practitioners and physician assistants practicing in
37 specialty care, their certification(s), alignment of their certification to their
38 specialty, and whether they have switched specialties during their career.
- 39 7. Our AMA will continue to support research that evaluates the impact of
40 specialty switching by nurse practitioners and physician assistants on the
41 cost and quality of patient care.
42

43 The Board of Trustees recommends that Policy H-35.960, "Physician Assistant and
44 Nurse Practitioner Movement Between Specialties," be amended by addition and the
45 remainder of the report be filed.
46

47
48 Policy H-35.960 "Physician Assistant and Nurse Practitioner Movement Between
49 Specialties"

- 1 1. Our American Medical Association encourages hospitals and other health care
- 2 entities employing nurse practitioners and physician assistants to ensure that the
- 3 practitioner's certification aligns with the specialty in which they will practice.
- 4 2. Our AMA will continue educating policymakers and lawmakers on the education,
- 5 training, and certification of nurse practitioners and physician assistants, including
- 6 the concept of specialty switching.
- 7 3. Our AMA will continue to support research into the cost and quality of primary care
- 8 delivered by nurse practitioners and physician assistants.
- 9 4. Our AMA will continue to support research into the distribution and impact of nurse
- 10 practitioners and physician assistants on primary care in underserved areas.
- 11 5. Our AMA will continue to support the expansion of access to physicians in under-
- 12 resourced areas.
- 13 6. Our AMA will continue to support workforce research, including surveys by state
- 14 medical and nursing boards, that specifically focus on gathering information on nurse
- 15 practitioners and physician assistants practicing in specialty care, their
- 16 certification(s), alignment of their certification to their specialty, and whether they
- 17 have switched specialties during their career. (Modify HOD Policy)
- 18 7. Our AMA will continue to support research that evaluates the impact of specialty
- 19 switching by nurse practitioners and physician assistants on the cost and quality of
- 20 patient care. (Modify HOD Policy)

21
22 Your Reference Committee heard unanimous testimony in support of Board of Trustees
23 Report 22. This Report shares new data on specialty switching by nurse practitioners and
24 physician assistants. The survey data discussed in the Report indicates that respondents
25 from both professions view specialty switching as common and relatively easy to do. The
26 findings also highlight that nurse practitioners and physician assistants rely heavily on
27 physicians for training when transitioning to a new specialty. Testimony emphasized that
28 these findings reinforce the importance of physician-led care. Therefore, your Reference
29 Committee recommends that Board of Trustees Report 22 be adopted, and the remainder
30 of the Report be filed.

31
32 (7) RESOLUTION 202 — DEEPFAKE TECHNOLOGY AND
33 HARM TO PHYSICIANS AND PATIENTS

34
35 RECOMMENDATION:

36
37 Your Reference Committee recommends that Resolution
38 202 be adopted.

39
40
41 **HOD ACTION: Resolution 202 adopted.**

42
43
44 RESOLVED, that our American Medical Association recognize that while there are
45 documented advantages of deepfake technology for medical education, training, and
46 patient engagement, there currently exists a significant regulatory void, and such lack of
47 oversight can result in harmful consequences, including the manipulation of patients, the
48 spread of misinformation, and the potential for injury or death (New HOD Policy); and be
49 it further

1 RESOLVED, that our AMA support relevant organizations including healthcare
2 professionals, technology developers, government regulators, social media platforms, and
3 the public, to formulate comprehensive federal legislation and regulations regarding
4 deepfake technology to uphold the integrity of the medical profession against malpractice,
5 increase awareness of the risks associated with deepfake content, and safeguard patient
6 well-being across all communities. (Directive to Take Action)

7
8 Supportive testimony was received for Resolution 202. Testimony expressed strong
9 support for the Resolution's focus on addressing the ethical and regulatory challenges of
10 deepfake technology in healthcare, emphasizing the need for safeguards to protect
11 patients, preserve trust, and prevent the spread of misinformation. Further testimony noted
12 that Resolution 202 adds to the increasing breadth of AMA policy on AI by reflecting on
13 the rapid advancement of deepfake technology in health care while emphasizing the need
14 for appropriate safeguards that protect patients and preserve trust in the medical system.
15 Commentors noted that while innovative applications of deepfakes may improve clinical
16 education and patient communication, the current lack of meaningful standards leaves
17 individuals and communities vulnerable to misinformation, exploitation, and serious harm.
18 Supportive testimony highlighted that by directing collaboration among healthcare
19 interested parties, policymakers, and technology leaders, this Resolution advances a
20 responsible, forward-looking approach that strengthens professional integrity and
21 prioritizes patient safety in an evolving digital landscape. Amendments was offered to
22 replace the term "deepfake"; however, while the Reference Committee appreciates the
23 recognition that "deepfake" may carry a negative connotation when reflecting on the harms
24 that can arise when used inappropriately or manipulatively, the remainder of the resolve
25 acknowledges the advantages of this technology for education and training, consequently
26 the Reference Committee recommends retaining the original language of the Resolution
27 for consistency and clarity regarding the duality of this form of AI. Therefore, your
28 Reference Committee recommends that Resolution 202 be adopted.

29
30 (8) RESOLUTION 204 — ADDRESSING ANTI-PHYSICIAN
31 CONTRACTUAL PROVISIONS

32
33 RECOMMENDATION:

34
35 Your Reference Committee recommends that Resolution
36 204 be adopted.

37
38
39 **HOD ACTION: Resolution 204 adopted.**
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41
42 RESOLVED, that our American Medical Association develop model state legislation to
43 prohibit the inclusion of clauses indemnifying employers in physician contracts (Directive
44 to Take Action); and be it further

45
46 RESOLVED, that our AMA will actively work to increase the education and awareness of
47 physicians on the implications of accepting employment contracts which require
48 physicians to (i) pay for tail insurance, or (ii) indemnify their employers. (Directive to Take
49 Action)

1 Supportive testimony was received for Resolution 204. Testimony noted that indemnity
2 clauses imposing liability on physicians for actions taken by their employers — actions for
3 which physicians are not responsible — are fundamentally unfair and must be prohibited.
4 Additional testimony highlighted that both indemnity clauses and malpractice insurance
5 stymie competition making state legislation to prohibit indemnification clauses necessary.
6 Our AMA is committed to doing all it can to advocate for employed physicians, and that
7 advocacy should include efforts to protect physicians from employers and others
8 attempting to inappropriately shift liability to physicians. Your Reference Committee
9 believes that the model bill and education called for by Resolution 204 would be a positive
10 addition to our AMA's effort to protect employed physicians. Though amendments were
11 offered, the majority of the testimony supported adoption of the Resolution as written.
12 Therefore, your Reference Committee recommends that Resolution 204 be adopted.

13
14 (9) RESOLUTION 210 — PBM DIVESTITURE AND
15 TRANSPARENCY

16
17 RECOMMENDATION:

18
19 Your Reference Committee recommends that Resolution
20 210 be adopted.

21
22
23 **HOD ACTION: Resolution 210 adopted.**

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25
26 RESOLVED, that our American Medical Association will work with appropriate parties to
27 support and lobby for divestment of Pharmacy Benefit Managers (PBMs) from ownership
28 by insurance companies (Directive to Take Action); and be it further

29
30 RESOLVED, that our AMA will work with appropriate parties to support and lobby for
31 divestment of PBMs from owning affiliate pharmacies and infusion centers. (Directive to
32 Take Action)

33
34 Supportive testimony was received for Resolution 210. Testimony recognized the growing
35 harm caused by vertical integration and consolidation among pharmacy benefit managers
36 (PBMs), insurers, and affiliated pharmacies or infusion centers. Significant testimony
37 noted that existing AMA policies already oppose anticompetitive practices and embody
38 the spirit of divestiture but emphasized that this Resolution goes further than existing AMA
39 policy by explicitly calling for mandatory structural separation (divestiture) as a needed
40 and timely step to restore transparency, competition, and fairness in the drug supply chain.
41 Some testimony cautioned that the Resolution should more clearly define the legal
42 mechanisms for divestiture and focus advocacy on strengthening Department of Justice
43 and Federal Trade Commission antitrust enforcement, particularly regarding vertical
44 integration and non-price-based market dominance. Despite differing views on strategy,
45 testimony broadly agreed that federal attention and AMA leadership are urgently needed
46 to confront PBM-driven consolidation and promote accountability, affordability, and
47 physician-led care. Therefore, your Reference Committee recommends that Resolution
48 210 be adopted.

1 (10) RESOLUTION 212 — ACKNOWLEDGING FLEXIBILITY
2 ON BUPRENORPHINE MONO-PRODUCT USE FOR
3 OPIOID USE DISORDER

4
5 RECOMMENDATION:

6
7 Your Reference Committee recommends that Resolution
8 212 be adopted.
9

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11 **HOD ACTION: Resolution 212 adopted.**
12

13
14 RESOLVED, that our American Medical Association advocate at the state and federal
15 level to remove “red-flag” or “suspicious order” designations suspecting or distinguishing
16 between buprenorphine mono-product and buprenorphine/naloxone that are approved for
17 treatment of OUD (Directive to Take Action); and be it further

18
19 RESOLVED, that our AMA advocate that Medicare, Medicaid, and all commercial health
20 plans and other payers, be required to cover medications to treat opioid use disorder in all
21 formulations without prior authorization, step therapy, fail first requirements, or other
22 inappropriate utilization management. (Directive to Take Action)
23

24 Supportive testimony was received for Resolution 212. Testimony highlighted that the
25 Resolution is in alignment with existing AMA advocacy to remove all barriers to
26 medications for opioid use disorder, including prior authorization, fail-first and step-therapy
27 policies. Using current policy, our AMA already has undertaken actions to engage the U.S.
28 Department of Justice and state attorneys general on the issues raised by the first resolve.
29 Our AMA also has advocated for all health insurers/payers to remove barriers to care for
30 Medications for Opioid Use Disorder, including those raised by the second resolve. This
31 Resolution adds specificity to our AMA policy base to further strengthen AMA advocacy
32 efforts. Though one amendment was offered, testimony opposing this amendment noted
33 that the terms used in the Resolution as originally written were currently used in practice
34 and noted that these terms accurately relay the intent of the Resolution. The majority of
35 the comments were in support of the Resolution as originally written. Therefore, your
36 Reference Committee recommends that Resolution 212 be adopted.

1 (11) RESOLUTION 218 — AMEND AMA POLICY D-160.921
2 ON SENSITIVE LOCATIONS TO PROTECTED AREAS
3

4 RECOMMENDATION:
5

6 Your Reference Committee recommends that Resolution
7 218 be adopted.
8

9
10 **HOD ACTION: Resolution 218 adopted.**
11

12 **ADOPTED LANGUAGE:**
13

14 **Presence and Enforcement Actions of Immigration and Customs Enforcement (ICE)**
15 **in Healthcare D-160.921**
16

17 **Our AMA: (1) advocates for and supports legislative efforts to designate healthcare**
18 **facilities as protected areas by law; (2) will work with appropriate stakeholders to**
19 **educate medical providers on the rights of undocumented patients while receiving**
20 **medical care, and the designation of healthcare facilities as protected areas where**
21 **U.S. Immigration and Customs Enforcement (ICE) enforcement actions should not**
22 **occur; (3) encourages healthcare facilities to clearly demonstrate and promote their**
23 **status as protected areas; and (4) opposes the presence of ICE enforcement at**
24 **healthcare facilities.**
25

26
27 **RESOLVED**, that our American Medical Association amend policy D-160.921 by addition
28 and deletion as follows:
29

30 “Our AMA: (1) advocates for and supports legislative efforts to designate healthcare
31 facilities as ~~sensitive locations~~ protected areas by law; (2) will work with appropriate
32 stakeholders to educate medical providers on the rights of undocumented patients while
33 receiving medical care, and the designation of healthcare facilities as ~~sensitive locations~~
34 protected areas where U.S. Immigration and Customs Enforcement (ICE) enforcement
35 actions should not occur; (3) encourages healthcare facilities to clearly demonstrate and
36 promote their status as ~~sensitive locations~~ protected areas; and (4) opposes the presence
37 of ICE enforcement at healthcare facilities.” (Modify Current HOD Policy)
38

39 Universally supportive testimony was received for Resolution 218. Testimony highlighted
40 that our AMA policy should be updated to ensure it is aligned with the current terminology
41 on this topic. As noted in the Whereas Clauses, the Department of Homeland Security
42 currently uses the term “protected areas” instead of “sensitive locations.” Accordingly, this
43 update to our AMA policy D-160.921 is needed. Therefore, your Reference Committee
44 recommends that Resolution 218 be adopted.

1 (12) RESOLUTION 226 — TRANSPARENCY WITH THE
2 TERM “EMERGENCY DEPARTMENT”
3

4 RECOMMENDATION:
5

6 Your Reference Committee recommends that Resolution
7 226 be adopted.
8

9
10 **HOD ACTION: Resolution 226 referred.**
11

12
13 RESOLVED, that our American Medical Association advocates for the designation of
14 “emergency department” or “emergency room” to be restricted to facilities with the
15 presence of at least one physician on-site and on-duty, who is responsible for the
16 emergency department at all times (Directive to Take Action); and be it further
17

18 RESOLVED, that our AMA recommends that facilities without physician staffing use
19 alternative terminology, such as Acute Care Unit, as a matter of truth and transparency
20 for patients, so that patients are not expecting care by a physician (New HOD Policy); and
21 be it further
22

23 RESOLVED, that our AMA work with the Joint Commission, Det Norske Veritas (DNV),
24 and other authorities/regulators to educate them about this issue, and to encourage them
25 to implement correct “emergency department” terminology designations to ensure truth
26 and transparency at all times for our patients. (Directive to Take Action)
27

28 While your Reference Committee heard mixed testimony on Resolution 226, the majority
29 of the testimony favored adoption. The commenters who supported adoption of the
30 resolution emphasized the importance of facilities that are designated as “emergency
31 departments” or “emergency rooms” having at least one physician on-site and on-duty at
32 all times. These commenters argued that such a requirement is in line with patient
33 expectations and would enhance transparency. Other commenters who opposed the
34 resolution argued that having a physician on-site 24/7 is not feasible in every
35 circumstance, especially in the case of facilities located in rural areas. Responding to this
36 point, supporters of the resolution noted that adopting this resolution would not require our
37 AMA to advocate for the abolishment of facilities that offer emergency care without a
38 physician on-site at all times, but rather that such facilities should use a different name.
39 One commenter suggested that existing AMA policy [H-130.929](#), “On-Site Physician
40 Requirements for Emergency Departments,” be reaffirmed in lieu of adoption.
41

42 Your Reference Committee appreciates that Resolution 226 involves a complex question
43 with arguments on both sides of the issue. The Board of Trustees addressed this topic in
44 [Board of Trustees Report 02](#) (page 33) at the 2024 Interim Meeting (“On-Site Physician
45 Requirements for Emergency Departments”). Your Reference Committee appreciates that
46 Resolution 226 involves a complex question with arguments on both sides of the issue,
47 however given the weight of the testimony in favor of adoption, your Reference Committee
48 recommends adoption of Resolution 226.

1 (13) RESOLUTION 228 — SUPPORT PERMANENT
2 FUNDING AND EXPANSION OF NATIVE HAWAIIAN
3 HEALTHCARE

4
5 RECOMMENDATION:

6
7 Your Reference Committee recommends that Resolution
8 228 be adopted.
9

10
11 **HOD ACTION: Resolution 228 adopted.**
12

13
14 RESOLVED, that our American Medical Association supports federal policies that uphold
15 the federal trust obligations to improve the health of Native Hawaiian communities by
16 strengthening access to comprehensive, culturally informed, and physician-led health care
17 (New HOD Policy); and be it further

18
19 RESOLVED, that our AMA supports stable, long-term federal funding and infrastructure
20 for Native Hawaiian health care programs to ensure continuity of care, workforce
21 development, and equitable access to services across all islands (New HOD Policy); and
22 be it further

23
24 RESOLVED, that our AMA supports the expansion of Native Hawaiian Health Care
25 Systems, including additional sites, mobile clinics, transportation support, workforce
26 development, and culturally grounded health services that integrate traditional Indigenous
27 healing alongside physician-led care (New HOD Policy); and be it further

28
29 RESOLVED, that our AMA encourages collaboration with Native Hawaiian organizations,
30 leaders, and communities to ensure that federally supported health care initiatives are
31 responsive to local needs, culturally respectful, and community-driven. (New HOD Policy)

32
33 Your Reference Committee heard testimony in strong support of Resolution 228. Testifiers
34 noted that the Resolution is consistent with our AMA's past work in promoting health care
35 for underserved populations and fills a gap in our AMA's policy compendium as it relates
36 to Native Hawaiian health care. Further testimony highlighted the unique health challenges
37 faced by Native Hawaiian communities and noted that Native Hawaiians are the only
38 Indigenous population in the United States without a permanently authorized and funded
39 health care system. Therefore, your Reference Committee recommends that Resolution
40 228 be adopted.

1 (14) RESOLUTION 230 — BANNING NON-COMPETE
2 AGREEMENTS IN STATES
3

4 RECOMMENDATION:
5

6 Your Reference Committee recommends that Resolution
7 230 be adopted.
8

9
10 **HOD ACTION: Resolution 230 adopted.**
11

12
13 RESOLVED, that our American Medical Association will work with state medical societies,
14 national specialty societies and/or other interested parties to advocate for legislation or
15 regulation that would prohibit covenants not-to-compete for all physicians in clinical
16 practice who hold employment contracts with for-profit or non-profit hospital, hospital
17 system, or staffing company employers, across all states in which a ban on non-to-
18 compete agreements is not in place. (Directive to Take Action)
19

20 Your Reference Committee heard testimony in strong support of Resolution 230.
21 Testimony was universally in favor of adoption and opposed to reaffirmation. Commenters
22 expressed that existing policy does not go far enough to protect physicians from harmful
23 non-compete contracts, and that the problem is increasingly salient as the proportion of
24 physicians who are employees grows. Multiple commenters noted that non-compete
25 contracts in medicine affect patients and can disrupt continuity of care. Multiple
26 commentators also noted that it might be appropriate to have some guardrails surrounding
27 small private physician practices.
28

29 One commenter, noting that large practice groups employ many physicians and use
30 restrictive non-compete clauses in their employment contracts, suggested that the wording
31 of the resolved clause be broadened to apply to employment contracts with large practice
32 groups, rather than just contracts with a “hospital, hospital system, or staffing company.”
33 However, another commenter recommended that the wording be left as-is.
34

35 Your Reference Committee would note that our AMA has engaged in significant work in
36 this area, including a 90-page document titled “Legislative Template: Covenants not-to-
37 Compete in Physician Contracts” that was developed and is repeatedly revised by the
38 Advocacy Resource Center, and is available to any AMA member upon request. At the
39 same time, the Committee acknowledges the importance of this issue and the strong
40 sentiment in favor of Resolution 230. For these reasons, your Reference Committee
41 recommends that Resolution 230 be adopted.

1 (15) RESOLUTION 236 — DECEPTIVE ADVERTISING IN
2 ACCREDITED ALLIED HEALTH PROFESSIONAL, NON-
3 PHYSICIAN GRADUATE PROGRAMS

4
5 RECOMMENDATION:

6
7 Your Reference Committee recommends that Resolution
8 236 be adopted.

10
11 **HOD ACTION: Resolution 236 adopted.**

13
14 RESOLVED, that our AMA support state and national medical societies to advance “Truth & Transparency” legislation, inclusive of accredited allied health professional, non-physician graduate education programs to instill transparency in non-physicians’ scope of practice and training under the direction of a licensed physician (New HOD Policy); and be it further

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19
20 RESOLVED, that Our AMA advocate for legislation and refinements to “Truth & Transparency” laws to prohibit production and dissemination of deceptive advertising and marketing materials by accredited allied health professional, non-physician graduate programs. These requirements should:

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1. Prohibit deceptive, misleading or false advertising inclusive of professional titles and scope of the allied health professional completing the program.
 2. Require that the advertised course of study at such programs is clearly consistent with applicable state laws and well-established and widely accepted medical standards for allied health professionals’ training, certification, and scope of practice.
 3. Mandate all advertising materials include clear and unambiguous statements that clarify the requisite levels of physician supervision for non-physician, allied health professionals, that will complete the program. (Directive to Take Action)

33
34 Supportive testimony was received for Resolution 236. Your Reference Committee would like to note that the existing [Truth in Advertising Campaign](#) is focused on promoting transparency and prohibiting [deceptive advertising](#) by licensed health care professionals. This campaign is built around ensuring that patients are informed about who is providing their care, something that has become more important given the increased complexity of the health care system. Therefore, your Reference Committee recommends that Resolution 236 be adopted.

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RECOMMENDED FOR ADOPTION AS AMENDED

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2
3 (16) BOARD OF TRUSTEES REPORT 01 — CALLING FOR A
4 MULTIFACETED APPROACH TO THE ILLICIT
5 FENTANYL CRISIS
6

RECOMMENDATION A:

7
8
9 Your Reference Committee recommends that
10 recommendation one of Board of Trustees Report 01 be
11 amended by addition to read as follows:
12

- 13 2. That our American Medical Association (AMA) continue
14 to support efforts that respect human life and minimize
15 harm by federal, state and local government officials and
16 agencies to curb and/or stop the manufacturing,
17 importation, and distribution of illicit drugs and related
18 chemical compounds.
19

RECOMMENDATION B:

20
21
22 Your Reference Committee recommends that Board of
23 Trustees Report 01 be adopted as amended, and the
24 remainder of the Report be filed.
25

26
27 **HOD ACTION: Board of Trustees Report 01 adopted as**
28 **amended and remainder of Report filed.**
29

ADOPTED LANGUAGE:

30
31
32 **The Board of Trustees recommends that the following recommendations be**
33 **adopted and the remainder of the report be filed.**
34

35 **1. That our American Medical Association amend Policy H-95.896 to read:**
36

- 37 1. **Our American Medical Association continue to support public education**
38 **and awareness about the rapidly evolving US illicit drug epidemic due to**
39 **dangers of illegally made fentanyl and other toxic substances.**
40 2. **That our American Medical Association (AMA) continue to support**
41 **efforts that respect human life and minimize harm by federal, state, and**
42 **local government officials and agencies to curb and/or stop the**
43 **manufacturing, importation, and distribution of illicit drugs and related**
44 **chemical compounds.**
45 3. **That our AMA continue to monitor trends in polysubstance use, including**
46 **the potential for drug checking technologies to assist public health**
47 **officials in identifying how such technologies can lead to public health**
48 **interventions, such as rapid deployment of naloxone and other overdose**
49 **reversal agents.**

1 **4. That our AMA encourage state medical associations and national**
2 **medical specialty societies to support legislative and other efforts to**
3 **strengthen state 911 Good Samaritan Overdose statutory protection**
4 **consistent with AMA policy. (Modify HOD Policy)**
5

6 **2. That our AMA reaffirm Policy H-95.940, “Addressing Emerging Trends in Illicit**
7 **Drug Use.” (Reaffirm HOD Policy)**
8

9
10 The Board of Trustees recommends that the following recommendations be adopted and
11 the remainder of the report be filed.

12
13 1. That our American Medical Association amend Policy H-95.896 to read:

14
15 1. Our American Medical Association continue to support public education and
16 awareness about the rapidly evolving US illicit drug epidemic due to dangers of illegally
17 made fentanyl and other toxic substances.

18 2. That our American Medical Association (AMA) continue to support efforts by federal,
19 state and local government officials and agencies to curb and/or stop the
20 manufacturing, importation, and distribution of illicit drugs and related chemical
21 compounds.

22 3. That our AMA continue to monitor trends in polysubstance use, including the potential
23 for drug checking technologies to assist public health officials in identifying how such
24 technologies can lead to public health interventions, such as rapid deployment of
25 naloxone and other overdose reversal agents.

26 4. That our AMA encourage state medical associations and national medical specialty
27 societies to support legislative and other efforts to strengthen state 911 Good
28 Samaritan Overdose statutory protection consistent with AMA policy. (Modify HOD
29 Policy)

30
31 2. That our AMA reaffirm Policy H-95.940, “Addressing Emerging Trends in Illicit Drug
32 Use.” (Reaffirm HOD Policy)

33
34 Your Reference Committee heard unanimous support for Board of Trustees Report 01.
35 Your Reference Committee heard strong support for an amendment to highlight the need
36 to respect human life and minimize harm. Your Reference Committee, therefore,
37 recommends that the Board of Trustees Report 01 be adopted as amended, and
38 the remainder of the report be filed.

1 (17) BOARD OF TRUSTEES REPORT 04 — AMERICAN
2 MEDICAL ASSOCIATION (AMA) EFFORTS ON
3 ADDRESSING AND REDUCING PATIENT BOARDING IN
4 EMERGENCY DEPARTMENTS (EDS)

5
6 RECOMMENDATION A:

7
8 Your Reference Committee recommends that the
9 recommendation of Board of Trustees Report 04 be
10 amended by addition and deletion to read as follows:

11
12 The Board of Trustees recommends that Policy D-130.957
13 be amended, in the sixth clause, by deletion of “Interim
14 Meeting 2025” and addition of “Interim Meeting 2026”, ~~by~~
15 ~~deletion of the sixth clause since it has been accomplished~~
16 ~~by this report and that the remainder of the report be filed.~~

17
18 RECOMMENDATION B:

19
20 Your Reference Committee recommends that Board of
21 Trustees Report 04 be adopted as amended, and the
22 remainder of the Report be filed.

23
24
25 **HOD ACTION: Board of Trustees Report 04 adopted as**
26 **amended and the remainder of the Report filed.**

27
28 **ADOPTED LANGUAGE:**

29
30 **The Board of Trustees recommends that Policy D-130.957 be amended, in the sixth**
31 **clause, by deletion of “Interim Meeting 2025” and addition of “Interim Meeting**
32 **2026”, and that the remainder of the Report be filed.**

33
34 **Addressing and Reducing Patient Boarding in Emergency Departments D-130.957**

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1. **Our American Medical Association will collaborate with interested parties, such as hospitals, insurance companies, the Centers for Medicare & Medicaid Services (CMS), and accrediting bodies such as the Joint Commission, to address and reduce emergency department boarding and overcrowding.**
 2. **Our AMA supports appropriate staffing and standards of care for all patients admitted to the hospital or awaiting transfer, including emergency department patients and admitted patients physically located in the emergency department, to mitigate patient harm and physician burnout.**
 3. **Our AMA advocates for increased state and federal assistance to address the systemic factors contributing to emergency department boarding.**
 4. **Our AMA supports other medical societies, hospital associations, accrediting organizations, and patient advocacy groups to raise awareness**

- 1 of the impacts of emergency department boarding and to identify and
2 propose solutions.
- 3 5. Our AMA will continue to monitor the development of CMS quality measures
4 related to patient boarding and work in collaboration with relevant medical
5 specialty associations to support improvements in quality standards related
6 to emergency department care.
- 7 6. Our AMA will report back to the House of Delegates at the 2026 Interim
8 Meeting on progress addressing and reducing patient boarding in
9 emergency departments.

11
12 The Board of Trustees recommends that Policy D-130.957 be amended by deletion of the
13 sixth clause since it has been accomplished by this report and the remainder of the report
14 be filed.

15
16 Supportive testimony was received for Board of Trustees Report 04. Your Reference
17 Committee recognizes that the persistent predicament of boarding in emergency
18 treatment units highlights profound systemic imbalances in access to health care and
19 appreciates that emergency department healthcare staff also face parallel challenges to
20 their patients when boarding occurs. Testimony noted an appreciation for the Board's
21 detailed response to the requests that originated this Report and the Board's continued
22 commitment to improving patient care and system efficiency. An amendment was
23 proposed to require a report back at the 2026 Interim Meeting and received broad support.
24 Therefore, your Reference Committee recommends that Board of Trustees Report 04 be
25 adopted as amended, and the remainder of the Report be filed.

26
27 [Addressing and Reducing Patient Boarding in Emergency Departments D-
28 130.957](#)

- 29
30 1. Our American Medical Association will collaborate with interested
31 parties, such as hospitals, insurance companies, the Centers for
32 Medicare & Medicaid Services (CMS), and accrediting bodies such as
33 the Joint Commission, to address and reduce emergency department
34 boarding and overcrowding.
- 35 2. Our AMA supports appropriate staffing and standards of care for all
36 patients admitted to the hospital or awaiting transfer, including
37 emergency department patients and admitted patients physically
38 located in the emergency department, to mitigate patient harm and
39 physician burnout.
- 40 3. Our AMA advocates for increased state and federal assistance to
41 address the systemic factors contributing to emergency department
42 boarding.
- 43 4. Our AMA supports other medical societies, hospital associations,
44 accrediting organizations, and patient advocacy groups to raise
45 awareness of the impacts of emergency department boarding and to
46 identify and propose solutions.
- 47 5. Our AMA will continue to monitor the development of CMS quality
48 measures related to patient boarding and work in collaboration with

1 relevant medical specialty associations to support improvements in
2 quality standards related to emergency department care.

- 3 6. Our AMA will report back to the House of Delegates at the 2025 Interim
4 Meeting on progress addressing and reducing patient boarding in
5 emergency departments.
6

7 (18) BOARD OF TRUSTEES REPORT 06 — INFORMATION
8 BLOCKING RULE
9

10 RECOMMENDATION A:

11
12 Your Reference Committee recommends that the first
13 resolve of Board of Trustees Report 06 be amended by
14 deletion to read as follows:
15

- 16 1. Our American Medical Association supports the use
17 of patient-directed, short-term embargoes for results
18 that indicate debilitating, life-limiting, or terminal
19 illnesses, and supports individual tailoring of
20 preferences for release of such information,
21 consistent with the harm exception to the
22 Information Blocking Rule.
23

24 RECOMMENDATION B:

25
26 Your Reference Committee recommends that the second
27 resolve of Board of Trustees Report 06 be amended by
28 addition and deletion to read as follows:
29

- 30 2. Our AMA supports the ability of patients to request
31 physician or surrogate review of potentially life-
32 altering reports and results information prior to its
33 their release, when consistent with the harm
34 exception to the Information Blocking Rule.
35

36 RECOMMENDATION C:

37
38 Your Reference Committee recommends that Board of
39 Trustees Report 06 be adopted as amended, and the
40 remainder of the report be filed.

HOD ACTION: Board of Trustees Report 06 adopted as amended and the remainder of the Report filed.

ADOPTED LANGUAGE:

The Board of Trustees recommends that the following be adopted in lieu of Resolution 226-I-24 and the remainder of the report be filed:

- 1. Our American Medical Association supports the use of patient-directed, short-term embargoes for results, and supports individual tailoring of preferences for release of such information, consistent with the harm exception to the Information Blocking Rule. (New HOD Policy)**
- 2. Our AMA supports the ability of patients to request physician or surrogate review of reports and results prior to their release, when consistent with the harm exception to the Information Blocking Rule. (New HOD Policy)**
- 3. Our AMA reaffirms Policy D-315.972, supporting expansion of the harm exception to the Information Blocking Rule to include emotional and psychological harm and urge relevant government agencies to adopt enforcement discretion that would afford medical practices additional compliance flexibilities. (Reaffirm HOD Policy)**

The Board of Trustees recommends that the following be adopted in lieu of Resolution 226-I-24 and the remainder of the report be filed:

1. Our American Medical Association supports the use of patient-directed, short-term embargoes for results that indicate debilitating, life-limiting, or terminal illnesses, and supports individual tailoring of preferences for release of such information, consistent with the harm exception to the Information Blocking Rule. (New HOD Policy)
2. Our AMA supports the ability of patients to request physician or surrogate review of potentially life-altering report and result information prior to its release, when consistent with the harm exception to the Information Blocking Rule. (New HOD Policy)
3. Our AMA reaffirms Policy D-315.972, supporting expansion of the harm exception to the Information Blocking Rule to include emotional and psychological harm and urge relevant government agencies to adopt enforcement discretion that would afford medical practices additional compliance flexibilities. (Reaffirm HOD Policy)

Supportive testimony was received for Board of Trustees Report 06. Supportive testimony noted that the Report allows for expanded physician discretion and judgment related to the potential harm of releasing test result to patients before their physicians by including emotional and psychological harm exception criteria, allowing for discussions to take place within the framework of the physician-patient relationship, where these harms can be appropriately mitigated and addressed by the clinician in a safe environment. Testimony further highlighted the importance of recognizing the emotional and psychological harm that patients experience when they receive results that require clinical nuance to correctly understand and noted that it is unfair for patients to suffer from undue distress after receiving an easily misunderstood lab result. Additional testimony noted support for interoperability and open notes when safe and feasible, however, this testimony also

1 agreed with the Board, that it is essential to respect patient autonomy and preference.
2 Your Reference Committee discussed the concern around the definition of “short term”
3 and felt the definition remains at the discretion of the patient-physician relationship.
4

5 An amendment was also offered which supported the spirit of the Report but which would
6 delete some of the descriptive words including “debilitating” and “life-limiting” while
7 retaining the patient-directed aspect which is critical because as noted, patients have a
8 legal right to view their results immediately and any infringement of that may only be done
9 at the patient’s request. Your Reference Committee heard additional supportive testimony
10 around this amendment which highlighted that the removal of this language would help to
11 further clarify who decides what is serious and life-altering and therefore which results will
12 not be made available to the patient right away. This testimony also noted that the
13 definition of life altering could vary widely between patients and therefore needed to be
14 removed. Your Reference Committee agrees that this amendment will help to strengthen
15 this Report. Therefore, your Reference Committee recommends that Board of Trustees
16 Report 06 be adopted, and the remainder of the Report be filed.
17

18 (19) BOARD OF TRUSTEES REPORT 12 — SUPPORT FOR
19 DOULA CARE PROGRAMS
20

21 RECOMMENDATION A:
22

23 Your Reference Committee recommends that the second
24 clause of Board of Trustees Report 12 be amended by
25 deletion to read as follows:
26

- 27 2. To help ensure that doula services enhance patient
28 care, our AMA supports doula services ~~only~~ when
29 doulas provide non-clinical peripartum and birthing
30 support and:
31

32 RECOMMENDATION B:
33

34 Your Reference Committee recommends that clause 2(a) of
35 Board of Trustees Report 12 be amended by addition to
36 read as follows:
37

- 38 a. possess registrations/licenses/certifications that
39 include training specifically limited to nonclinical
40 support and adhere to state certification
41 requirements;
42

43 RECOMMENDATION C:
44

45 Your Reference Committee recommends that clause 2(b) of
46 Board of Trustees Report 12 be amended by addition to
47 read as follows:
48

- 49 b. retain registrations/licenses/certifications that are
50 continuously monitored and overseen by a

1 disciplinary board within the state that the doula is
2 certified and delivering services;

3
4 **RECOMMENDATION D:**

5
6 Your Reference Committee recommends that Board of
7 Trustees Report 12 be adopted as amended, and the
8 remainder of the Report be filed.

10
11 **HOD ACTION: Board of Trustees Report 12 adopted as**
12 **amended and the remainder of the Report filed.**

13
14 **ADOPTED LANGUAGE:**

15
16 **The Board of Trustees recommends that the following be adopted in lieu of**
17 **Resolution 908-I-24, and the remainder of the report be filed.**

- 18
19 1. **Our American Medical Association (AMA) recognizes that access to doula**
20 **services for pregnant and birthing individuals can have a positive impact on**
21 **birth outcomes.**
22 2. **To help ensure that doula services enhance patient care, our AMA supports**
23 **doula services when doulas provide non-clinical peripartum and birthing**
24 **support and:**
25
26 a) **possess registrations/licenses/certifications that include training**
27 **specifically limited to nonclinical support and adhere to state**
28 **certification requirements;**
29 b) **retain registrations/licenses/certifications that are continuously**
30 **monitored and overseen by a disciplinary board within the state that the**
31 **doula is certified and delivering services;**
32 c) **obtain liability insurance that has an adequate level of coverage;**
33 d) **fully disclose relevant training, experience, and credentials, to help**
34 **patients understand the scope of non-clinical support the doula is**
35 **qualified to provide;**
36 e) **work in partnership with a physician-led care team; and**
37 f) **do not compromise access to physician care. (New HOD Policy)**
38
39 3. **That existing AMA Policy H-373.994, "Patient Navigation Programs," be**
40 **reaffirmed. (Reaffirm HOD Policy)**

42
43 The Board of Trustees recommends that the following be adopted in lieu of Resolution
44 908-I-24, and the remainder of the report be filed.

- 45
46 1. Our American Medical Association (AMA) recognizes that access to doula services for
47 pregnant and birthing individuals can have a positive impact on birth outcomes.
48 2. To help ensure that doula services enhance patient care, our AMA supports doula
49 services only when doulas provide non-clinical peripartum and birthing support and:

- 1 a. possess licenses/certifications that include training specifically limited to nonclinical
 - 2 support and adhere to state certification requirements;
 - 3 b. retain licenses/certifications that are continuously monitored and overseen by a
 - 4 disciplinary board within the state that the doula is certified and delivering services;
 - 5 c. obtain liability insurance that has an adequate level of coverage;
 - 6 d. fully disclose relevant training, experience, and credentials, to help patients
 - 7 understand the scope of non-clinical support the doula is qualified to provide;
 - 8 e. work in partnership with a physician-led care team; and
 - 9 f. do not compromise access to physician care. (New HOD Policy)
- 10
 - 11 3. That existing AMA Policy H-373.994, "Patient Navigation Programs," be reaffirmed.
 - 12 (Reaffirm HOD Policy)
 - 13

14 Supportive testimony was received for Board of Trustees Report 12. Testimony thanked
15 the Board for a thoughtful approach that struck a balance between physician-led team-
16 based care and access to additional maternal care. Supportive testimony noted that the
17 Report underscored the importance of balancing patient safety, quality outcomes,
18 reimbursement issues, and scope of practice when shaping guidance for doula services.
19 Additional testimony noted that the recommendations of this Report strike an excellent
20 balance between recognizing the benefits of doula services on the health outcomes of the
21 mother-infant dyad while also establishing a broad set of guidelines that recognizes the
22 ongoing changes regarding payment, training, and oversight for doula services. Though
23 the spirit of the Report was supported amendments were offered. One related to removing
24 a requirement for liability coverage, the Reference Committee did not accept this
25 amendment due to concerns about patient safety and access to remedies should improper
26 doula care be provided. Another proposed amendment suggested making our policy focus
27 on state-based requirements, however since not all states have requirements the
28 amendment was not accepted.

29
30 An additional amendment requested that reference to "registration" be added in, since
31 currently some states are using that metric. Your Reference Committee accepted this
32 additional amendment but kept references to licensure and certifications since
33 certifications are currently utilized in some states and since this space is quickly growing
34 and it is likely that licensure will follow in the near future. This way our AMA policy can
35 remain flexible and relevant as this field continues to grow. Additionally, the word "only"
36 was removed to create additional flexibility for our AMA to support doulas regardless of
37 the different state laws that exist in this space. Therefore, your Reference Committee
38 recommends that Board of Trustees Report 12 be adopted as amended, and the
39 remainder of the Report be filed.

1 (20) BOARD OF TRUSTEES REPORT 13 —
2 ANTIDISCRIMINATION PROTECTIONS FOR LGBTQ+
3 YOUTH IN FOSTER CARE
4

5 RECOMMENDATION A:
6

7 Your Reference Committee recommends that the
8 Recommendation of Board of Trustees Report 13 be
9 amended by addition and deletion to read as follows:
10

11 That our AMA support advocacy efforts by youth, families,
12 foster care organizations, foster care workers, health care
13 professionals, and public health authorities to establish and
14 strengthen youth-centered privacy protections for sexual
15 orientation and gender identity (SOGI) data in-across foster
16 care systems, including the safe collection, aggregation,
17 and use of such data for reporting and health equity
18 purposes, with clearly defined safeguards and actionable
19 standards to ensure both ethical protection and meaningful
20 utilization.
21

22 RECOMMENDATION B:
23

24 Your Reference Committee recommends that Board of
25 Trustees Report 13 be adopted as amended, and the
26 remainder of the Report be filed.
27

28 **HOD ACTION: Board of Trustees Report 13 adopted as**
29 **amended and the remainder of the Report filed.**
30

31 **ADOPTED LANGUAGE:**
32

33 **The Board of Trustees recommends that the following be adopted in lieu of BOT**
34 **Report 17-A-25 and the remainder of the report be filed:**
35

36 **That our AMA support advocacy efforts by youth, families, foster care**
37 **organizations, foster care workers, health care professionals, and public health**
38 **authorities to establish and strengthen youth-centered privacy protections for**
39 **sexual orientation and gender identity (SOGI) data across foster care systems,**
40 **including the safe collection, aggregation, and use of such data for reporting and**
41 **health equity purposes, with clearly defined safeguards and actionable standards**
42 **to ensure both ethical protection and meaningful utilization. (New HOD Policy)**
43
44

45 **The Board of Trustees recommends that the following be adopted in lieu of BOT Report**
46 **17-A-25 and the remainder of the report be filed:**
47

1 That our AMA support advocacy efforts by youth, families, foster care organizations, foster
2 care workers, health care professionals, and public health authorities to strengthen youth-
3 centered privacy protections for sexual orientation and gender identity (SOGI) data in
4 foster care. (New HOD Policy)
5

6 Your Reference Committee heard mostly supportive testimony for Board of Trustees
7 Report 13, highlighting the benefits of having sexual orientation and gender identity
8 (SOGI) data among foster youth, only if privacy is carefully protected. Testimony
9 highlighted the need for increased protection of this important SOGI data as well as the
10 importance of being able to utilize this data, when appropriate and in the best interest of
11 the child. Testimony further noted that accurate SOGI data is essential to understanding
12 and addressing the disproportionate challenges faced by LGBTQ+ youth, especially those
13 within foster care systems, such as higher rates of placement instability, mental health
14 concerns, and discrimination. However, the concern for protecting LGBTQ+ communities,
15 especially those within foster care remained. An amendment was offered, and the Board
16 supported the amended language noting that the language further clarified the purpose of
17 data collection and aggregation and encompassed the need for sensitivity and privacy in
18 this data gathering. Your Reference Committee made amendments to their initial
19 recommendation to remove references to “federal agencies” based on additional
20 testimony. Therefore, your Reference Committee recommends that Board of Trustees
21 Report 13 be adopted as amended, and the remainder of the Report be filed.
22

23 (21) RESOLUTION 201 — MODEL STATE LEGISLATION
24 INCORPORATING MEDICAL MALPRACTICE TORT
25 REFORM BASED ON UTAH H.B. 503 (2025)
26

27 RECOMMENDATION A:
28

29 Your Reference Committee recommends that Resolution
30 201 be amended by addition and deletion to read as follows:
31

32 RESOLVED, That our American Medical Association
33 develop model state legislation
34 incorporating state medical liability malpractice tort
35 reforms, based on Utah H.B. 503 enacted into law March
36 27, 2025. including but not be limited to provisions that: (1)
37 limit economic damages for past medical expenses to
38 amounts actually paid; (2) safeguard physicians’ personal
39 assets; (3) prohibit plaintiffs from making allegations that
40 are irrelevant, coercive, or pertain to a physician’s income
41 or personal assets; (4) address prelitigation review panels;
42 and (5) expand circumstances where physicians are entitled
43 to attorney fees.
44

45 RECOMMENDATION B:
46

47 Your Reference Committee recommends that Resolution
48 201 be adopted as amended.
49

1 RECOMMENDATION C:
2

3 Your Reference Committee recommends that the title of
4 Resolution 201 be changed to read as follows:
5

6 **MODEL STATE LEGISLATION INCORPORATING**
7 **MEDICAL MALPRACTICE TORT REFORM**
8

9
10 **HOD ACTION: Resolution 201 adopted as amended with a**
11 **change in title.**
12

13 **ADOPTED LANGUAGE:**

14
15 **MODEL STATE LEGISLATION INCORPORATING MEDICAL MALPRACTICE TORT**
16 **REFORM**
17

18 **RESOLVED**, that our American Medical Association develop model state legislation
19 incorporating state medical liability tort reforms, including but not limited to
20 provisions that: (1) limit economic damages for past medical expenses to amounts
21 actually paid; (2) safeguard physicians' personal assets; (3) prohibit plaintiffs from
22 making allegations that are irrelevant, coercive, or pertain to a physician's income
23 or personal assets; (4) address prelitigation review panels; and (5) expand
24 circumstances where physicians are entitled to attorney fees.
25

26
27 **RESOLVED**, that our American Medical Association develop model state legislation
28 incorporating medical malpractice tort reform based on Utah H.B. 503 enacted into law
29 March 27, 2025. (Directive to Take Action)
30

31 Supportive testimony was received for Resolution 201. Testimony noted that our AMA's
32 policy favors clarity and consistency in standards for alleging malpractice and stated that
33 the Resolution's objectives align with AMA policy on medical liability reform. However,
34 additional testimony stated that our AMA policy typically does not reference specific state
35 or federal bills because these bills can shift and be altered over time in a manner that is
36 outside the control of our AMA. In alignment with this, an amendment was proposed, and
37 supported by the Resolution author, that contains the main topics covered in H.B. 503,
38 thereby preserving the essence of the Resolution, while at the same time providing our
39 AMA with flexibility and strong principled policy that can be successfully implemented
40 regardless of the success of Utah H.B. 503. Therefore, your Reference Committee
41 recommends that Resolution 201 be adopted as amended.

1 (22) RESOLUTION 206 — RESTORE FUNDING TO U.S.
2 AGENCY FOR INTERNATIONAL DEVELOPMENT
3 (USAID)

4
5 RECOMMENDATION A:

6
7 Your Reference Committee recommends that the first
8 resolve of Resolution 206 be deleted.

9
10 ~~RESOLVED, that our American Medical Association~~
11 ~~vigorously advocate for restoration of funding to USAID~~
12 ~~including resumption of aid to Africa (Directive to Take~~
13 ~~Action); and be it further~~

14
15 RECOMMENDATION B:

16
17 Your Reference Committee recommends Resolution 206 be
18 amended by addition of a new resolve clause to read as
19 follows:

20
21 RESOLVED, that our American Medical Association policy
22 D-250.986 be reaffirmed.

23
24 RECOMMENDATION C:

25
26 Your Reference Committee recommends that Resolution
27 206 be adopted as amended.

28
29
30 **HOD ACTION: Resolution 206 adopted as amended.**

31
32 **ADOPTED LANGUAGE:**

33
34 **RESOLVED, that our AMA make public statements regarding the cost in human life**
35 **of withdrawal of funding for USAID (Directive to Take Action); and be it further**

36
37 **RESOLVED, that our AMA make public statements regarding the worldwide health**
38 **risks associated with withdrawal of funding for treatment of infectious diseases**
39 **such as Tuberculosis, HIV, Ebola, and others. (Directive to Take Action)**

40
41 **RESOLVED, that our American Medical Association policy D-250.986**
42 **be reaffirmed.**

43
44
45 **RESOLVED, that our American Medical Association vigorously advocate for restoration**
46 **of funding to USAID including resumption of aid to Africa (Directive to Take Action); and**
47 **be it further**

1 RESOLVED, that our AMA make public statements regarding the cost in human life of
2 withdrawal of funding for USAID (Directive to Take Action); and be it further
3

4 RESOLVED, that our AMA make public statements regarding the worldwide health risks
5 associated with withdrawal of funding for treatment of infectious diseases such as
6 Tuberculosis, HIV, Ebola, and others. (Directive to Take Action)
7

8 Your Reference Committee heard strong testimony in support of Resolution 206, with
9 multiple testifiers emphasizing the critical work of the United States Agency for
10 International Development (USAID) and arguing that existing AMA policy does not fully
11 cover the asks contained in the resolution. Your Reference Committee agrees with respect
12 to the second and third resolves, but believes that existing AMA policy D-250.986
13 encompasses the objectives of the first resolve, and further believes that the existing
14 policy is preferable because it allows our AMA to oppose future cuts to USAID that would
15 threaten global health initiatives, as well as advocating for the restoration of recent cuts to
16 funding. Therefore, your Reference Committee recommends that Resolution 206 be
17 adopted as amended.
18

19 [Continued Support of World Health Organization \(WHO\) & United States](#)
20 [Agency for International Development \(USAID\) D-250.986](#)
21

- 22 1. Our AMA opposes withdrawal from the World Health Organization
23 (WHO) as a continued public health threat to the U.S population by
24 limiting early access to evolving worldwide epidemics.
- 25 2. Our AMA opposes any cuts to USAID (United States Agency for
26 International Development) programs that would increase the risk of
27 infection among vulnerable populations, that would increase the risk or
28 burden of disability, or that would withhold funding from critical
29 initiatives supporting agriculture, economic development,
30 environmental protection, education, democracy, human rights, and
31 governance in developing countries.

1 (23) RESOLUTION 207 — SUPPORT FOR A FEDERAL TAX
2 INCENTIVE FOR VOLUNTEER COMMUNITY
3 PRECEPTORS

4
5 RECOMMENDATION A:

6
7 Your Reference Committee recommends that Resolution
8 207 be amended by addition and deletion to read as follows:

9
10 RESOLVED, that our American Medical Association
11 ~~advocate for the establishment of a national~~ support
12 proposals to establish a federal tax credit or tax deduction
13 for physicians who serve as community preceptors for
14 medical students and residents, provided these services are
15 rendered without financial compensation from any
16 educational institution. (Directive to Take Action)

17
18 RECOMMENDATION B:

19
20 Your Reference Committee recommends that Resolution
21 207 be adopted as amended.

22
23
24 **HOD ACTION: Resolution 207 adopted as amended.**

25
26 **ADOPTED LANGUAGE:**

27
28 **RESOLVED, that our American Medical Association support proposals to establish**
29 **a federal tax credit or tax deduction for physicians who serve as community**
30 **preceptors for medical students and residents, provided these services are**
31 **rendered without financial compensation from any educational institution.**
32 **(Directive to Take Action)**

33
34
35 **RESOLVED, that our American Medical Association advocate for the establishment of a**
36 **national tax credit or tax deduction for physicians who serve as community preceptors for**
37 **medical students and residents, provided these services are rendered without financial**
38 **compensation from any educational institution. (Directive to Take Action)**

39
40 Your Reference Committee heard universally supportive testimony on Resolution 207.
41 Multiple testifiers noted the importance of community-based preceptors to medical
42 education and agreed that creating incentives for physicians to volunteer in this capacity
43 is a worthy goal. Two friendly amendments were offered. One commenter offering an
44 amendment noted in their testimony that the resolution would require our AMA staff to
45 advocate for an outcome that is not clearly defined and proposed alternative language
46 that would give clear guidance to staff to support proposals put forward in Congress to
47 establish a federal tax credit or deduction for physicians who serve as community
48 preceptors. Your Reference Committee agrees with this rationale and therefore
49 recommends that Resolution 207 be adopted as amended.

1 (24) RESOLUTION 215 — EXTENDING THE MEDICAID
2 WORK REQUIREMENT EXEMPTION UP TO 12
3 MONTHS POSTPARTUM

4
5 RECOMMENDATION A:

6
7 Your Reference Committee recommends that Resolution
8 215 be amended by addition and deletion to read as follows:

9
10 RESOLVED, that our American Medical Association
11 supports a clear, mandatory exemption from Medicaid work
12 requirements for all postpartum individuals for women up to
13 12 months postpartum.

14
15 RECOMMENDATION B:

16
17 Your Reference Committee recommends that Resolution
18 215 be adopted as amended.

19
20
21 **HOD ACTION: Resolution 215 adopted as amended.**

22
23 **ADOPTED LANGUAGE:**

24
25 **RESOLVED, that our American Medical Association supports a clear, mandatory**
26 **exemption from Medicaid work requirements for all postpartum individuals for 12**
27 **months postpartum. (New HOD Policy)**

28
29
30 RESOLVED, that our American Medical Association supports a clear, mandatory
31 exemption from Medicaid work requirements for all postpartum women up to 12 months
32 postpartum. (New HOD Policy)

33
34 Supportive testimony was received for Resolution 215. Significant testimony emphasized
35 the importance of continuous coverage during the postpartum period and noted that
36 postpartum women should be exempt from Medicaid work requirements for a full year
37 following the end of a pregnancy. Additional testimony expressed opposition to work
38 requirements as a condition of Medicaid coverage and highlighted that existing
39 AMA [policy](#) opposes Medicaid work requirements. Further testimony noted that, while the
40 law includes exemptions for postpartum women, these exemptions may not capture all
41 postpartum women for the full 12-month period following the end of a pregnancy and
42 supported the addition of the policy in Resolution 215 to fill this potential gap. An
43 amendment was offered to clarify that the exemption to the work requirement for
44 postpartum women should be for the full 12-month period following the end of a pregnancy
45 and not “up to” 12 months following the end of a pregnancy. This amendment was
46 supported by additional commentors, and your Reference Committee accepted this
47 amendment. Another amendment proposed to use more inclusive language when
48 referring to postpartum individuals, and your Reference Committee accepted this

1 amendment as well. Therefore, your Reference Committee recommends that Resolution
2 215 be adopted as amended.

3
4 (25) RESOLUTION 224 — RECOUPMENT BY CMS
5 RECOVERY AND AUDIT CONTRACTORS (RAC) — DUE
6 PROCESS

7
8 RECOMMENDATION A:

9
10 Your Reference Committee recommends that the second
11 and third resolves of Resolution 224 be deleted.

12
13 ~~RESOLVED, that our AMA advocates for legislation and~~
14 ~~regulation that Medicare contractors (recovery and audit~~
15 ~~contractors and others) must pay the physician for expenses~~
16 ~~incurred during the appeal process (Directive to Take~~
17 ~~Action); and be it further~~

18
19 ~~RESOLVED, that our AMA advocate that successful~~
20 ~~appeals be further compensated equal to the amount that~~
21 ~~the Centers for Medicare & Medicaid Services pays to~~
22 ~~contractors to recoup successfully. (Directive to Take~~
23 ~~Action)~~

24
25 RECOMMENDATION B:

26
27 Your Reference Committee recommends that Resolution
28 224 be amended by addition of a new resolve to read as
29 follows:

30
31 RESOLVED, that existing AMA policies D-320.991, H-
32 330.921, and H-335.981 be reaffirmed.

33
34 RECOMMENDATION C:

35
36 Your Reference Committee recommends that Resolution
37 224 be adopted as amended.

38
39
40 **HOD ACTION: Resolution 224 adopted as amended.**

41
42 **ADOPTED LANGUAGE:**

43
44 **RESOLVED, that our American Medical Association advocates for legislation and**
45 **regulation that Medicare contractors must be compelled to appear during**
46 **administrative or legal proceedings if requested (Directive to Take Action); and be**
47 **it further**

1 **RESOLVED, that existing AMA policies D-320.991, H-28 330.921, and H-335.981 be**
2 **reaffirmed.**
3

4
5 RESOLVED, that our American Medical Association advocates for legislation and
6 regulation that Medicare contractors must be compelled to appear during administrative
7 or legal proceedings if requested (Directive to Take Action); and be it further
8

9 RESOLVED, that our AMA advocates for legislation and regulation that Medicare
10 contractors (recovery and audit contractors and others) must pay the physician for
11 expenses incurred during the appeal process (Directive to Take Action); and be it further
12

13 RESOLVED, that our AMA advocate that successful appeals be further compensated
14 equal to the amount that the Centers for Medicare & Medicaid Services pays to contractors
15 to recoup successfully. (Directive to Take Action)
16

17 Your Reference Committee heard testimony that was largely in favor of adopting
18 Resolution 224. Many commenters testified about the lack of due process in the Medicare
19 recovery audit contractor recoupment process, as well as the skewed incentives that
20 disproportionately reward RACs for recouping overpayments rather than identifying
21 underpayments. Testimony was offered in favor of reaffirming existing AMA policies in lieu
22 of adopting Resolution 224, noting that existing policies already address the core intent of
23 the resolution and create a comprehensive and balanced framework for protecting
24 physicians from unfair audit practices while upholding program integrity. Other
25 commenters disagreed that existing policies were sufficient, while another commenter
26 agreed that existing policies overlap with many of the goals of the resolution but argued
27 that some of the goals of the resolution are not addressed by existing policy.
28

29 An additional point was raised that D-320.991 already directs our AMA to seek fines,
30 penalties, and cost recovery when physicians prevail in RAC appeals, as reflected in
31 section 8 of that policy. During the live hearing, several commenters strongly supported
32 the original language, describing significant burdens placed on practices and highlighting
33 the absence of any meaningful deterrent against aggressive audit activity.
34

35 Your Reference Committee agrees that existing AMA policies do address many of the
36 goals of Resolution 224 but also finds that Resolution 224 includes novel objectives.
37 Therefore, your Reference Committee recommends that the first resolve of
38 Resolution 224 be adopted and existing AMA policies D-320.991 section 8, H-330.921,
39 and H-335.981 be reaffirmed in lieu of the second and third resolves of Resolution 224.
40

41 [Creating a Fair and Balanced Medicare and Medicaid RAC Program D-](#)
42 [320.991](#)

- 43 1. Our AMA will continue to monitor Medicare and Medicaid Recovery
44 Audit Contractor (RAC) practices and recovery statistics and continue
45 to encourage the Centers for Medicare and Medicaid Services (CMS)
46 to adopt new regulations which will impose penalties against RACs for
47 abusive practices.
- 48 2. Our AMA will continue to encourage CMS to adopt new regulations
49 which require physician review of all medical necessity cases in post-

- 1 payment audits, as medical necessity is quintessentially a physician
2 determination and judgment.
- 3 3. Our AMA will encourage CMS to discontinue the denial of payments or
4 imposition of negative action during an audit due to the absence of
5 specific words in the chief complaint when the note provides adequate
6 documentation of the reason for the visit and services rendered.
- 7 4. Our AMA will assist states by providing recommendations regarding
8 state implementation of Medicaid RAC rules and regulations in order to
9 lessen confusion among physicians and to ensure that states properly
10 balance the interest in overpayment and underpayment audit
11 corrections for Recovery Contractors.
- 12 5. Our AMA will petition CMS to amend CMS' rules governing the use of
13 extrapolation in the RAC audit process, so that the amended CMS rules
14 conform to Section 1893 of the Social Security Act Subsection (f) (3) -
15 Limitation on Use of Extrapolation; and insists that the amended rules
16 state that when an RAC initially contacts a physician, the RAC is not
17 permitted to use extrapolation to determine overpayment amounts to
18 be recovered from that physician by recoupment, offset, or otherwise,
19 unless (as per Section 1893 of the Social Security Act) the Secretary of
20 Health and Human Services has already determined, before the RAC
21 audit, either that (a) previous, routine pre- or post-payment audits of the
22 physician's claims by the Medicare Administrative Contractor have
23 found a sustained or high level of previous payment errors, or that (b)
24 documented educational intervention has failed to correct those
25 payment errors.
- 26 6. Our AMA, in coordination with other stakeholders such as the American
27 Hospital Association, will seek to influence Congress to eliminate the
28 current RAC system and ask CMS to consolidate its audit systems into
29 a more balanced, transparent, and fair system, which does not increase
30 administrative burdens on physicians.
- 31 7. Our AMA will: (A) seek to influence CMS and Congress to require that
32 a physician, and not a lower level provider, review and approve any
33 RAC claim against physicians or physician-decision making, (B) seek
34 to influence CMS and Congress to allow physicians to be paid any
35 denied claim if appropriate services are rendered, and (C) seek the
36 enactment of fines, penalties and the recovery of costs incurred in
37 defending against RACs whenever an appeal against them is won in
38 order to discourage inappropriate and illegitimate audit work by RACs.
- 39 8. Our AMA will advocate for penalties and interest to be imposed on the
40 auditor and payable to the physician when a RAC audit or appeal for a
41 claim has been found in favor of the physician.

[Medicare Prepayment and Postpayment Audits H-330.921](#)

- 42
43
44 1. AMA policy is that with respect to prepayment and postpayment audits
45 by the Medicare program, the following principles guide AMA advocacy
46 efforts:
- 47 a) The confidential medical record should be preserved as an
48 instrument of clinical care, with strong confidentiality protections
49 and, we oppose its use as an accounting document;

- 1 b) CMS should discontinue random prepayment audits of E&M
2 services;
- 3 c) In lieu of prepayment audits, CMS should use focused medical
4 review of outliers based on reviews of patterns of services,
5 using an independent medical peer review process, where
6 physicians practicing in the same specialty, review their peers;
- 7 d) No financial or legal penalties should be assessed based on
8 one level of disagreement in E&M code assignment; and
- 9 e) CMS must stop the practice of requiring physicians to repay
10 alleged Medicare overpayments before an actual appeal is
11 rejected or a final administrative decision or a court order is
12 rendered. Legislative relief will be sought if advocacy with CMS
13 is not successful in this regard.
- 14 2. Our AMA advocates that all government recovery programs contain
15 complete physician access to any data mining criteria and programs,
16 that there is same-specialty/same-subspecialty physician review prior
17 to denial of claims, and that any denial of claims be based on medical
18 necessity review as determined by that same-specialty/same-
19 subspecialty physician reviewer, and will explore options for increased
20 reimbursement of physician costs related to government audits,
21 including remedies available through the Equal Access to Justice Act.
- 22 3. Our AMA supports the enactment of federal legislation or regulation
23 that requires fairness in the practice of conducting physicians' post-
24 payment audits as contained in paragraph 1 above, and which would
25 include the following:
- 26 a) The requirement for such audits to be reviewed by a physician
27 board certified within the same specialty prior to any
28 requirement for repayment by the audited physician
- 29 b) The requirement for the repayment to be placed in escrow until
30 the appeals process is complete
- 31 c) The removal of any incentives that are based upon a
32 percentage of recovery for contracted government auditors
- 33 d) The establishment of a mechanism for recovery of a practice's
34 legal fees incurred for unsuccessful audits
- 35 e) The full disclosure of contract terms with audit contractors
- 36 f) The elimination or improvement of the extrapolation formula
- 37 g) The payment for costly documentation requests
- 38 h) Imposition of penalties on auditors for inaccurate findings, and
- 39 i) Incentivizing the auditors to perform more physician education.
- 40 4. Our AMA will formally request that Medicare employ rules for
41 prepayment and postpayment audits that are at least as protective as
42 the Recovery Audit Contractor (RAC) rules for physicians, and that our
43 AMA continue to advocate for reforms to the audit process, including
44 giving great weight to the treating physician's determination of medical
45 necessity.
- 46 5. Our AMA will propose to Medicare that there be a mechanism by which
47 prepayment and postpayment audit denials can be resolved via the
48 telephone or other electronic communications.

1 [Medical Office Screens H-335.981](#)

2 It is the policy of the AMA to take the following actions:

- 3 1. seek specific clarification from CMS on the process, procedures, and
4 criteria of physician office postpayment review and recoupment;
5 2. lobby for full due process protection for carrier postpayment review and
6 recoupment situation;
7 3. oppose the concept and application of extrapolation;
8 4. oppose arbitrary, erratic, or inappropriate components of postpayment
9 review and recoupment; and
10 5. seek appropriate relief to achieve equitable treatment of physicians in
11 office postpayment review and recoupment situations.

12
13 (26) RESOLUTION 227 — CALL FOR IMMEDIATE AND
14 AGGRESSIVE ACTION BY THE AMA TO REVERSE
15 MEDICAID CUTS IMPACTING SENIORS

16
17 RECOMMENDATION A:

18
19 Your Reference Committee recommends that the first
20 resolve of Resolution 227 be amended by addition and
21 deletion to read as follows:

22
23 RESOLVED, that our AMA publicly denounce cuts to
24 Medicaid in Public Law 119-21 (known as the "One Big
25 Beautiful Bill Act of 2025") ~~the 'One Big Beautiful Bill Act'~~
26 ~~(Public Law No. 119-21) in no uncertain terms (Directive to~~
27 ~~Take Action); and be it further~~

28
29 RECOMMENDATION B:

30
31 Your Reference Committee recommends that the second
32 resolve of Resolution 227 be amended by addition and
33 deletion to read as follows:

34
35 RESOLVED, that our AMA through, but not limited to, press
36 releases, position statements, op-eds in major outlets, press
37 conferences and ~~reinvigorated~~ lobbying ~~on House and~~
38 ~~Senate leadership,~~ work to reverse or mitigate the ~~'One Big~~
39 ~~Beautiful Bill Act,'~~ Public Law 119-21 as it relates to
40 Medicaid (Directive to Take Action); and be it further

41
42 RECOMMENDATION C:

43
44 Your Reference Committee recommends that the third
45 resolve of Resolution 227 be amended by addition and
46 deletion to read as follows:

47
48 RESOLVED, that our AMA ~~build coalitions~~ continue working
49 with state medical societies, specialty societies, patient
50 advocacy groups, hospital systems and safety net

1 organizations to ~~unite and advocate with a single voice~~ for
2 the reversal or mitigation of Medicaid-related cuts in Public
3 Law 119-21 the ~~'One Big Beautiful Bill Act.'~~ (Directive to
4 Take Action); and be it further
5

6 RECOMMENDATION D:

7
8 Your Reference Committee recommends that the fourth
9 resolve of Resolution 227 be deleted:

10
11 ~~RESOLVED, that our AMA hold policymakers publicly~~
12 ~~accountable using public scorecards and highlight the~~
13 ~~electoral consequences for cutting funding to essential~~
14 ~~health care (Directive to Take Action); and be it further~~
15

16 RECOMMENDATION E:

17
18 Your Reference Committee recommends that the fifth
19 resolve of Resolution 227 be amended by deletion to read
20 as follows:

21
22 RESOLVED, that our AMA report back to the AMA's House
23 of Delegates at A-26 ~~on measurable progress to remove~~
24 ~~cuts, passage of any mitigating legislation and maintain its~~
25 ~~robust communications with coalition partners and our~~
26 ~~elected representatives. (Directive to Take Action)~~
27

28 RECOMMENDATION F:

29
30 Your Reference Committee recommends that Resolution
31 227 be adopted as amended.

32
33 RECOMMENDATION G:

34
35 Your Reference Committee recommends that the title of
36 Resolution 227 be changed to read as follows:

37
38 **CALL FOR ACTION BY THE AMA TO REVERSE OR**
39 **MITIGATE MEDICAID CUTS**

1
2 **HOD ACTION: Resolution 227 adopted as amended with a**
3 **change in title.**

4
5 **ADOPTED LANGUAGE:**

6
7 **CALL FOR ACTION BY THE AMA TO REVERSE OR MITIGATE MEDICAID CUTS**

8
9 **RESOLVED, that our AMA publicly denounce cuts to Medicaid in Public Law 119-21**
10 **(known as the “One Big Beautiful Bill Act of 2025”); and be it further**

11
12 **RESOLVED, that our AMA through, but not limited to, press releases, position**
13 **statements, op-eds in major outlets, press conferences and lobbying, work to**
14 **reverse or mitigate Public Law 119-21 as it relates to Medicaid; and be it further**

15
16 **RESOLVED, that our AMA continue working with state medical societies, specialty**
17 **societies, patient advocacy groups, hospital systems and safety net organizations**
18 **to advocate for the reversal or mitigation of Medicaid-related cuts in Public Law 119-**
19 **21; and be it further**

20
21 **RESOLVED, that our AMA report back to the AMA’s House of Delegates at A-26.**
22

23
24 **RESOLVED, that our American Medical Association publicly denounce cuts to Medicaid**
25 **in the ‘One Big Beautiful Bill Act’ (Public Law No: 119-21) in no uncertain terms (Directive**
26 **to Take Action); and be it further**

27
28 **RESOLVED, that our AMA through, but not limited to, press releases, position statements,**
29 **op-eds in major outlets, press conferences and reinvigorated lobbying on House and**
30 **Senate leadership, work to reverse or mitigate the ‘One Big Beautiful Bill Act,’ as it relates**
31 **to Medicaid (Directive to Take Action); and be it further**

32
33 **RESOLVED, that our AMA build coalitions with state medical societies, patient advocacy**
34 **groups, hospital systems and safety net organizations to unite and advocate with a single**
35 **voice for the reversal of Medicaid-related cuts in the ‘One Big Beautiful Bill Act.’ (Directive**
36 **to Take Action); and be it further**

37
38 **RESOLVED, that our AMA hold policymakers publicly accountable using public**
39 **scorecards and highlight the electoral consequences for cutting funding to essential health**
40 **care (Directive to Take Action); and be it further**

41
42 **RESOLVED, that our AMA report back to the AMA’s House of Delegates at A-26 on**
43 **measurable progress to remove cuts, passage of any mitigating legislation and maintain**
44 **its robust communications with coalition partners and our elected representatives.**
45 **(Directive to Take Action)**

46
47 Your Reference Committee heard substantial testimony in support of Resolution 227.
48 Commenters focused on the importance of the Medicaid program to the health care
49 system and argued that the severe cuts to Medicaid included in Public Law 119-21

1 demand a correspondingly strong response from our AMA. There was no testimony
2 opposing adoption.

3
4 The [background information](#) provided on the online forum page was also taken into
5 consideration by your Reference Committee. This background information demonstrated
6 the significant AMA policy and ongoing work by our AMA to reverse or mitigate the
7 Medicaid cuts made by Public Law 119-21. The totality of the comments and the
8 background information demonstrated a need to align Resolution 227 with our existing
9 AMA policy on Medicaid and provide a platform for our AMA to effectively advocate for the
10 reversal or mitigation of these Medicaid cuts.

11
12 At the 2025 Annual Meeting of the House of Delegates, the House of Delegates adopted
13 policy [H-290.951](#), which “elevates Medicaid to an urgent and top legislative priority.” In
14 alignment with this policy, our AMA has taken strong actions with respect to Public Law
15 119-21, both while the law was being debated in Congress and after it was enacted into
16 law.

17
18 During Congressional consideration, in addition to extensive in-person lobbying on Capitol
19 Hill, our AMA sent letters expressing opposition to the bill (and the Medicaid cuts in
20 particular) to the House of Representatives on [May 13, 2025](#), and [May 20, 2025](#), and to
21 the Senate on [June 20, 2025](#). Our AMA also issued public statements opposing the bill,
22 including but not limited to social media posts such as an [X thread](#) “sounding the alarm”
23 about the harmful cuts to Medicaid and a [video statement](#) on Instagram in which AMA
24 President Dr. Mukkamala described the cuts to Medicaid as “disappointing, maddening,
25 and unacceptable.”

26
27 Following passage of Public Law 119-21, our AMA issued a [statement](#) that the law “moves
28 health care in the wrong direction.” With the bill now law, our AMA has continued to work
29 to mitigate the negative impacts of the Medicaid cuts. In September our AMA launched a
30 dedicated [webpage](#) on the changes made by Public Law 119-21—the webpage is updated
31 on a regular basis and includes resources such as issue briefs, summaries of key
32 provisions, and implementation timelines.

33
34 Through the Advocacy Resource Center, our AMA is deeply engaged in assisting state
35 medical associations with implementation of Public Law 119-21 and is providing
36 educational opportunities for all physicians such as the November 5, 2025, webinar on the
37 impact of Public Law 119-21 on physicians and patients. At the federal level, our AMA
38 continues to engage with key policymakers and will be offering preemptive comments to
39 the Centers for Medicare & Medicaid Services regarding the implementation of several
40 important provisions to ensure that they are implemented in a manner that minimizes the
41 potential harm to patients and physicians.

42
43 The amendments proposed by your Reference Committee take these efforts into account
44 and support advocacy to reverse the Medicaid cuts while also continuing the robust and
45 ongoing work of advocating at the federal and state levels to mitigate the impact of the
46 law’s implemented provisions. To this end, your Reference Committee also recommends
47 that the fourth resolve, which calls for our AMA to hold policymakers accountable using
48 public scorecards, be deleted. While the Committee understands the intent to hold
49 policymakers accountable for harmful Medicaid cuts, adopting a strategy of public
50 scorecards or highlighting electoral consequences would undermine our AMA’s credibility

1 and nonpartisan relationships with key decisionmakers in both political parties. Such an
2 approach risks alienating allies whose cooperation is essential to reversing or mitigating
3 the cuts and advancing broader reforms. Our AMA's influence depends on constructive,
4 evidence-based engagement, not political tactics that could diminish access and trust.

5
6 Your Reference Committee also notes that, while a report back is included in this
7 Resolution, a Board of Trustees report providing updates on our AMA's advocacy activities
8 is provided at every meeting of the House of Delegates. This meeting, that is [Board of](#)
9 [Trustees Report 09 "2025 AMA Advocacy Efforts."](#) Your Reference Committee would also
10 like to highlight [Board of Trustees Report 16 "Preservation of Medicaid"](#), which addresses
11 some of the issues noted in Resolution 227.

12
13 A friendly amendment was offered to the third resolve to add a reference to specialty
14 societies. This more accurately reflects the coalition of interested parties our AMA is
15 engaging with, and the Reference Committee accepts this amendment.

16
17 Finally, your Reference Committee agrees with the suggestion to remove references to
18 the "One Big Beautiful Bill Act" and instead to reference the official law — Public Law 119-
19 21. This amendment will also ensure that our AMA policy is tied to existing law rather than
20 a piece of legislation, thereby making our AMA policy more accurate.

21
22 Your Reference Committee agrees that Medicaid is an essential program and that the cuts
23 to Medicaid require a strong and effective response from our AMA. Your Reference
24 Committee therefore recommends that Resolution 227 be adopted as amended.

25
26 (27) RESOLUTION 229 — PROTECTION OF MEDICAID
27 BENEFICIARIES' PRIVATE HEALTH INFORMATION
28 FROM IMMIGRATION ENFORCEMENT

29
30 RECOMMENDATION A:

31
32 Your Reference Committee recommends that the second
33 resolve of Resolution 229 be amended by addition and
34 deletion to read as follows:

35
36 RESOLVED, that our AMA ~~work with support efforts~~
37 by interested parties to educate physicians, medical
38 students, and patients about existing privacy
39 ~~protections and available legal remedies~~ to safeguard
40 confidential health information, ~~particularly for~~ and to help
41 ensure that this information reaches immigrant and mixed-
42 status families.

43
44 RECOMMENDATION B:

45
46 Your Reference Committee recommends that Resolution
47 229 be adopted as amended.

1
2 **HOD ACTION: Resolution 229 adopted as amended.**

3
4 **ADOPTED LANGUAGE:**

5
6 **RESOLVED, that our American Medical Association amend H-315.966 “Patient and**
7 **Physician Rights Regarding Immigration Status” by addition and deletion to read**
8 **as follows:**

9
10 **Our AMA supports protections that prohibit U.S. Immigration and Customs**
11 **Enforcement, U.S. Customs and Border Protection, or other law enforcement**
12 **agencies from utilizing information from medical records, Medicaid, Children’s**
13 **Health Insurance Program (CHIP), or other health program data, including but not**
14 **limited to Emergency Medicaid and related immigrant-specific programs, for**
15 **immigration enforcement purposes (Modify Current HOD Policy); and be it further**
16

17 **RESOLVED, that our AMA support efforts by interested parties to educate**
18 **physicians, medical students, and patients about existing privacy protections to**
19 **safeguard confidential health information, and to help ensure that this information**
20 **reaches immigrant and mixed-status families.**

21
22
23 **RESOLVED, that our American Medical Association amend H-315.966 “Patient and**
24 **Physician Rights Regarding Immigration Status” by addition and deletion to read as**
25 **follows:**

26
27 **Our AMA supports protections that prohibit U.S. Immigration and Customs Enforcement,**
28 **U.S. Customs and Border Protection, or other law enforcement agencies from utilizing**
29 **information from medical records, Medicaid, Children’s Health Insurance Program (CHIP),**
30 **or other health program data, including but not limited to Emergency Medicaid and related**
31 **immigrant-specific programs, to pursue immigration enforcement actions against patients**
32 **who are undocumented for immigration enforcement purposes (Modify Current HOD**
33 **Policy); and be it further**

34
35 **RESOLVED, that our AMA work with interested parties to educate physicians and patients**
36 **about existing privacy protections and available legal remedies to safeguard confidential**
37 **health information, particularly for immigrant and mixed-status families. (Directive to Take**
38 **Action)**

39
40 Supportive testimony was received for Resolution 229. However, two amendments were
41 also offered, both of which your Reference Committee accepted. One amendment
42 expanded this Resolution to include medical students. The other amendment noted that
43 there are no known confidential health information protections specific to
44 immigrants/noncitizens or related programs. Accordingly, the practicality of implementing
45 Resolution 229 would be mostly a Health Insurance Portability and Accountability Act
46 (HIPAA) education campaign. However, the amendment noted that protections
47 guaranteed by HIPAA are not specific to immigrant and mixed-status families but rather
48 apply to all individuals. In alignment this, the amendment made the Resolution actionable.

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

3
4 (28) RESOLUTION 231 — ENSURING EQUITABLE AND
5 TIMELY MEDICAL LICENSURE FOR PHYSICIANS
6 PROVIDING ABORTION AND GENDER-AFFIRMING
7 CARE

8
9 RECOMMENDATION A:

10
11 Your Reference Committee recommends that the second
12 resolve of Resolution 231 be amended by addition and
13 deletion to read as follows:

14
15 RESOLVED, that our AMA support policies, ~~and legislation,~~
16 and state medical society initiatives that prohibit
17 discrimination by state medical boards or licensing
18 authorities against applicants based on their provision of
19 abortion or gender-affirming care (Directive to Take Action);
20 and be it further

21
22 RECOMMENDATION B:

23
24 Your Reference Committee recommends that the third
25 resolve of Resolution 231 be amended by addition and
26 deletion to read as follows:

27
28 RESOLVED, that our AMA work with
29 relevant interested parties ~~stakeholders~~, including state
30 medical boards and specialty societies, to ~~develop~~ support
31 the development of guidance ensuring that physicians
32 seeking licensure are evaluated in a timely manner,
33 equitably and without bias relating to reproductive or
34 gender-affirming care practices.

35
36 RECOMMENDATION C:

37
38 Your Reference Committee recommends that Resolution
39 231 be adopted as amended.

1
2 **HOD ACTION: Resolution 231 adopted as amended.**

3
4 **ADOPTED LANGUAGE:**

5
6 **RESOLVED, that our American Medical Association advocate that no physician be**
7 **disqualified from medical licensure or subject to unnecessary delay in the licensure**
8 **process solely due to having provided abortion care or gender-affirming care in**
9 **accordance with then-current standards of medical practice and/or while such care**
10 **was legal in their jurisdiction; and be it further**

11
12 **RESOLVED, that our AMA support policies, legislation, and state medical society**
13 **initiatives that prohibit discrimination by state medical boards or licensing**
14 **authorities against applicants based on their provision of abortion or gender-**
15 **affirming care; and be it further**

16
17 **RESOLVED, that our AMA work with relevant interested parties, including state**
18 **medical boards and specialty societies, to support the development of guidance**
19 **ensuring that physicians seeking licensure are evaluated in a timely manner,**
20 **equitably and without bias relating to reproductive or gender-affirming care**
21 **practices.**

22
23
24 **RESOLVED, that our American Medical Association advocate that no physician be**
25 **disqualified from medical licensure or subject to unnecessary delay in the licensure**
26 **process solely due to having provided abortion care or gender-affirming care in**
27 **accordance with then-current standards of medical practice and/or while such care was**
28 **legal in their jurisdiction (Directive to Take Action); and be it further**

29
30 **RESOLVED, that our AMA support policies and legislation that prohibit discrimination by**
31 **state medical boards or licensing authorities against applicants based on their provision**
32 **of abortion or gender-affirming care (New HOD Policy); and be it further**

33
34 **RESOLVED, that our AMA work with relevant stakeholders, including state medical**
35 **boards and specialty societies, to develop guidance ensuring that physicians seeking**
36 **licensure are evaluated in a timely manner, equitably and without bias relating to**
37 **reproductive or gender-affirming care practices. (Directive to Take Action)**

38
39 Supportive testimony was received for Resolution 231. Testimony acknowledged our
40 AMA's existing policies in support of gender-affirming care and reproductive health
41 services, but argued that additional policies are needed to protect physicians from being
42 punished for providing evidence-based care. Your Reference Committee notes that Policy
43 [G-605.009](#) established a Task Force to Preserve the Patient-Physician Relationship When
44 Evidence-Based, Appropriate Care Is Banned or Restricted which is directed to coordinate
45 actions to protect physicians against professional liability and retaliation for providing
46 needed medical care. The Task Force established by Policy G-605.009 has created a
47 website, the [Reproductive Health Resource Navigator](#), to serve as a comprehensive and

1 accessible clearinghouse, empowering physicians with reliable, evidence-based
2 resources to navigate the increasingly complex landscape of reproductive care in the
3 United States. This website includes resources to assist physicians with licensing issues.
4

5 An amendment was offered to streamline coordination and focus on engagement with
6 licensing authorities and boards responsible for implementation which your Reference
7 Committee accepted. Therefore, your Reference Committee recommends that Resolution
8 231 be adopted as amended.
9

10 (29) RESOLUTION 232 — SAFEGUARDING ACCESS TO IVF
11 AMID RESTORATIVE REPRODUCTIVE MEDICINE
12 LEGISLATION
13

14 RECOMMENDATION A:
15

16 Your Reference Committee recommends that the second
17 resolve of Resolution 232 be amended by deletion to read
18 as follows:
19

20 RESOLVED, that our AMA should advocate for ~~increased~~
21 NIH funding for women's health, including reproductive
22 health, so that we can expand research on the potential
23 underlying causes of infertility; and ~~be it further~~
24

25 RECOMMENDATION B:
26

27 Your Reference Committee recommends that Resolution
28 232 be adopted as amended.
29

30
31 **HOD ACTION: Resolution 232 adopted as amended.**
32

33 **ADOPTED LANGUAGE:**
34

35 **RESOLVED, that our American Medical Association opposes any efforts to limit**
36 **patient access to the full scope of evidence-based fertility treatments, including but**
37 **not limited to: In Vitro Fertilization (IVF) (New HOD Policy); and be it further**
38

39 **RESOLVED, that our AMA should advocate for NIH funding for women's health,**
40 **including reproductive health, so that we can expand research on the potential**
41 **underlying causes of infertility (Directive to Take Action); and be it further**
42

43 **RESOLVED, that our AMA acknowledges that practices considered “restorative**
44 **reproductive medicine” constitute part of what Reproductive Endocrinology and**
45 **Infertility physicians, Urologists, and other fertility specialists provide in their daily**
46 **practice through patient-centered evaluation and individualized treatment of**
47 **underlying conditions (New HOD Policy); and be it further**

1 **RESOLVED, that our AMA acknowledges that IVF is an important part of the**
2 **comprehensive, evidence-based infertility treatment options that should be offered**
3 **to patients and is often the most successful option for many patients looking to**
4 **grow or start their families. (New HOD Policy)**
5

6
7 RESOLVED, that our American Medical Association opposes any efforts to limit patient
8 access to the full scope of evidence-based fertility treatments, including but not limited to:
9 In Vitro Fertilization (IVF) (New HOD Policy); and be it further

10
11 RESOLVED, that our AMA should advocate for increased NIH funding for women's health,
12 including reproductive health, so that we can expand research on the potential underlying
13 causes of infertility (Directive to Take Action); and be it further

14
15 RESOLVED, that our AMA acknowledges that practices considered “restorative
16 reproductive medicine” constitute part of what Reproductive Endocrinology and Infertility
17 physicians, Urologists, and other fertility specialists provide in their daily practice through
18 patient-centered evaluation and individualized treatment of underlying conditions (New
19 HOD Policy); and be it further

20
21 RESOLVED, that our AMA acknowledges that IVF is an important part of the
22 comprehensive, evidence-based infertility treatment options that should be offered to
23 patients and is often the most successful option for many patients looking to grow or start
24 their families. (New HOD Policy)

25
26 Mixed testimony was received for Resolution 232. A number of individuals testified on
27 behalf of themselves, opposing adoption of this Resolution. However, multiple Sections
28 and States provided supportive testimony for this Resolution. Testimony was also
29 provided asking for an equalized approach in advocating for expanded research funding.
30 In alignment with this, your Reference Committee recommends that Resolution 232 be
31 adopted as amended.

1 (30) RESOLUTION 233 — RENEWING MENTAL HEALTH
2 INFRASTRUCTURE IN THE SCHOOL SYSTEM
3

4 RECOMMENDATION A:
5

6 Your Reference Committee recommends that the first
7 resolve of Resolution 233 be amended by addition and
8 deletion to read as follows:
9

10 RESOLVED, that our American Medical Association
11 support sustained, stable, and equitable state and federal
12 funding and infrastructure, advocate for federal legislation
13 establishing a permanent School Mental Health
14 Infrastructure Fund, modeled on a federal-state partnership
15 such as the FMAP, to ensure stable and equitable financing
16 for the training, placement, and retention of school-based
17 mental health professionals, with priority given to rural and
18 underserved communities; and be it further
19

20 RECOMMENDATION B:
21

22 Your Reference Committee recommends that the second
23 resolve of Resolution 233 be amended by addition and
24 deletion to read as follows:
25

26 RESOLVED, that our AMA advocate for federal legislation
27 incorporating automatic continuity protections (such as
28 bridge funding or carryover authority) within school-based
29 mental health programs, to prevent disruptions in student
30 services care and workforce stability when federal
31 appropriations are delayed or rescinded. (Directive to Take
32 Action)
33

34 RECOMMENDATION C:
35

36 Your Reference Committee recommends that Resolution
37 233 be adopted as amended.

1
2 **HOD ACTION: Resolution 233 adopted as amended.**

3
4 **ADOPTED LANGUAGE:**

5
6 **RESOLVED, that our American Medical Association support sustained, stable, and**
7 **equitable state and federal funding and infrastructure, for the training, placement,**
8 **and retention of school-based mental health professionals, with priority given to**
9 **rural and underserved communities; and be it further**

10
11 **RESOLVED, that our AMA advocate for federal legislation incorporating automatic**
12 **continuity protections (such as bridge funding or carryover authority) within**
13 **school-based mental health programs, to prevent disruptions in student services**
14 **and workforce stability when federal appropriations are delayed or rescinded.**
15

16
17 RESOLVED, that our American Medical Association advocate for federal legislation
18 establishing a permanent School Mental Health Infrastructure Fund, modeled on a
19 federal–state partnership such as the FMAP, to ensure stable and equitable financing for
20 the training, placement, and retention of school-based mental health professionals, with
21 priority given to rural and underserved communities (Directive to Take Action); and be it
22 further

23
24 RESOLVED, that our AMA advocate for federal legislation incorporating automatic
25 continuity protections (such as bridge funding or carryover authority) within school-based
26 mental health programs, to prevent disruptions in student care and workforce stability
27 when federal appropriations are delayed or rescinded. (Directive to Take Action)

28
29 Your Reference Committee heard broad support in favor of Resolution 233. Many
30 commenters testified about the importance of school-based mental health services in
31 increasing access to mental health services and reducing barriers to care. An amendment
32 was offered to replace the word “care” with “services” in the second resolve and received
33 support from two other commenters. Another commenter offered an amendment that, in
34 addition to making this change, would also change the first resolve to provide additional
35 flexibility to AMA advocacy staff in achieving the goal of increased funding for school-
36 based mental health services. The commenter noted that this change is advisable
37 because otherwise our AMA would be limited to pursuing only one model for funding
38 school-based services even if other models were more feasible. Another commenter
39 supported this amendment. Another amendment was offered to express support for the
40 development of sustainable infrastructure for school-based mental health services. Your
41 Reference Committee agrees with the testimony about the importance of access to
42 school-based mental health services and with the rationale behind the proposed
43 amendments. Therefore, your Reference Committee recommends that Resolution 233 be
44 adopted as amended.

1 (31) RESOLUTION 234 — STUDY ON IMPACT OF
2 INFLATION REDUCTION ACT ON ONCOLOGY, OTHER
3 PHYSICIAN PRACTICES
4

5 RECOMMENDATION A:
6

7 Your Reference Committee recommends that the first
8 resolve of Resolution 234 be amended by addition and
9 deletion to read as follows:
10

11 RESOLVED, that our American Medical Association will
12 work with ~~relevant stakeholders~~ to ~~conduct a~~
13 ~~comprehensive study~~ interested parties to monitor,
14 evaluate, and educate on the impact of the Inflation
15 Reduction Act's (IRA) drug price negotiation provisions,
16 particularly for drugs covered under Medicare Part B and
17 physician-administered drugs due to concerns it could
18 jeopardize patient access to critical therapies as the IRA's
19 potential for reimbursement reductions may lead to less
20 availability of these medications in smaller, community-
21 based clinics where a significant amount of care is provided
22 (Directive to Take Action); and be it further
23

24 RECOMMENDATION B:
25

26 Your Reference Committee recommends that the second
27 and third resolves of Resolution 234 be deleted:
28

29 ~~RESOLVED, that our AMA will specifically evaluate the~~
30 ~~potential impact on the sustainability of community-based~~
31 ~~physician practices, with a particular focus on oncology~~
32 ~~practices (Directive to Take Action); and be it further~~
33

34 ~~RESOLVED, that our AMA will consider using the findings~~
35 ~~of this study to inform its advocacy efforts to ensure that any~~
36 ~~future drug pricing policies balance patient affordability with~~
37 ~~the stability of physician practices, patient access, and the~~
38 ~~continued advancement of drug innovation. (Directive to~~
39 ~~Take Action).~~
40

41 RECOMMENDATION C:
42

43 Your Reference Committee recommends that Resolution
44 234 be adopted as amended.

1
2 **HOD ACTION: Resolution 234 adopted as amended.**

3
4 **ADOPTED LANGUAGE:**

5
6 **RESOLVED**, that our American Medical Association will work with relevant
7 stakeholders to conduct a comprehensive study on the impact of the Inflation
8 Reduction Act's (IRA) drug price negotiation provisions, particularly for drugs
9 covered under Medicare Part B and physician-administered drugs due to concerns
10 it could jeopardize patient access to critical therapies as the IRA's potential for
11 reimbursement reductions may lead to less availability of these medications in
12 smaller, community-based clinics where a significant amount of care is provided;
13 and be it further

14
15 **RESOLVED**, that our AMA will specifically evaluate the potential impact of the
16 Inflation Reduction Act on the sustainability of community-based physician
17 practices, with a particular focus on oncology practices; and be it further

18
19 **RESOLVED**, that our AMA will consider using the findings of the study on the
20 impact of the Inflation Reduction Act (IRA) drug price negotiation provisions on the
21 sustainability of community based practices to inform its advocacy efforts to
22 ensure that any future drug pricing policies balance patient affordability with the
23 stability of physician practices, patient access, and the continued advancement of
24 drug innovation.
25

26
27 **RESOLVED**, that our American Medical Association will work with relevant stakeholders
28 to conduct a comprehensive study on the impact of the Inflation Reduction Act's (IRA)
29 drug price negotiation provisions, particularly for drugs covered under Medicare Part B
30 and physician-administered drugs due to concerns it could jeopardize patient access to
31 critical therapies as the IRA's potential for reimbursement reductions may lead to less
32 availability of these medications in smaller, community-based clinics where a significant
33 amount of care is provided (Directive to Take Action); and be it further

34
35 **RESOLVED**, that our AMA will specifically evaluate the potential impact on the
36 sustainability of community-based physician practices, with a particular focus on oncology
37 practices (Directive to Take Action); and be it further

38
39 **RESOLVED**, that our AMA will consider using the findings of this study to inform its
40 advocacy efforts to ensure that any future drug pricing policies balance patient affordability
41 with the stability of physician practices, patient access, and the continued advancement
42 of drug innovation. (Directive to Take Action).
43

44 Your Reference Committee heard mixed testimony on Resolution 234. Testifiers broadly
45 agreed that while the Inflation Reduction Act (IRA) aims to improve drug affordability and
46 patient access, its implementation may have unintended consequences for community-
47 based physician practices, particularly in oncology and other specialties that rely on
48 provider-administered drugs. Testimony in support of Resolution 234 expressed concern
49 that current reimbursement mechanisms, especially the use of the "Maximum Fair Price"

1 (MFP), could threaten the financial sustainability of independent practices and limit patient
2 access to care.

3
4 At the same time, other commenters emphasized that the IRA is still in early stages of
5 implementation, with limited new data available to justify a comprehensive study. One
6 commenter proposed an amendment to encourage targeted collaboration with other
7 interested parties to monitor, evaluate, and educate around the IRA's effects rather than
8 launching a full-scale study prematurely. The commenter also recommended striking the
9 second resolve for consistency. Another commenter spoke in favor of this proposed
10 amendment and offered a separate amendment to strike the third resolve, also in the
11 interest of internal consistency.

12
13 Your Reference Committee agrees that a full-scale study of the effects of the IRA is
14 premature at this point and believes that the proposed amendments to the first resolve
15 appropriately balance the need for more information about IRA's impacts and the need to
16 wait until the law has been more fully implemented to conduct a more formal study. Given
17 the amendments to the first resolve, the second and third resolves are not needed. Your
18 Reference Committee also heard two minor technical amendments within the
19 commenters' testimony that did not alter the outcome of the preliminary recommendation
20 and for which testimony was inconsistent and limited. Therefore, your Reference
21 Committee recommends that Resolution 234 be adopted as amended.

22
23 (32) RESOLUTION 235 — ENSURING MEDICAL LIABILITY
24 INSURANCE TRANSPARENCY AND CONTINUITY

25
26 RECOMMENDATION A:

27
28 Your Reference Committee recommends that the first
29 resolve be amended by addition and deletion to read as
30 follows:

31
32 RESOLVED, that our American Medical Association
33 advocate for legislation requiring ~~immediate~~ ~~(within 3~~
34 ~~business days)~~ prior notification of at least 30 business days
35 by the medical liability insurance carrier to the covered
36 physician for any policy changes, or ~~or~~ cancellation, or and
37 immediate (within 3 business days) notification of a missed
38 payment (Directive to Take Action); and be it further

39
40 RECOMMENDATION B:

41
42 Your Reference Committee recommends that Resolution
43 235 be adopted as amended.

1
2 **HOD ACTION: The first resolve of Resolution 235 adopted**
3 **as amended. The second resolve of Resolution 235**
4 **referred. The third resolve of Resolution 235 adopted.**

5
6 **ADOPTED LANGUAGE:**

7
8 **RESOLVED, that our American Medical Association advocate for legislation**
9 **requiring prior notification of at least 30 business days by the medical liability**
10 **insurance carrier to the covered physician for any policy changes or cancellation,**
11 **and immediate (within 10 business days) notification of a missed payment**
12 **(Directive to Take Action); and be it further**

13
14 **RESOLVED, that our AMA policy D-215.980 “Support Before, During, and After**
15 **Hospital Closure or Reduction in Services” be amended so as to include physician**
16 **group closures. (Modify HOD Policy)**

17
18
19 **Support Before, During, and After Hospital or Physician Group Closure or**
20 **Reduction in Services D-215.980**

21
22 **1. Our American Medical Association will work with appropriate federal and state**
23 **bodies to assure that whenever there is a threatened, or actual, hospital or**
24 **physician group closure a process be instituted to safeguard the continuity of**
25 **patient care and preserve the physician-patient relationship. Such a process**
26 **should:**

27 **a. assure adequate capacity exists in the immediate service area**
28 **surrounding the hospital or physician group closure, including**
29 **independent health resources, physicians, and support personnel to**
30 **provide for the citizens of that area;**

31 **b. allow that in said circumstances, restrictive covenants, records access,**
32 **and financial barriers which prevent the movement of physicians and**
33 **their patients to surrounding hospitals or physician groups should be**
34 **waived for an appropriate period of time; and**

35 **c. ensure financial reserves exist, and are sufficient to cover any previous**
36 **contractual obligations to physicians, e.g., medical liability tail coverage.**

37 **2. Our AMA will proactively offer support to physicians, residents and fellows,**
38 **patients, and civic leaders affected by threatened or actual healthcare facility or**
39 **physician group closures, change in ownership, or significant reductions in**
40 **services via provision of information, resources, and effective, actionable**
41 **advocacy.**

42
43
44 **RESOLVED, that our American Medical Association advocate for legislation**
45 **requiring immediate (within 3 business days) notification by the medical liability insurance**
46 **carrier to the covered physician for any policy changes, cancellation, or missed payment**
47 **(Directive to Take Action); and be it further**
48

1 RESOLVED, that our AMA recognize that occurrence-based medical liability insurance or
2 claims-made medical liability insurance with a pre-paid tail is the gold standard for medical
3 liability coverage (New HOD Policy); and be it further
4

5 RESOLVED, that our AMA policy D-215.980 "Support Before, During, and After Hospital
6 Closure or Reduction in Services" be amended so as to include physician group
7 closures. (Modify HOD Policy)
8

9 Your Reference Committee heard testimony overwhelmingly in support of the spirit of
10 Resolution 235. Your Reference Committee received an amendment that would require
11 a medical liability carrier to give a physician advance notice of at least 30 business
12 days, rather than three days, of any changes to or cancellation of the physician's medical
13 liability insurance coverage. Your Reference Committee heard testimony supporting this
14 amendment because it would provide greater protection to physicians who are put into
15 positions where they urgently need to find alternative medical liability insurance
16 coverage. Your Reference Committee agrees that amending Resolution 235 to require
17 an advance notice period of at least 30 business days offers more protection than the
18 three-day notice period in the original language of Resolution 235. Therefore, your
19 Reference Committee recommends that Resolution 235 be adopted as amended.
20

21 (33) RESOLUTION 238 — OPPOSE UNFAIR HOSPITAL
22 PRIVILEGE DECISION BASED ON INSURANCE PLAN
23 PARTICIPATION
24

25 RECOMMENDATION A:
26

27 Your Reference Committee recommends that the first
28 resolve of Resolution 238 be amended by addition and
29 deletion to read as follows:
30

31 RESOLVED, that our American Medical Association
32 advocate for legislation, regulation, or other regulatory
33 interventions to prevent health insurers from threatening
34 hospitals with payment cuts, administrative fee imposition,
35 network termination, or other negative financial policies, if
36 an out of network physician is involved in the treatment of
37 care of for a patient at that hospital; and be it further
38

39 RECOMMENDATION B:
40

41 Your Reference Committee recommends that the second
42 resolve of Resolution 238 be amended by addition and
43 deletion to read as follows:
44

45 RESOLVED, that our AMA collaborates with specialty
46 societies and state medical societies to develop model
47 legislation to oppose such unfair and/or coercive business
48 practices which undermine patient access and/or physician
49 practices.

1 RECOMMENDATION C:
2

3 Your Reference Committee recommends that Resolution
4 238 be adopted as amended.
5

6
7 **HOD ACTION: Resolution 238 adopted as amended.**
8

9 **ADOPTED LANGUAGE:**
10

11 **RESOLVED, that our American Medical Association advocate for legislation,**
12 **regulation, or other interventions to prevent health insurers from threatening**
13 **hospitals with payment cuts, administrative fee imposition, network termination, or**
14 **other negative financial policies, if an out of network physician is involved in the**
15 **treatment or care of a patient at that hospital; and be it further**
16

17 **RESOLVED, that our AMA collaborates with specialty societies and state medical**
18 **societies oppose unfair and/or coercive business practices which undermine**
19 **patient access and/or physician practices.**
20

21
22 RESOLVED, that our American Medical Association advocate for legislation or other
23 regulatory intervention to prevent health insurers from threatening hospitals with payment
24 cuts, administrative fee imposition, network termination, or other negative financial
25 policies, if an out of network physician is involved in the treatment of care for a patient at
26 that hospital (Directive to Take Action); and be it further
27

28 RESOLVED, that our AMA collaborates with specialty societies and state medical
29 societies to develop model legislation to oppose such unfair and coercive business
30 practices which undermine patient access and physician practices. (Directive to Take
31 Action)
32

33 Your Reference Committee heard testimony in support of AMA advocacy to prevent
34 implementation of this Anthem BCBS policy, as it will hurt patient access and pressure
35 physician practices to either take contracts that are not a good fit for their practice
36 or become employed by hospitals. Your Reference Committee also heard that this policy
37 is in direct conflict with the No Surprises Act. However, some testimony expressed
38 concern about the limited forms of advocacy directed by the Resolution and suggested
39 that private sector advocacy, in addition to potential legislative or regulatory advocacy
40 if appropriate, may need to happen. Therefore, your Reference Committee recommends
41 that Resolution 238 be adopted as amended.

RECOMMENDED FOR ADOPTION IN LIEU OF

1
2
3 (34) RESOLUTION 203 — RESTORE AND ENHANCE
4 FEDERAL LOAN PROGRAMS FOR MEDICAL
5 EDUCATION

6
7 RESOLUTION 217 — PROTECTING ACCESS TO
8 PUBLIC SERVICE LOAN FORGIVENESS (PSLF),
9 INCOME-DRIVEN REPAYMENT (IDR), AND DIRECT
10 PLUS LOANS FOR GRADUATE OR PROFESSIONAL
11 STUDENTS (GRAD PLUS LOANS)

12
13 RECOMMENDATION:

14
15 Your Reference Committee recommends that Alternate
16 Resolution 203 be adopted in lieu of Resolutions 203 and
17 217.

18
19 RESOLVED, that our American Medical Association
20 continue to advocate for federal student loan limits that
21 accurately reflect the cost of attendance of graduate
22 medical education programs.

23
24 RESOLVED, that our AMA continue to support diverse and
25 beneficial repayment plans for federal student loans,
26 including income-based repayment plans that are favorable
27 to individuals who took out loans for graduate medical
28 education.

29
30 RESOLVED, that our AMA continue to advocate for the
31 protection of the Public Service Loan Forgiveness (PSLF)
32 Program for physicians.

1
2 **HOD ACTION: Alternate Resolution 203 adopted in lieu of**
3 **Resolutions 203 and 217.**

4
5 **ADOPTED LANGUAGE:**

6
7 **RESOLVED, that our American Medical Association continue to advocate for federal**
8 **student loan limits that accurately reflect the cost of attendance of graduate medical**
9 **education programs.**

10
11 **RESOLVED, that our AMA continue to support diverse and beneficial repayment**
12 **plans for federal student loans, including income-based repayment plans that are**
13 **favorable to individuals who took out loans for graduate medical education.**

14
15 **RESOLVED, that our AMA continue to advocate for the protection of the Public**
16 **Service Loan Forgiveness (PSLF) Program for physicians.**

17
18
19 **Resolution 203 — Restore And Enhance Federal Loan Programs For Medical**
20 **Education**

21
22 RESOLVED, that our American Medical Association advocates for the restoration of the
23 Grad PLUS program with loan limits established to support the cost of attendance of
24 medical education programs. (Directive to Take Action)

25
26 **Resolution 217 — Protecting Access To Public Service Loan Forgiveness (PSLF),**
27 **Income-Driven Repayment (IDR), And Direct Plus Loans For Graduate Or**
28 **Professional Students (Grad Plus Loans)**

29
30 RESOLVED, that our American Medical Association advocates for protection of access to
31 Public Service Loan Forgiveness (PSLF), Income-Driven Repayment (IDR), and Direct
32 Plus Loans for Graduate or Professional Students (Grad PLUS Loans). (Directive to Take
33 Action)

34
35 Mixed testimony was received for Resolutions 203 and 217. However, testimony was
36 unanimous in the opinion that the elimination of the GRAD Plus student loan program, the
37 student loan caps, the change in repayment plans, and the changes to the Public Service
38 Loan Forgiveness (PSLF) Program will cause students from low-income backgrounds to
39 be unable to afford medical school. Your Reference Committee acknowledges the
40 significant negative impacts and outcomes that these changes will have, especially for
41 individuals who want to engage in graduate medical education.

42
43 Additional testimony noted that our AMA has consistently worked to ensure that medical
44 students have adequate access to federal student loans, regardless of the name of the
45 federal student loan program. Thanks to our existing AMA policy, our AMA has sent out
46 multiple letters [opposing the elimination](#) of the Grad PLUS program and [supporting](#)
47 [providing](#) medical students with adequate financial assistance during their education and
48 training years. Additional letters supporting the PSLF program were also recently sent out

1 and can be found [here](#) and [here](#). Additional information about our AMA advocacy on
2 student loans and graduate medical education (GME) issues can be found [here](#).

3
4 Commentors also noted that Resolutions 203 and 217 covered similar issues and
5 recommended that these two Resolutions be considered together. Your Reference
6 Committee agrees that it is appropriate to handle these two Resolutions as one.

7
8 Moreover, your Reference Committee notes that tying our AMA policy to programs which
9 are being phased out, like GRAD Plus, will quickly make our AMA policy outdated. In order
10 to ensure that appropriate advocacy can continue in this space our AMA policy should not
11 be tied to a specific loan program but rather to the concept of providing adequate access
12 to federal student loans, and student loan repayment plans, to ensure that individuals can
13 graduate from medical school without having to struggle to find multiple funding streams
14 to support their education. Your Reference Committee heard significant testimony in favor
15 of Alternate Resolution 203. Therefore, your Reference Committee recommends that
16 Alternate Resolution 203 be adopted in lieu of Resolutions 203 and 217.

17
18 (35) RESOLUTION 213 — PATHWAYS TO U. S.
19 PERMANENT RESIDENCY FOR H-1B PHYSICIANS

20
21 RESOLUTION 214 — PHYSICIAN VISA PROTECTION
22 AND PATHWAY TO SERVE UNDERSERVED
23 COMMUNITIES

24
25 RECOMMENDATION A:

26
27 Your Reference Committee recommends that Alternate
28 Resolution 213 be adopted in lieu of Resolutions 213 and
29 214.

30
31 **PHYSICIAN VISA PROTECTION AND PATHWAY TO**
32 **U. S. PERMANENT RESIDENCY**

33
34 RESOLVED, that our American Medical Association
35 support a viable, expedited, and separate pathway for
36 physicians to obtain permanent residence in the United
37 States.

38
39 RESOLVED, that our American Medical Association
40 advocate for the federal government to work to ensure
41 physicians are exempt from unreasonable increases in H-
42 1B visa fees.

**HOD ACTION: Alternate Resolution 213 adopted in lieu of
Resolutions 213 and 214.**

ADOPTED LANGUAGE:

PHYSICIAN VISA PROTECTION AND PATHWAY TO U.S. PERMANENT RESIDENCY

RESOLVED, that our American Medical Association advocate for a viable, expedited, and separate pathway for physicians to obtain permanent residence in the United States.

RESOLVED, that our American Medical Association advocate for the federal government to work to ensure physicians are exempt from unreasonable increases in H-1B visa fees.

RESOLVED, that our AMA advocate for the creation of a dedicated visa pathway specifically for physicians.

Resolution 213 — Pathways To U. S. Permanent Residency For H-1b Physicians

RESOLVED, that our American Medical Association urgently, aggressively, and continuously collaborate with the Office of the Inspector General, the Department of Veterans Affairs, U.S. Citizenship and Immigration Services, Congress, and the Executive Branch to advocate for establishing an expedited and separate pathway for physicians to obtain permanent residence and U.S. citizenship, enabling them to practice immediately and without restrictions—including within the Veterans Affairs healthcare system—to address the critical and rapidly worsening physician shortages threatening access to care across the United States. (Directive to Take Action)

Resolution 214 — Physician Visa Protection And Pathway To Serve Underserved Communities

RESOLVED, that our American Medical Association advocate for the federal government to work to ensure physicians are exempt from any proposed increases in H-1B visa fees, including the proposed \$100,000 charge, through feasible alternatives such as by including them in the National Interest Waiver (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for the creation of a dedicated non-immigrant visa pathway specifically for physicians, in recognition of their essential role in U.S. healthcare and to prevent them from being unintended casualties of broader immigration policy changes. (Directive to Take Action)

Supportive testimony was received for Resolutions 213 and 214. Testimony universally acknowledged the important role that international medical graduates (IMGs) play in the U.S. health care system. Additional testimony highlighted the backlog that exists for some physicians who apply for green cards. Further testimony supported the creation of a dedicated non-immigrant visa pathway. Multiple amendments were offered for these

1 Resolutions, and it was noted that these two Resolutions cover similar issues and have
2 some overlapping asks.

3
4 Additionally, your Reference Committee notes that our AMA has policy that supports
5 ensuring that IMGs are properly certified, licensed, and trained before they are allowed to
6 practice medicine in the U.S. in opposition to Resolution 213 which states that it would
7 support “enabling [IMGs] to practice immediately and without restrictions” upon first
8 entering the U.S.

9
10 Your Reference Committee would also like to highlight that our AMA is consistently
11 supporting programs like [Conrad 30](#), which makes it easier for physicians to remain in the
12 U.S. Additionally, our AMA participates in groups such as the [Advisory Commission on](#)
13 [Additional Licensing Models](#). Furthermore, our AMA led a [sign on letter](#) to the Department
14 of Homeland Security (DHS) in opposition to the Proclamation entitled, “Restriction on
15 Entry of Certain Nonimmigrant Workers” that implemented the \$100,000 H-1B visa fee. In
16 addition, our AMA has had meetings with Congress to discuss the issue of the increased
17 H-1B visa fee and to educate Congress on the importance of H-1B physicians. Our AMA
18 has also created a grassroots campaign on the H-1B visa fee issue: [Be Heard | Physicians](#)
19 [Grassroots Network](#). Please see more of our advocacy work regarding visas and green
20 cards [here](#).

21
22 An additional amendment was offered for Alternate Resolution 213. Your Reference
23 Committee heard that this amendment would provide greater latitude for our AMA to seek
24 a viable pathway for physicians to obtain permanent residence. Testimony noted that this
25 amendment would help our AMA to avoid the unintended consequence of Congress
26 passing legislation that may create a separate pathway for physicians but then restrict
27 physicians from obtaining visas through other existing visa programs that ultimately lead
28 to a green card. Your Reference Committee agrees.

29
30 Given the overlapping content of Resolution 213 and 214, the existing AMA policy and
31 advocacy work in this space, and the multiple amendments that were offered, your
32 Reference Committee recommends that Alternate Resolution 213 be adopted in lieu of
33 Resolutions 213 and 214.

34
35 (36) RESOLUTION 216 — ENSURING TIMELY J-1 VISA
36 PROCESSING TO PROTECT IMG PARTICIPATION IN
37 RESIDENCY PROGRAMS

38
39 RECOMMENDATION:

40
41 Your Reference Committee recommends that Alternate
42 Resolution 216 be adopted in lieu of Resolution 216.

43
44 RESOLVED, that our American Medical Association work
45 with all relevant federal agencies to support timely J-1 visa
46 appointments and expedited processing for international
47 medical graduates matched into U. S. residency and
48 fellowship programs.

1
2 **HOD ACTION: Alternate Resolution 216 adopted in lieu of**
3 **Resolution 216.**

4
5 **ADOPTED LANGUAGE:**

6
7 **RESOLVED, that our American Medical Association work with all relevant federal**
8 **agencies to support timely J-1 visa appointments and expedited processing for**
9 **international medical graduates matched into U. S. residency and fellowship**
10 **programs.**

11
12
13 RESOLVED, that our American Medical Association advocate with the U.S. Department
14 of State, Department of Homeland Security, and other relevant agencies to guarantee
15 timely J-1 visa appointments and processing for all IMGs who have matched into U.S.
16 residency programs, ensuring arrival and participation by July 1 (Directive to Take Action);
17 and be it

18
19 RESOLVED, that the American Medical Association collaborate with key stakeholders,
20 including Intealth and the Educational Commission for Foreign Medical Graduates
21 (ECFMG), to advocate for the timely issuance and scheduling of J-1 visas for eligible
22 IMGs, while addressing misinformation about immigration policies that may discourage or
23 mislead potential IMGs and residency programs (Directive to Take Action); and be it
24 further

25
26 RESOLVED, that our AMA work with relevant stakeholders to improve processes that
27 reduce visa delays and ensure equitable opportunities for international medical graduates,
28 thereby strengthening the physician workforce (Directive to Take Action); and be it further

29
30 RESOLVED, that our AMA advocate for contingency protocols at federal agencies to
31 prevent future visa disruptions from jeopardizing IMG participation in the U.S. residency
32 Match (Directive to Take Action); and be it further

33
34 RESOLVED, that our AMA report back at the 2026 Annual Meeting on actions taken to
35 secure timely visa processing for IMGs entering U.S. residency programs. (Directive to
36 Take Action)

37
38 Mixed testimony was received for Resolution 216. Testimony universally acknowledged
39 the important role that international medical graduates (IMGs) play in the U.S. medical
40 system. However, testimony noted that our AMA already has existing policy in place that
41 ensures that our AMA works with interested parties, relevant government agencies, and
42 Congress to achieve timely and reliable visa acquisition for J-1 medical students. Our
43 existing AMA policy highlights the importance of working with entities such as Department
44 of State, Intealth/ECFMG, and others to help and assure smooth visa processes for
45 incoming medical students and residents. Furthermore, testimony highlighted that our
46 AMA consistently responds when there is a systemic visa delay that impacts J-1
47 physicians, and physicians in other visa categories.

1 Additional testimony noted that our AMA is rightfully an active collaborator but not the lead
2 entity when it comes to J-1 physicians. While our AMA continues to advocate strongly for
3 IMGs, the primary operational authority lies with Intealth/ECFMG, which oversee J-1
4 sponsorship, documentation, and compliance. Our AMA's role is to support, coordinate,
5 and amplify these efforts through policy advocacy and federal engagement, which
6 testimony highlighted our AMA is already doing. Our AMA is engaged in ongoing advocacy
7 with Congress and federal agencies to address J-1 processing disruptions. Examples of
8 recent correspondence include:

- 9
- 10 • [Letter to the U.S. Department of State](#) urging resumption of J-1 visa interviews
11 (June 18, 2025) shortly after the AMA's State Department letter, the Department
12 of State [resumed visa processing and prioritized J-1 physicians](#).
 - 13 • [Letter to the U.S. Department of Homeland Security](#) urging for the exclusion of
14 foreign national physicians in the Department of State's (DOS) Exchange Visitor
15 Program in J-1 visa status, and their J-2 dependents, from the proposed rule which
16 would eliminate duration of status. (September 24, 2025).
 - 17 • [Letter to the U.S. Senate in support of the Healthcare Workforce Resilience Act](#),
18 which would expand visa availability (September 30, 2025).
- 19

20 These ongoing advocacy efforts demonstrate that our AMA has already taken, and
21 continues to take, the actions outlined in Resolution 216.

22

23 Your Reference Committee also received an Alternate Resolution that received supportive
24 testimony. Your Reference Committee accepted the majority of this Alternate Resolution
25 while making minor technical amendments to ensure that our AMA can continue to
26 advocate on these important issues. These technical amendments recognize that the
27 United States is only in control of a portion of the visa processing, while the home country
28 oversees the remainder of this process and acknowledges that our AMA works in
29 collaboration with other organizations on this issue including Intealth. Therefore, your
30 Reference Committee recommends that Alternate Resolution 216 be adopted in lieu of
31 Resolution 216.

RECOMMENDED FOR REFERRAL

(37) RESOLUTION 205 — RESTORING BALANCE BILLING
AND ALLOWING COPAY FORGIVENESS TO
PRESERVE INDEPENDENT PRACTICE AND IMPROVE
ACCESS TO CARE

RECOMMENDATION:

Your Reference Committee recommends that Resolution
205 be referred.

HOD ACTION: Resolution 205 referred.

RESOLVED, that our American Medical Association assign high priority to advocacy to support legislation or regulatory reform to restore private physicians' ability to balance bill patients for non-emergency, outpatient medical services, regardless of insurance network participation status (Directive to Take Action); and be it further

RESOLVED, that our AMA oppose artificial caps on private physician balance billing amounts, especially of less than 100 percent above the insurer's allowed amount, to reflect and offset decades of reimbursement erosion (New HOD Policy); and be it further

RESOLVED, that our AMA support the continuation of protections from balance billing for emergency care, Medicaid beneficiaries, and other vulnerable populations as currently required under state and federal law (New HOD Policy); and be it further

RESOLVED, that our AMA advocate at the federal level for reform of anti-kickback and payer contracting rules that prohibit physicians from waiving co-pays and deductibles for patients experiencing financial hardship. (Directive to Take Action)

Mixed testimony was received for Resolution 205. Some testimony supported the entire Resolution noting the importance of the financial stability of small physician practices. However, additional testimony only supported portions of the Resolution, in particular noting that the last resolve brought in topics that did not align with the rest of the Resolution such as anti-kickback rules. Others opposed the Resolution in its entirety or offered amendments. Further testimony stated that referral was appropriate since our AMA already has policy on this topic. Given the lack of consensus, the existence of relevant AMA policy, and the need to ensure consistency within the Resolution, your Reference Committee recommends that Resolution 205 be referred.

1 (38) RESOLUTION 209 — SUPPORT FOR LEGISLATIVE
2 CHANGES ALLOWING PARTIAL MEDICARE OPT-OUT
3 FOR PHYSICIANS
4

5 RECOMMENDATION:
6

7 Your Reference Committee recommends that Resolution
8 209 be referred.
9

10
11 **HOD ACTION: Resolution 209 referred.**
12

13
14 RESOLVED, that our American Medical Association advocate for federal legislation or
15 regulatory changes to allow physicians to opt out of Medicare in one employment setting
16 while maintaining the ability to bill Medicare for services provided in other practice settings
17 (e.g., private practices, hospice, inpatient hospital care, or other defined roles). (Directive
18 to Take Action)
19

20 Mixed testimony was received for Resolution 209. Some testimony advocated for adoption
21 noting that the current system of all-in or all-out for Medicare was antiquated and needed
22 to be remedied. Other testimony opposed the Resolution stating that the approach
23 suggested in the Resolution may lead to patient confusion. Additional testimony
24 recommended referral highlighting the need to allow our AMA time to examine key
25 questions related to feasibility, administrative impact, and policy alignment before
26 determining whether new policy is necessary. Given the mixed testimony and the existence
27 of AMA policy on this topic, your Reference Committee recommends that Resolution 209
28 be referred.
29

30 (39) RESOLUTION 211 — ACCESS TO, AND RETENTION
31 OF, ELECTRONIC MEDICAL RECORDS
32

33 RECOMMENDATION:
34

35 Your Reference Committee recommends that Resolution
36 211 be referred.
37

38
39 **HOD ACTION: Resolution 211 referred.**
40

41
42 RESOLVED, that our American Medical Association support federal legislation to
43 standardize the duration of all medical record retention and to require that records of
44 discharged patients be compiled, reviewed for completeness, and authenticated within 30
45 days of discharge (New HOD Policy); and be it further
46

47 RESOLVED, that our American Medical Association adopt as its formal policy and also
48 support federal legislation that mandates the following:

- 1 a) All EMR vendors must retain patient data electronically to comply with state laws
2 regardless of whether the provider or health-care system contract is still in effect;
3 b) All EMR vendors must arrange for custodians of all electronic medical files to comply
4 with state law regarding medical record retention in case of insolvency; and
5 c) All EMR vendors must deliver an individual patient's medical records when requested
6 to lawful recipients in a timely manner, at reasonable or no cost, and in formats that
7 are readily accessible to the general public. (New HOD Policy)
8

9 Mixed testimony was received for Resolution 211. Testimony broadly supported the goal
10 of ensuring timely access to and retention of medical records to improve patient care,
11 facilitate forensic and clinical processes, and prevent data loss during transitions between
12 electronic medical record (EMR) systems. Testimony also supported the concepts of
13 interoperability, accountability of EMR vendors, and continuity of care. However, some
14 testimony expressed concern about aspects of the Resolution as written and offered
15 amended language. Several commentors noted that terms like "timely" should be clearly
16 defined, and that EMR vendors should not serve as the primary repositories of patient
17 data, as this could raise privacy, legal, and ethical risks. Other testimony warned that
18 federal standardization of medical record retention could conflict with or weaken existing
19 state laws and impose costly burdens on smaller practices. Significant testimony
20 recommended referral for further study to address the complex overlap of federal and state
21 regulations, vendor accountability, and data ownership issues before pursuing legislation.
22 Therefore, your Reference Committee recommends that Resolution 211 be referred.
23

24 (40) RESOLUTION 220 — MEDICARE SHOULD NOT
25 UNFAIRLY PENALIZE PHYSICIANS

26
27 RESOLUTION 223 — HALT THE ROLLOUT OF NEW
28 PAYMENT MODELS BY THE CENTER FOR MEDICARE
29 & MEDICAID INNOVATION (CMMI) — A NEW
30 ADMINISTRATION OFFERS AN OPPORTUNITY

31
32 RECOMMENDATION:

33
34 Your Reference Committee recommends that Resolution
35 220 and 223 be referred.
36

37
38 **HOD ACTION: Resolution 220 and 223 referred.**
39

40
41 **Resolution 220 — Medicare Should Not Unfairly Penalize Physicians**

42
43 RESOLVED, that our American Medical Association advocate for the repeal of any law or
44 regulation that imposes a penalty or deduction on Medicare physician payment based
45 upon the result of a value-based payment program. (Directive to Take Action)
46
47

1 **Resolution 223 — Halt The Rollout Of New Payment Models By The Center For**
2 **Medicare & Medicaid Innovation (CMMI) — A New Administration Offers An**
3 **Opportunity**

4
5 RESOLVED, that our American Medical Association advocate and urge Congress to halt
6 the Center for Medicare & Medicaid Innovation's (CMMI) creation and rollout of new value-
7 based payment models, quickly discontinue programs that have had negative effects on
8 care, while supporting CMMI's evaluation of the models currently being tested. (Directive
9 to Take Action)

10
11 Mixed testimony was received for Resolutions 220 and 223. Testimony noted that
12 Medicare reimbursement processes can be burdensome and frequently penalize
13 physicians and other providers. Additionally, significant testimony noted that the Center
14 for Medicare and Medicaid Innovation (CMMI) had previously implemented value
15 based payment models that have negative impacts on care, but there was disagreement
16 over how best to address the problems with CMMI. Multiple testifiers recommended
17 reaffirmation of these two Resolutions together noting concerns about the complexity and
18 limited success of CMMI payment models. Testimony in favor of reaffirmation stated that
19 the directive to halt the development of all new CMMI payment models would conflict with
20 established AMA policy that supports voluntary, physician developed payment reform.
21 Testimony further highlighted that referral would provide our AMA with the opportunity to
22 evaluate how to strengthen advocacy around CMMI accountability and model redesign,
23 while making certain that any future models reflect physician leadership, local flexibility,
24 and data driven evaluation. Live testimony emphasized the high failure rate of CMMI
25 models and the burdens of the upcoming WISeR program, while additional testimony
26 focused on the need for referral since the WISeR model will begin on January first and our
27 AMA Board is already engaged in active work on this issue. This additional testimony
28 reinforced that perspectives on the best course of action remain mixed and that referral
29 would allow the most complete and coordinated approach. Your Reference Committee
30 believes that referral of Resolution 223, along with Resolution 220, preserves consistency
31 with our AMA's existing policy framework and avoids creating conflicting directives in the
32 policy compendium. Therefore, your Reference Committee recommends that
33 Resolutions 220 and 223 be referred.

34
35 (41) RESOLUTION 221 — NOT-FOR-PROFIT STATUS

36
37 RECOMMENDATION:

38
39 Your Reference Committee recommends that Resolution
40 221 be referred.

41
42
43 **HOD ACTION: Resolution 221 referred.**
44

45
46 RESOLVED, that our American Medical Association advocate that the granting and
47 maintenance of healthcare entities of not-for-profit status be reassessed by both the state
48 legislature and the US Congress. (Directive to Take Action)
49

1 Your Reference Committee heard mixed testimony on Resolution 221. Multiple testifiers
2 expressed concern with the vagueness of the language, the complicated legal and
3 technical questions involved, and the potential for unintended consequences. Two
4 testifiers opposed the resolution altogether on these bases, while three others
5 recommended referral. An amendment to clarify the intent of the resolution was proposed.
6

7 Your Reference Committee agrees that Resolution 221 involves highly technical questions
8 of federal and state tax law and should be carefully considered to ensure that our AMA
9 does not advocate for an outcome that could lead to harmful unintended consequences.
10 Therefore, your Reference Committee recommends that Resolution 221 be referred.

11
12 (42) RESOLUTION 225 — FEDERAL LEGISLATION TO
13 PROHIBIT THE CORPORATE PRACTICE OF MEDICINE

14
15 RECOMMENDATION:

16
17 Your Reference Committee recommends that Resolution
18 225 be referred with report back at A-26.
19

20
21 **HOD ACTION: Resolution 225 referred with report back at**
22 **A-26.**
23

24
25 RESOLVED, that our American Medical Association advocate for federal legislation that
26 prohibits lay corporations, including insurance companies, private equity firms, and other
27 non-physician-owned entities, from owning or controlling medical practices and healthcare
28 decision-making, and prohibits such entities from participation in federal healthcare
29 payment programs, in order to protect physician autonomy and strengthen the physician-
30 patient relationship (Directive to Take Action); and be it further

31
32 RESOLVED, that our AMA amend Policy H-215.981 - Corporate Practice of Medicine
33 under items #1 and #2 by addition and deletion as follows:

- 34
35 1. Our American Medical Association ~~vigorously opposes any effort to pass federal~~
36 ~~legislation or regulation preempting state laws~~ supports the passage of federal
37 legislation prohibiting the corporate practice of medicine.
38 2. Our AMA vigorously opposes any effort to pass state or federal legislation or regulation
39 that removes or weakens existing state laws prohibiting the corporate practice of
40 medicine. (Modify Current HOD Policy)

41
42 Your Reference Committee heard mixed testimony on Resolution 225. Multiple
43 commenters testified that ownership of medical practices by corporate and other non-
44 physician-owned entities undermines physician autonomy and can threaten patient care.
45 They emphasized the accelerating pace of private equity and corporate consolidation in
46 health care and argued that our AMA must adopt stronger advocacy
47 positions opposing the corporate practice of medicine (CPOM). While generally in
48 agreement that our AMA should oppose the corporate practice of medicine, other
49 testifiers raised concerns about the appropriateness and feasibility of pursuing a federal

1 CPOM ban and noted that prohibiting all non-physician entities from owning a practice
2 or participating in federal health care payment programs may carry unintended
3 consequences that merit careful evaluation.

4 Three amendments were offered. One proposed that our AMA advocate for legislation
5 prohibiting the corporate practice of medicine “as it is legally defined.” The other two would
6 create flexibility for our AMA to pursue CPOM prohibitions at either the state or federal
7 level, with one specifically calling on our AMA to investigate the feasibility and impact of
8 restricting non-physician-owned entities in federal payment programs.

9
10 Your Reference Committee appreciates the urgency driving Resolution 225. Your
11 Reference Committee notes that the proposed amendments, online testimony, and verbal
12 testimony collectively raise significant questions of law and policy, including, for
13 example, around the legal definition of CPOM, the extent to which federal
14 action would preempt state law, the appropriate scope of CPOM prohibitions, and the
15 potential impact of excluding non-physician-owned entities from health care payment
16 programs. This is a deeply important but also highly complex area of law and
17 health policy, and your Reference Committee believes that further research and analysis
18 are required to ensure that AMA policy is well-grounded and legally sound. Your
19 Reference Committee appreciates the sentiment of the need for our AMA to investigate
20 the feasibility and potential impact of prohibiting non-physician owned entities from
21 participation in federal healthcare payment programs and feels that referral will address
22 these and other concerns.

23
24 Accordingly, your Reference Committee recommends that Resolution 225 be referred,
25 with a report due back at the 2026 Annual Meeting of the AMA House of Delegates.

RECOMMENDATION FOR REAFFIRMATION IN LIEU OF**(43) RESOLUTION 208 — CENTRALIZATION OF MEDICARE
PROVIDER DATA SOURCES****RECOMMENDATION:**

Your Reference Committee recommends that existing AMA policies H-285.902, D-478.984, and H-355.979 be reaffirmed in lieu of Resolution 208.

HOD ACTION: Existing AMA policies H-285.902, D-478.984, and H-355.979 reaffirmed in lieu of Resolution 208.

RESOLVED, that our American Medical Association advocate that the Centers for Medicare and Medicaid Services (CMS) adopt centralized, standardized, and interoperable provider data repositories for Medicare and Medicare Advantage provider directory purposes, including acceptance of validated data from nationally recognized sources such as the Coalition for Affordable Quality Healthcare (CAQH) or equivalent, and eliminate duplicative attestations by physicians when accurate data has already been submitted through such systems (Directive to Take Action); and be it further

RESOLVED, that our AMA continue to urge CMS to harmonize provider directory requirements across programs and promote automation, data governance standards, and streamlined workflows that improve directory accuracy, reduce administrative burden, and ensure patients have timely access to reliable provider information. (Directive to Take Action)

Minimal and mixed testimony was received for Resolution 208. The intent of this resolution directs our AMA to advocate that the Centers for Medicare & Medicaid Services (CMS) adopt centralized, standardized, and interoperable provider data repositories for Medicare and Medicare Advantage provider directory purposes, including the use of validated data from national sources such as the Coalition for Affordable Quality Healthcare (CAQH) or equivalent, and to eliminate duplicative attestations by physicians when accurate data has already been submitted through such systems. The resolution also calls for harmonized directory requirements across programs, improved automation, and data governance standards to enhance directory accuracy, reduce administrative burden, and promote timely patient access to reliable provider information. As noted in the testimony, our AMA already has existing policy that fulfills the asks of Resolution 208 including submitting accurate directories annually, creating and using centralized data repositories, and ensuring accessibility, accuracy, and governance of practitioner data repositories. Therefore, your Reference Committee recommends that existing AMA policies H-285.902, D-478.984, and H-355.979 be reaffirmed in lieu of Resolution 208.

1 (44) RESOLUTION 219 — ADDRESSING THE HARMS AND
2 MISLEADING NATURE OF MEDICARE ADVANTAGE
3 PLANS

4
5 RECOMMENDATION:

6
7 Your Reference Committee recommends that existing AMA
8 policies D-330.888, D-185.979, D-330.923, H-330.878, D-
9 70.950, D-330.930, D-390.967, H-390.832, and H-330.862
10 be reaffirmed in lieu of Resolution 219.
11

12
13 **HOD ACTION: Existing AMA policies D-330.888, D-185.979,
14 D-330.923, H-330.878, D-70.950, D-330.930, D-390.967, H-
15 390.832, and H-330.862 reaffirmed in lieu of Resolution 219**
16

17
18 RESOLVED, that our American Medical Association emphasize to Congress the
19 excessive cost, the use of taxpayer funding, the depletion of taxpayer monies supporting
20 traditional Medicare by the Medicare Advantage (MA) programs. (Directive to Take
21 Action)
22

23 Mixed testimony was received for Resolution 219. Supportive testimony argued that
24 Medicare Advantage plans mislead patients, drain the Medicare Trust Fund, and impose
25 administrative barriers that restrict access to necessary care. This testimony emphasized
26 that MA programs divert taxpayer dollars and often trap patients in narrow networks with
27 limited options to return to traditional Medicare. Additional testimony during the live
28 hearing highlighted ongoing MA abuses despite existing AMA policy and called for
29 stronger action, but other delegations reiterated that current AMA directives already
30 address the core concerns in this space. Further substantive testimony in favor of
31 reaffirmation noted that MA plans do have shortcomings but maintained that our AMA has
32 extensive policy on parity, physician participation, oversight, and the need for improved
33 accountability. This testimony also stressed that value-based care models within MA
34 continue to hold potential for improvement rather than rejection.
35

36 Your Reference Committee also notes that adopting this resolution would not create a
37 substantive change in our advocacy efforts since our AMA already has extensive
38 directives on these issues and significant work in this space is already
39 underway. Therefore, your Reference Committee recommends that existing AMA policies
40 D-330.888, D-185.979, D-330.923, H-330.878, D-70.950, D-330.930, D-390.967, H-
41 390.832, and H-330.862 be reaffirmed in lieu of Resolution 219.
42

43 [Medigap, Pre-Existing Conditions, and Medicare Coverage Education D-
44 330.888](#)

- 45 1. Our AMA will create an educational campaign on both Medicare
46 Advantage (MA) and Medicare Fee-for-Service (FFS) coverage.
- 47 2. Our AMA will advocate for the elimination of Medigap insurers' ability
48 to deny coverage due to a patient's pre-existing health conditions and
49 work with Congress and the Centers for Medicare & Medicaid Services

1 (CMS) to ensure coverage in MA is, at a minimum, no less than
2 coverage provided under Medicare FFS that includes Part A, Part B,
3 Part D, and a Medigap policy.
4

5 [Aligning Clinical and Financial Incentives for High-Value Care D-185.979](#)

- 6 1. Our American Medical Association supports Value-Based Insurance
7 Design (VBID) plans designed in accordance with the tenets of “clinical
8 nuance,” recognizing that
9 a. medical services may differ in the amount of health produced.
10 b. the clinical benefit derived from a specific service depends on
11 the person receiving it, as well as when, where, and by whom
12 the service is provided.
- 13 2. Our AMA supports initiatives that align provider-facing financial
14 incentives created through payment reform and patient-facing financial
15 incentives created through benefit design reform, to ensure that patient,
16 provider, and payer incentives all promote the same quality care. Such
17 initiatives may include reducing patient cost-sharing for the items and
18 services that are tied to provider quality metrics.
- 19 3. Our AMA will develop coding guidance tools to help providers
20 appropriately bill for zero-dollar preventive interventions and promote
21 common understanding among health care providers, payers, patients,
22 and health care information technology vendors regarding what will be
23 covered at given cost-sharing levels.
- 24 4. Our AMA will develop physician educational tools that prepare
25 physicians for conversations with their patients about the scope of
26 preventive services provided without cost-sharing and instances where
27 and when preventive services may result in financial obligations for the
28 patient.
- 29 5. Our AMA will continue to support requiring private health plans to
30 provide coverage for evidence-based preventive services without
31 imposing cost-sharing (such as co-payments, deductibles, or
32 coinsurance) on patients.
- 33 6. Our AMA will continue to support implementing innovative VBID
34 programs in Medicare Advantage plans.
- 35 7. Our AMA supports legislative and regulatory flexibility to accommodate
36 VBID that
37 a. preserves health plan coverage without patient cost-sharing for
38 evidence-based preventive services.
39 b. allows innovations that expand access to affordable care,
40 including changes needed to allow High Deductible Health
41 Plans paired with Health Savings Accounts to provide pre-
42 deductible coverage for preventive and chronic care
43 management services.
- 44 8. Our AMA encourages national medical specialty societies to identify
45 services that they consider to be high-value and collaborate with payers
46 to experiment with benefit plan designs that align patient financial
47 incentives with utilization of high-value services.

1 [Medicare Advantage Plans D-330.923](#)

2 Our AMA encourages the Centers for Medicare & Medicaid Services to
3 award Medicare Advantage Programs only to those health plans that meet
4 all of the following criteria: (1) an 85% or higher medical loss ratio; (2)
5 physician payment rates are no less than Medicare Fee for Service rates;
6 and (3) use enforceable contracts that prohibit unilateral changes in
7 physician payment rates.
8

9 [Medicare Advantage Policies H-330.878](#)

- 10 2. Our American Medical Association supports that Medicare Advantage
11 plans must provide enrollees with coverage for, at a minimum, all Part
12 A and Part B original Medicare services, if the enrollee is entitled to
13 benefits under both parts.
- 14 3. Our AMA will advocate:
- 15 a. for better enforcement of Medicare Advantage regulations to
16 hold the Centers for Medicare & Medicaid Services (CMS)
17 accountable for presenting transparency of minimum standards
18 and to determine if those standards are being met for physicians
19 and their patients.
 - 20 b. that Medicare Advantage plans be required to post all
21 components of Medicare covered and not covered in all plans
22 across the US on their website along with the additional benefits
23 provided.
 - 24 c. that CMS maintain a publicly available database of physicians
25 in network under Medicare Advantage and the status of each of
26 these physicians in regard to accepting new patients in a
27 manner least burdensome to physicians.
28

29 [Standardization of Advance Beneficiary Notification of Non-Coverage
30 Forms for Medicare Advantage Plans and Original Fee-For-Service
31 Medicare D-70.950](#)

- 32 1. Our AMA will request the Centers for Medicare & Medicaid Services
33 provide a standardized Advance Beneficiary Notice of Non-coverage
34 (ABN) that will be sufficient notification to inform all Medicare
35 Advantage Plan and Original (Fee-For-Service) Medicare beneficiaries
36 when Medicare may deny payment for an item or service.
- 37 2. Our AMA will advocate that Medicare Advantage Plan requirements for
38 carrier specific advance beneficiary notice of non-coverage and similar
39 forms be eliminated.
40

41 [Deemed Participation and Misleading Marketing by Medicare Advantage
42 Private Fee for Service Plans D-330.930](#)

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

1 [Elimination of Subsidies to Medicare Advantage Plans D-390.967](#)

- 2 1. Our AMA will seek to have all subsidies to private plans offering
3 alternative coverage to Medicare beneficiaries eliminated, that these
4 private Medicare plans compete with traditional Medicare fee-for-
5 service plans on a financially neutral basis and have accountability to
6 the Centers for Medicare and Medicaid Services.
7 2. Our AMA will seek to prohibit all private plans offering coverage to
8 Medicare beneficiaries from deeming any physician to be a
9 participating physician without a signed contract specific to that
10 product, and that our AMA work with CMS to prohibit all-products
11 clauses from applying to Medicare Advantage plans and private fee-
12 for-service plans.
13

14 [Saving Traditional Medicare H-390.832](#)

- 15 1. Our American Medical Association will continue its efforts to fix the
16 flawed Medicare payment system for physicians recognizing that
17 Traditional Medicare is a critical healthcare program while educating
18 the public on the benefits and threats of Medicare Part C expansion.
19 2. Our AMA will continue to address the funding challenges facing
20 Traditional Medicare through legislative reform and policy changes,
21 while at the same time advocating for sustainable, inflation-adjusted
22 reimbursement to clinicians.
23 3. Our AMA acknowledges that the term "Medicare Advantage" can be
24 misleading, as it implies a superiority or enhanced value over traditional
25 Medicare, which may not accurately reflect the nature and challenges
26 of these plans.
27

28 [Increasing Transparency Surrounding Medicare Advantage Plans H-
29 330.862](#)

30 Our AMA supports policy to increase financial transparency of Medicare
31 Advantage plans, including mandated public reporting of prior authorization
32 practices, claim denials, marketing expenses, supplemental benefits, and
33 provider networks.

1 (45) RESOLUTION 222 — TACKLING ADMINISTRATIVE
2 WASTE—LET US BE PART OF THE SOLUTION TO
3 PUTTING OUR HEALTH SYSTEM ON A SUSTAINABLE
4 PATH

5
6 RECOMMENDATION:

7
8 Your Reference Committee recommends that existing AMA
9 policy D-155.996 be reaffirmed in lieu of Resolution 222.

11 **HOD ACTION: Existing AMA policy D-155.996 reaffirmed in**
12 **lieu of Resolution 222**

15
16 RESOLVED, that our American Medical Association work with all relevant government
17 agencies to identify sources of administrative waste to advocate for elimination of high-
18 cost bureaucratic excesses and revision or replacement of the counterproductive payment
19 strategies of the past two decades. (Directive to Take Action)

20
21 Your Reference Committee heard testimony in support of reaffirming existing policy in lieu
22 of adopting Resolution 222 with limited testimony in favor of adoption. Your Reference
23 Committee agrees with the majority of testifiers, who noted that our AMA has strong
24 existing policy on the issue of administrative waste and is already doing extensive
25 advocacy work on the topic, making new policy unnecessary. Therefore, your Reference
26 Committee recommends reaffirming existing AMA policy D-155.996 in lieu of Resolution
27 222.

28 [Health Care Expenditures D-155.996](#)

- 29
30 1. Our AMA will work to improve our health care system by: (a)
31 researching and collating existing studies on how health care dollars
32 are currently spent; (b) identifying the amount of public and private
33 health care spending that is transferred to insurance administration
34 compared to industry and corporate standards, including money spent
35 on defensive medicine; and (c) disseminating these findings to the
36 American public, US Congress, and appropriate agencies.
37 2. Our AMA will continue its efforts to identify ways to reduce waste in the
38 health care sector so that the trend of increasing health care costs over
the years could be reversed.

1 (46) RESOLUTION 237 — PROTECTING AND IMPROVING
2 RURAL HEALTH
3

4 RECOMMENDATION:
5

6 Your Reference Committee recommends that existing AMA
7 policies H-290.951, H-130.954, H-465.99, H-200.949, and
8 H-200.954 be reaffirmed in lieu of Resolution 237.
9

10 **HOD ACTION: Existing AMA policies H-290.951, H-130.954,**
11 **H-465.99, H-200.949, and H-200.954 reaffirmed in lieu of**
12 **Resolution 237.**
13
14

15
16 RESOLVED, that our American Medical Association assist state medical associations,
17 specialty societies and physician practices with the implementation of HR 1, The One Big
18 Beautiful Bill Act, to mitigate the negative impact of the Medicaid, ACA and student loan
19 cuts to physicians and patients, particularly in rural areas (Directive to Take Action); and
20 be it further

21
22 RESOLVED, that our AMA continue to assist state medical associations and physician
23 practices with the HR 1 implementation of the Rural Transformation Program to ensure
24 funding and assistance for physician practices (Directive to Take Action); and be it further
25

26 RESOLVED, that our AMA support the provision and payment of physician-to-physician
27 virtual telehealth consultations as an option to increase access to primary and specialty
28 care in rural communities, acknowledging that significant investments in rural telehealth
29 broadband must be made in order to effectively deliver telehealth services (New HOD
30 Policy); and be it further

31
32 RESOLVED, that our AMA encourage the development of programs and financial
33 assistance models for rural physician practices in need of health information technology
34 and other technological modernization and security, as well as access to specialty
35 equipment to provide quality care (New HOD Policy); and be it further
36

37 RESOLVED, that our AMA support investments in and payment for a wide variety of
38 medical transportation options to connect rural residents to primary and specialty care
39 services and return to their communities (New HOD Policy); and be it further
40

41 RESOLVED, that our AMA continue to address the nation's obstetrics and gynecology
42 training and workforce needs, including but not limited to increasing postgraduate
43 positions in OB-GYN and family medicine OB fellowships, increasing ACGME funding,
44 and evaluating other ways to increase physicians providing OB-GYN services in shortage
45 areas (Directive to Take Action); and be it further
46

47 RESOLVED, that our AMA support expansion of Family Practice Obstetricians (FPOB)
48 who are family practice physicians that are certified after completing an obstetrics
49 fellowship (New HOD Policy); and be it further

1 RESOLVED, that our AMA urge the Centers for Medicare and Medicaid Services and
2 others to provide funding for standby capacity payments to sustain obstetric services at
3 hospitals at risk of closing access to maternity care (New HOD Policy); and be it further
4

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

10
11 RESOLVED, that our AMA continue to research and distribute successful state and
12 specialty society models that have improved access to maternal care in rural areas and
13 reduced maternal mortality rates. (Directive to Take Action)

14
15 Your Reference Committee heard mixed testimony on Resolution 237. While most
16 testifiers supported adoption, many testifiers acknowledged that our AMA has existing
17 policies on the issues covered by the resolution. One commenter testified in favor of
18 reaffirmation, noting that existing AMA policies “encompass the Resolution’s intent to
19 mitigate the negative effect of Medicaid and Affordable Care Act (ACA) cuts, strengthen
20 the rural health workforce, and expand access to care through telehealth, transportation,
21 and targeted support for physician practices.” This commenter also noted that our AMA is
22 already deeply engaged in assisting state medical associations with the implementation
23 of Public Law 119-21, including by providing technical support related to the newly
24 established Rural Health Transformation Program (see [Board of Trustees Report 16](#)
25 [“Preservation of Medicaid”](#) and this report’s discussion of Resolution 227 for more
26 information about our AMA’s work on recent Medicaid and ACA cuts).

27
28 During the live hearing, your Reference Committee received an amendment that would
29 replace the original Resolves with three new Resolves. Your Reference Committee is
30 concerned that the Resolves offered may not be germane and believes that there was not
31 enough time to adequately consider the new concepts proposed by the amendment at this
32 meeting. Your Reference Committee suggests that the amendment be offered again at a
33 future meeting as its own Resolution.

34
35 Your Reference Committee agrees that existing policy accomplishes the goals of
36 Resolution 237 and therefore recommends that existing AMA policies H-290.951, H-
37 130.954, H-465.99, H-200.949, and H-200.954 be reaffirmed in lieu of Resolution 237.

38 39 [Preservation of Medicaid H-290.951](#)

- 40 1. Our American Medical Association elevates Medicaid to an
41 urgent and top legislative advocacy priority alongside Medicare
42 payment reform, specifically advocating for maintaining and
43 expanding Medicaid coverage, access, federal funding, and
44 eligibility, and request report back on the Board of Trustees’
45 actions at I-25.
- 46 2. Our AMA strongly opposes federal and state efforts to restrict
47 eligibility, coverage, access, and funding for Medicaid and the
48 Children’s Health Insurance Program (CHIP).

1 [Non-Emergency Patient Transportation Systems H-130.954](#)

2 Our AMA: (1) supports the education of physicians, first responders, and
3 the public about the costs associated with inappropriate use of emergency
4 patient transportation systems; and (2) encourages the development of
5 non-emergency patient transportation systems that are affordable to the
6 patient, thereby ensuring cost effective and accessible health care for all
7 patients.

8
9 [Improving Rural Health H-465.994](#)

- 10 1. Our American Medical Association:
- 11 a. supports continued and intensified efforts to develop and
12 implement proposals for improving rural health care and public
13 health,
 - 14 b. urges physicians practicing in rural areas to be actively involved
15 in these efforts, and
 - 16 c. advocates widely publicizing AMA's policies and proposals for
17 improving rural health care and public health to the profession,
18 other concerned groups, and the public.
- 19 2. Our AMA will work with other entities and organizations interested in
20 public health to:
- 21 a. Encourage more research to identify the unique needs and
22 models for delivering public health and health care services in
23 rural communities.
 - 24 b. Identify and disseminate concrete examples of administrative
25 leadership and funding structures that support and optimize
26 local, community-based rural public health.
 - 27 c. Develop an actionable advocacy plan to positively impact local,
28 community-based rural public health including but not limited to
29 the development of rural public health networks, training of
30 current and future rural physicians and public health
31 professionals in core public health techniques and novel funding
32 mechanisms to support public health initiatives that are led and
33 managed by local public health authorities.
 - 34 d. Advocate for adequate and sustained funding for public health
35 staffing and programs
- 36 3. Our American Medical Association will work with relevant stakeholders
37 to develop a national strategy to eliminate rural cancer disparities in
38 screening, treatment, and outcomes and achieve health equity in
39 cancer outcomes across all geographic regions.
- 40 4. Our AMA calls for increased federal and state funding to support
41 research on rural cancer disparities and equity in care, access, and
42 outcomes and development of interventions to address those
43 disparities.
- 44 5. Our AMA advocates for evidence-based collaborative models for
45 innovative telementoring/ teleconsultation between health care
46 systems, academic medical centers, and community physicians to
47 improve access to cancer screening, diagnosis, treatment,
48 rehabilitation, and patient services in rural areas.

1 [Principles of and Actions to Address Primary Care Workforce H-200.949](#)

- 2 1. Our patients require a sufficient, well-trained supply of primary care
3 physicians--family physicians, general internists, general pediatricians,
4 and obstetricians/gynecologists--to meet the nation's current and
5 projected demand for health care services.
- 6 2. To help accomplish this critical goal, our American Medical Association
7 (AMA) will work with a variety of key stakeholders, to include federal
8 and state legislators and regulatory bodies; national and state specialty
9 societies and medical associations, including those representing
10 primary care fields; and accreditation, certification, licensing, and
11 regulatory bodies from across the continuum of medical education
12 (undergraduate, graduate, and continuing medical education).
- 13 3. Through its work with these stakeholders, our AMA will encourage
14 development and dissemination of innovative models to recruit medical
15 students interested in primary care, train primary care physicians, and
16 enhance both the perception and the reality of primary care practice, to
17 encompass the following components: a) Changes to medical school
18 admissions and recruitment of medical students to primary care
19 specialties, including counseling of medical students as they develop
20 their career plans; b) Curriculum changes throughout the medical
21 education continuum; c) Expanded financial aid and debt relief options;
22 d) Financial and logistical support for primary care practice, including
23 adequate reimbursement, and enhancements to the practice
24 environment to ensure professional satisfaction and practice
25 sustainability; and e) Support for research and advocacy related to
26 primary care.
- 27 4. Admissions and recruitment: The medical school admissions process
28 should reflect the specific institution's mission. Those schools with
29 missions that include primary care should consider those predictor
30 variables among applicants that are associated with choice of these
31 specialties.
- 32 5. Medical schools, through continued and expanded recruitment and
33 outreach activities into secondary schools, colleges, and universities,
34 should develop and increase the pool of applicants likely to practice
35 primary care by seeking out those students whose profiles indicate a
36 likelihood of practicing in primary care and underserved areas, while
37 establishing strict guidelines to preclude discrimination.
- 38 6. Career counseling and exposure to primary care: Medical schools
39 should provide to students career counseling related to the choice of a
40 primary care specialty, and ensure that primary care physicians are
41 well-represented as teachers, mentors, and role models to future
42 physicians.
- 43 7. Financial assistance programs should be created to provide students
44 with primary care experiences in ambulatory settings, especially in
45 underserved areas. These could include funded preceptorships or
46 summer work/study opportunities.
- 47 8. Curriculum: Voluntary efforts to develop and expand both
48 undergraduate and graduate medical education programs to educate
49 primary care physicians in increasing numbers should be continued.

- 1 The establishment of appropriate administrative units for all primary
2 care specialties should be encouraged.
- 3 9. Medical schools with an explicit commitment to primary care should
4 structure the curriculum to support this objective. At the same time, all
5 medical schools should be encouraged to continue to change their
6 curriculum to put more emphasis on primary care.
- 7 10. All four years of the curriculum in every medical school should provide
8 primary care experiences for all students, to feature increasing levels
9 of student responsibility and use of ambulatory and community-based
10 settings.
- 11 11. Federal funding, without coercive terms, should be available to
12 institutions needing financial support to expand resources for both
13 undergraduate and graduate medical education programs designed to
14 increase the number of primary care physicians. Our AMA will advocate
15 for public (federal and state) and private payers to a) develop enhanced
16 funding and related incentives from all sources to provide education for
17 medical students and resident/fellow physicians, respectively, in
18 progressive, community-based models of integrated care focused on
19 quality and outcomes (such as the patient-centered medical home and
20 the chronic care model) to enhance primary care as a career choice; b)
21 fund and foster innovative pilot programs that change the current
22 approaches to primary care in undergraduate and graduate medical
23 education, especially in urban and rural underserved areas; and c)
24 evaluate these efforts for their effectiveness in increasing the number
25 of students choosing primary care careers and helping facilitate the
26 elimination of geographic, racial, and other health care disparities.
- 27 12. Medical schools and teaching hospitals in underserved areas should
28 promote medical student and resident/fellow physician rotations
29 through local family health clinics for the underserved, with financial
30 assistance to the clinics to compensate their teaching efforts.
- 31 13. The curriculum in primary care residency programs and training sites
32 should be consistent with the objective of training generalist physicians.
33 Our AMA will encourage the Accreditation Council for Graduate
34 Medical Education to (a) support primary care residency programs,
35 including community hospital-based programs, and (b) develop an
36 accreditation environment and novel pathways that promote
37 innovations in graduate medical education, using progressive,
38 community-based models of integrated care focused on quality and
39 outcomes (such as the patient-centered medical home and the chronic
40 care model).
- 41 14. The visibility of primary care faculty members should be enhanced
42 within the medical school, and positive attitudes toward primary care
43 among all faculty members should be encouraged.
- 44 15. Support for practicing primary care physicians: Administrative support
45 mechanisms should be developed to assist primary care physicians in
46 the logistics of their practices, along with enhanced efforts to reduce
47 administrative activities unrelated to patient care, to help ensure
48 professional satisfaction and practice sustainability.
- 49 16. There should be increased financial incentives for physicians practicing
50 primary care, especially those in rural and urban underserved areas, to

- 1 include scholarship or loan repayment programs, relief of professional
2 liability burdens, and Medicaid case management programs, among
3 others. Our AMA will advocate to state and federal legislative and
4 regulatory bodies, among others, for development of public and/or
5 private incentive programs, and expansion and increased funding for
6 existing programs, to further encourage practice in underserved areas
7 and decrease the debt load of primary care physicians. The imposition
8 of specific outcome targets should be resisted, especially in the
9 absence of additional support to the schools.
- 10 17. Our AMA will continue to advocate, in collaboration with relevant
11 specialty societies, for the recommendations from the AMA/Specialty
12 Society RVS Update Committee (RUC) related to reimbursement for
13 E&M services and coverage of services related to care coordination,
14 including patient education, counseling, team meetings and other
15 functions; and work to ensure that private payers fully recognize the
16 value of E&M services, incorporating the RUC-recommended
17 increases adopted for the most current Medicare RBRVS.
- 18 18. Our AMA will advocate for public (federal and state) and private payers
19 to develop physician reimbursement systems to promote primary care
20 and specialty practices in progressive, community-based models of
21 integrated care focused on quality and outcomes such as the patient-
22 centered medical home and the chronic care model consistent with
23 current AMA Policies H-160.918 and H-160.919.
- 24 19. There should be educational support systems for primary care
25 physicians, especially those practicing in underserved areas.
- 26 20. Our AMA will urge urban hospitals, medical centers, state medical
27 associations, and specialty societies to consider the expanded use of
28 mobile health care capabilities.
- 29 21. Our AMA will encourage the Centers for Medicare & Medicaid Services
30 to explore the use of telemedicine to improve access to and support for
31 urban primary care practices in underserved settings.
- 32 22. Accredited continuing medical education providers should promote and
33 establish continuing medical education courses in performing,
34 prescribing, interpreting and reinforcing primary care services.
- 35 23. Practicing physicians in other specialties--particularly those practicing
36 in underserved urban or rural areas--should be provided the opportunity
37 to gain specific primary care competencies through short-term
38 preceptorships or postgraduate fellowships offered by departments of
39 family medicine, internal medicine, pediatrics, etc., at medical schools
40 or teaching hospitals. In addition, part-time training should be
41 encouraged, to allow physicians in these programs to practice
42 concurrently, and further research into these concepts should be
43 encouraged.
- 44 24. Our AMA supports continued funding of Public Health Service Act, Title
45 VII, Section 747, and encourages advocacy in this regard by AMA
46 members and the public.
- 47 25. Research: Analysis of state and federal financial assistance programs
48 should be undertaken, to determine if these programs are having the
49 desired workforce effects, particularly for students from disadvantaged
50 groups and those that are underrepresented in medicine, and to gauge

1 the impact of these programs on elimination of geographic, racial, and
2 other health care disparities. Additional research should identify the
3 factors that deter students and physicians from choosing and remaining
4 in primary care disciplines. Further, our AMA should continue to monitor
5 trends in the choice of a primary care specialty and the availability of
6 primary care graduate medical education positions. The results of these
7 and related research endeavors should support and further refine AMA
8 policy to enhance primary care as a career choice.
9

10 [US Physician Shortage H-200.954](#)

- 11 1. Our AMA explicitly recognizes the existing shortage of physicians
12 in many specialties and areas of the US.
- 13 2. Our AMA supports efforts to quantify the geographic maldistribution
14 and physician shortage in many specialties.
- 15 3. Our AMA supports current programs to alleviate the shortages in
16 many specialties and the maldistribution of physicians in the US.
- 17 4. Our AMA encourages medical schools and residency programs to
18 consider developing admissions policies and practices and targeted
19 educational efforts aimed at attracting physicians to practice in
20 underserved areas and to provide care to underserved populations.
- 21 5. Our AMA encourages medical schools and residency programs to
22 continue to provide courses, clerkships, and longitudinal
23 experiences in rural and other underserved areas as a means to
24 support educational program objectives and to influence choice of
25 graduates' practice locations.
- 26 6. Our AMA encourages medical schools to include criteria and
27 processes in admission of medical students that are predictive of
28 graduates' eventual practice in underserved areas and with
29 underserved populations.
- 30 7. Our AMA will continue to advocate for funding from public and
31 private payers for educational programs that provide experiences
32 for medical students in rural and other underserved areas.
- 33 8. Our AMA will continue to advocate for funding from all payers
34 (public and private sector) to increase the number of graduate
35 medical education positions in specialties leading to first
36 certification.
- 37 9. Our AMA will work with other groups to explore additional innovative
38 strategies for funding graduate medical education positions,
39 including positions tied to geographic or specialty need.
- 40 10. Our AMA continues to work with the Association of American
41 Medical Colleges (AAMC) and other relevant groups to monitor the
42 outcomes of the National Resident Matching Program; and
- 43 11. Our AMA continues to work with the AAMC and other relevant
44 groups to develop strategies to address the current and potential
45 shortages in clinical training sites for medical students.
- 46 12. Our AMA will:
 - 47 a. promote greater awareness and implementation of the
48 Project ECHO (Extension for Community Healthcare
49 Outcomes) and Child Psychiatry Access Project models

- 1 among academic health centers and community-based
2 primary care physicians;
- 3 b. work with stakeholders to identify and mitigate barriers to
4 broader implementation of these models in the United
5 States; and
- 6 c. monitor whether health care payers offer additional payment
7 or incentive payments for physicians who engage in clinical
8 practice improvement activities as a result of their
9 participation in programs such as Project ECHO and the
10 Child Psychiatry Access Project; and if confirmed, promote
11 awareness of these benefits among physicians.
- 12 13. Our AMA will work to augment the impact of initiatives to address
13 rural physician workforce shortages.
- 14 14. Our AMA supports opportunities to incentivize physicians to select
15 specialties and practice settings which involve delivery of health
16 services to populations experiencing a shortage of providers, such
17 as women, LGBTQ+ patients, children, elder adults, and patients
18 with disabilities, including populations of such patients who do not
19 live in underserved geographic areas.

DRAFT

This concludes the report of Reference Committee B. I would like to thank Jennifer Hone, MD, Carlos Latorre, MD, Eli Freiman, MD, Rachel Kylo, MD, Michael Cromer, MD, Robert Emmick, MD, and all those who testified before the Committee.

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DISCLAIMER

The following is a preliminary report of actions taken by the House of Delegates at its 2025 Interim Meeting and should not be considered final. Only the Official Proceedings of the House of Delegates reflect official policy of the Association.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (I-25)

Final Report of Reference Committee C

Rose Berkun, MD, Chair

RECOMMENDED FOR ADOPTION

1. Council on Medical Education Report 1 - Additional Pathways for International Medical Graduates
2. Resolution 312 - Promoting the Equitable Evaluation of the Non-Research Domains in Trainee Selection

RECOMMENDED FOR ADOPTION AS AMENDED

3. Resolution 301 - Preventing Sleep Deprivation and Supporting Medical Student Wellness
4. Resolution 304 - Systemic Exclusion of IMGs from Residency Programs
5. Resolution 305 - Paid Sick Leave and Flexible Work Arrangements for Caregivers of Individuals with Special Needs, Chronic Illness, or Elderly Parents
6. Resolution 306 - Support for Paid Prenatal Leave
7. Resolution 307 - Integrating Artificial Intelligence (AI) Literacy into UME, GME, and CME
8. Resolution 308 - Enhancing the Pathway for Black Male Medical Students
9. Resolution 309 - Reasonable Workplace Accommodations for Residents and Fellows during Pregnancy
10. Resolution 310 - Remedying the Harms of AMA's Role in the Flexner Report
11. Resolution 311 - Gender and URiM Disparities in Surgical Training Volume
12. Resolution 313 - Hardship for International Medical Graduates from Palestine

RECOMMENDED FOR ADOPTION

- 1
2
3 (1) COUNCIL ON MEDICAL EDUCATION REPORT 1 -
4 ADDITIONAL PATHWAYS FOR INTERNATIONAL
5 MEDICAL GRADUATES

6
7 RECOMMENDATION:

8
9 Your Reference Committee recommends that Council on
10 Medical Education Report 1 be adopted.

11
12 The Council on Medical Education recommends that the following be adopted and the
13 remainder of the report be filed.

- 14
15 1. That the first clause of AMA Policy D-255.971, "Alternative Pathways for
16 International Medical Graduates," be rescinded as having been accomplished
17 by this report. (Rescind AMA Policy)

18
19
20 **HOD ACTION: CME 1 adopted and remainder of report filed.**

21
22
23 The recommendations in Council on Medical Education Report 1 received supportive
24 testimony in the Online Reference Committee (ORC). While one testimony favored annual
25 updates to the HOD on this topic, your Reference Committee believes that this report
26 satisfies the ask of the I-24 resolution. Your Reference Committee recommends that CME
27 1 be adopted.

- 28
29 (2) RESOLUTION 312 - PROMOTING THE EQUITABLE
30 EVALUATION OF NON-RESEARCH DOMAINS IN
31 TRAINEE SELECTION

32
33 RECOMMENDATION:

34
35 Your Reference Committee recommends that Resolution
36 312 be adopted.

37
38
39 **HOD ACTION: Resolution 312 adopted.**

40
41
42 RESOLVED, that our American Medical Association support efforts and work with
43 relevant parties to:

- 44 a) Improve the holistic and equitable consideration of research, advocacy, service,
45 teaching, mentorship, and other non-research domains in medical school and
46 residency/fellowship selection; and
47 b) Reduce the emphasis on research expectations for applicants; and

1 c) Improve medical school and residency/fellowship application services to allow
2 applicants to comprehensively showcase the non-research domains that best
3 align with their experiences and career goals. (Directive to Take Action)
4

5 Resolution 312 was not available in the ORC and only received in-person testimony.
6 Testimony was supportive, emphasizing the importance of valuing applicant activities
7 beyond peer-reviewed research publications, as well as the importance of not diluting
8 high-quality research by overemphasizing it as a means to distinguish oneself in
9 applications. Though individuals expressed varying application content preferences,
10 minimal testimony expressed opposition to the resolution itself. Therefore, Your Reference
11 Committee recommends that Resolution 312 be adopted.

DRAFT

RECOMMENDED FOR ADOPTION AS AMENDED

- 1
2
3 (3) RESOLUTION 301 - PREVENTING SLEEP
4 DEPRIVATION AND SUPPORTING MEDICAL STUDENT
5 WELLNESS

6
7 RECOMMENDATION A:

8
9 Your Reference Committee recommends that Resolution
10 301 be amended by addition and deletion to read as follows:

11
12 RESOLVED, that our American Medical Association
13 support encourage the LCME, COCA, AAMC, and AACOM
14 to continue the development of guidelines for medical
15 student work-hour limits, time off after a 24-hour shift, and
16 work-hour guidelines.

17
18 RECOMMENDATION B:

19
20 Your Reference Committee recommends that Resolution
21 301 be adopted as amended.

22
23
24 **HOD ACTION: Resolution 301 adopted as amended.**

25
26 **ADOPTED LANGUAGE:**

27
28 **RESOLVED, that our American Medical Association encourage the LCME, COCA,**
29 **AAMC, and AACOM to continue the development of guidelines for medical student**
30 **work-hour limits, time off after a 24-hour shift, and work-hour guidelines.**

31
32
33 RESOLVED, that our American Medical Association support the development of national
34 standards to act as the official guideline for medical student work-hour limits, time off after
35 a 24-hour shift, and work-hour guidelines. (New HOD Policy)

36
37 Resolution 301 received mixed online testimony. The Council on Medical Education
38 recommended this resolution be not adopted, explaining that current LCME and COCA
39 requirements instruct medical schools to develop their own independent policies and this
40 resolution is not the correct mechanism for advocacy. Other testimony was supportive of
41 the resolution and offered amended language, including new language from the author.
42 Your Reference Committee reviewed the proffered language and agrees it is appropriate
43 to encourage ongoing work on guidelines, which differs from dictating specific policies.
44 AAMC and AACOM were added to the proposed language as appropriate entities to
45 develop guidelines in this area. Your Reference Committee therefore recommends that
46 Resolution 301 be adopted as amended.

1 (4) RESOLUTION 304 - SYSTEMIC EXCLUSION OF IMGs
2 FROM RESIDENCY PROGRAMS

3
4 RECOMMENDATION A:

5
6 Your Reference Committee recommends that the first
7 resolve of Resolution 304 be amended by addition and
8 deletion to read as follows:

9
10 RESOLVED, that our AMA ~~reaffirm~~ uphold its commitment
11 to opposing discrimination against IMGs in all aspects of
12 medical education and training;

13
14 RECOMMENDATION B:

15
16 Your Reference Committee recommends that the second
17 and third resolves of Resolution 304 be deleted.

18
19 ~~RESOLVED, that our AMA, through its Council on Medical~~
20 ~~Education, work with the Accreditation Council for Graduate~~
21 ~~Medical Education, the National Resident Matching~~
22 ~~Program, and InTealth to prohibit categorical exclusion of~~
23 ~~IMGs from residency applications; (Directive to Take~~
24 ~~Action); and be it further~~

25
26 ~~RESOLVED, that our AMA, through its Council on Medical~~
27 ~~Education, advocate for mandatory transparency in~~
28 ~~residency program eligibility requirements, including IMG~~
29 ~~eligibility, published in a standardized and accessible format~~
30 ~~(Directive to Take Action).~~

31
32 RECOMMENDATION C:

33
34 Your Reference Committee recommends the addition of a
35 new second resolve to read as follows:

36
37 RESOLVED, that our AMA will work with relevant parties to
38 advocate for universal transparency of residency program
39 eligibility requirements, including IMG eligibility and visa
40 sponsorship policies, in electronic residency application
41 systems and FREIDA™ to be published in a standardized,
42 accessible format, to reduce unnecessary financial and
43 emotional burdens on applicants;

44
45 RECOMMENDATION D:

46
47 Your Reference Committee recommends that Resolution
48 304 be adopted as amended.

1
2 **HOD ACTION: Resolution 304 adopted as amended.**

3
4 **ADOPTED LANGUAGE:**

5
6 **RESOLVED, that our AMA uphold its commitment to opposing discrimination**
7 **against IMGs in all aspects of medical education and training; and be it further**

8
9 **RESOLVED, that our AMA will work with relevant parties to advocate for universal**
10 **transparency of residency program eligibility requirements, including IMG**
11 **eligibility and visa sponsorship policies, in electronic residency application**
12 **systems and FREIDA™ to be published in a standardized, accessible format, to**
13 **reduce unnecessary financial and emotional burdens on applicants.**
14

15
16 RESOLVED, that our AMA reaffirm its commitment to opposing discrimination against
17 IMGs in all aspects of medical education and training (Directive to Take Action); and be it

18
19 RESOLVED, that our AMA, through its Council on Medical Education, work with the
20 Accreditation Council for Graduate Medical Education, the National Resident Matching
21 Program, and InTealth to prohibit categorical exclusion of IMGs from residency
22 applications; (Directive to Take Action); and be it further

23
24 RESOLVED, that our AMA, through its Council on Medical Education, advocate for
25 mandatory transparency in residency program eligibility requirements, including IMG
26 eligibility, published in a standardized and accessible format (Directive to Take Action).

27 Resolution 304 received mixed but favorable testimony. In the ORC, AMA staff provided
28 AMA policies that could be considered for reaffirmation (H-255.988; D-310.977) in lieu of
29 this resolution. The Council on Medical Education also recommended reaffirmation, citing
30 H-255.988 and H-255.963, which was supported by another testimony. Others offered
31 comments as well as amended language, emphasizing the critical importance of IMGs to
32 the physician workforce, structural threats to IMGs, and gaps in policies suggested for
33 reaffirmation.

34
35 In-person testimony favored a proposed alternate second resolve to replace the second
36 and third resolves of the preliminary report. This alternate language, and testimony
37 supportive of it, recognized that some programs are financially or logistically incapable of
38 offering visa sponsorship, and focused on the vital importance of transparency in order to
39 alleviate significant time and financial burdens on applicants and programs when IMGs
40 unknowingly apply to programs that cannot consider them. Testimony also raised
41 questions about lack of access to FREIDA™ for non-AMA members; therefore, language
42 also includes reporting mechanisms other than FREIDA. Substantial testimony focused
43 on the pros and cons of using the word “mandatory” regarding transparency. The Council
44 on Medical Education and others noted that transparency, while vital, cannot realistically
45 be mandated within the medical education community, as there is no mechanism to
46 enforce it. Your Reference Committee also discussed the possibility that “mandatory”
47 language could harm the process of work toward transparency by harming the AMA’s
48 relationships and collaboration with the relevant parties. Your Reference Committee
49 instead proffered “universal” language to reflect the spirit of the amendment: the goal of

1 full transparency within all residency application systems, as well as FREIDA when
2 possible. Your Reference Committee recommends that Resolution 304 be adopted as
3 amended.

4
5 (5) RESOLUTION 305 - PAID SICK LEAVE AND FLEXIBLE
6 WORK ARRANGEMENTS FOR CAREGIVERS OF
7 INDIVIDUALS WITH SPECIAL NEEDS, CHRONIC
8 ILLNESS, OR ELDERLY PARENTS

9
10 RECOMMENDATION A:

11
12 Your Reference Committee recommends that the first
13 resolve of Resolution 305 be amended by addition and
14 deletion to read as follows:

15
16 RESOLVED, that our American Medical Association amend
17 H-420.979, "AMA Statement on Family, Medical, and Safe
18 Leave," by addition as follows:

19
20 Our American Medical Association supports policies that
21 provide employees with reasonable job security and
22 continued availability of health plan benefits in the event
23 leave by an employee becomes necessary due to
24 documented medical conditions, caregiving obligations, or
25 reasons related to personal safety. Such policies should
26 provide for reasonable periods of paid or unpaid:

- 27 1. Medical leave for the employee, including pregnancy,
28 abortion, and stillbirth.
- 29 2. ~~Maternity and paternity~~ Parental leave for the employee.
- 30 3. Leave if medically appropriate to care for a member of the
31 employee's immediate family, i.e., a spouse, children, ~~or~~
32 elderly parents, or other individual for whom the employee
33 is the primary caregiver.
- 34 4. Leave for adoption or for foster care leading to adoption.
- 35 5. Safe leave provisions for those experiencing any
36 instances of violence, including but not limited to intimate
37 partner violence, sexual violence or coercion, and stalking.
- 38 6. Flexible work arrangements such as flexible work hours
39 and the ability to work remotely, without creating intolerable
40 increases in the workloads of other physicians and students.

41
42 Such periods of leave may differ with respect to each of the
43 foregoing classifications and may vary by categories of
44 employers. Such policies should encourage voluntary
45 programs by employers and may provide for appropriate
46 legislation (with or without financial assistance from
47 government). Any legislative proposals will be reviewed
48 through the Association's normal legislative process for
49 appropriateness, taking into consideration all elements
50 therein, including classifications of employees and
51 employers, reasons for the leave, periods of leave

1 recognized (whether paid or unpaid), obligations on return
2 from leave, and other factors involved in order to achieve
3 reasonable objectives recognizing the legitimate needs of
4 employees and employers. Our AMA recognizes the
5 positive impact of paid safe leave on public health outcomes
6 and supports legislation that offers safe leave.

7
8 **RECOMMENDATION B:**

9
10 Your Reference Committee recommends that the second
11 resolve of Resolution 305 be amended by addition and
12 deletion to read as follows:

13
14 RESOLVED, that our AMA supports physicians ~~mothers~~
15 who are caregivers to alleviate physician burnout.

16 **RECOMMENDATION C:**

17
18 Your Reference Committee recommends that Resolution
19 305 be adopted as amended.

20
21 **RECOMMENDATION D:**

22
23 Your Reference Committee recommends a change in title to
24 read as follows:

25
26 PAID SICK LEAVE AND FLEXIBLE WORK
27 ARRANGEMENTS FOR PHYSICIANS WHO ARE
28 CAREGIVERS
29

30
31 **HOD ACTION: Resolution 305 adopted as amended.**

32
33 **ADOPTED LANGUAGE:**

34
35 **PAID SICK LEAVE AND FLEXIBLE WORK ARRANGEMENTS FOR PHYSICIANS**
36 **WHO ARE CAREGIVERS**

37
38 **RESOLVED, that our American Medical Association amend H-420.979, “AMA**
39 **Statement on Family, Medical, and Safe Leave” to read as follows:**

40
41 **Our American Medical Association supports policies that provide employees**
42 **with reasonable job security and continued availability of health plan**
43 **benefits in the event leave by an employee becomes necessary due to**
44 **documented medical conditions, caregiving obligations, or reasons related**
45 **to personal safety. Such policies should provide for reasonable periods of**
46 **paid or unpaid:**

- 47 **1. Medical leave for the employee, including pregnancy, abortion, and**
48 **stillbirth.**
49 **2. Parental leave for the employee.**

1 **3. Leave if medically appropriate to care for a member of the employee’s**
2 **family, i.e., a spouse, children, or other individual for whom the employee is**
3 **the primary caregiver.**

4 **4. Leave for adoption or foster care leading to adoption.**

5 **5. Safe leave provisions for those experiencing any instances of violence,**
6 **including but not limited to intimate partner violence, sexual violence or**
7 **coercion, and stalking.**

8 **6. Flexible work arrangements such as flexible work hours and the ability to**
9 **work remotely, without creating intolerable increases in the workloads of**
10 **other physicians and students.**

11
12 **Such periods of leave may differ with respect to each of the foregoing**
13 **classifications and may vary by categories of employers. Such policies**
14 **should encourage voluntary programs by employers and may provide for**
15 **appropriate legislation (with or without financial assistance from**
16 **government). Any legislative proposals will be reviewed through the**
17 **Association’s normal legislative process for appropriateness, taking into**
18 **consideration all elements therein, including classifications of employees**
19 **and employers, reasons for the leave, periods of leave recognized (whether**
20 **paid or unpaid), obligations on return from leave, and other factors involved**
21 **in order to achieve reasonable objectives recognizing the legitimate needs**
22 **of employees and employers. Our AMA recognizes the positive impact of**
23 **paid safe leave on public health outcomes and supports legislation that**
24 **offers safe leave.**

25
26 **RESOLVED, that our AMA supports physicians who are caregivers to alleviate**
27 **physician burnout.**
28

29
30 **RESOLVED, that our American Medical Association that our American Medical**
31 **Association amend H-420.979, “AMA Statement on Family, Medical, and Safe Leave”, by**
32 **addition as follows:**
33

34 **Our American Medical Association supports policies that provide employees with**
35 **reasonable job security and continued availability of health plan benefits in the event leave**
36 **by an employee becomes necessary due to documented medical conditions, caregiving**
37 **obligations, or reasons related to personal safety. Such policies should provide for**
38 **reasonable periods of paid or unpaid:**
39

- 40 **1. Medical leave for the employee, including pregnancy, abortion, and stillbirth.**
41 **2. Maternity and paternity leave for the employee.**
42 **3. Leave if medically appropriate to care for a member of the employee’s immediate**
43 **family, i.e., a spouse, or children, or elderly parents.**
44 **4. Leave for adoption or for foster care leading to adoption.**
45 **5. Safe leave provisions for those experiencing any instances of violence, including**
46 **but not limited to intimate partner violence, sexual violence or coercion, and**
47 **stalking.**
48 **6. Flexible work arrangements such as flexible work hours and the ability to work**
49 **remotely.**
50

1 Such periods of leave may differ with respect to each of the foregoing classifications and
2 may vary with reasonable categories of employers. Such policies should encourage
3 voluntary programs by employers and may provide for appropriate legislation (with or
4 without financial assistance from government). Any legislative proposals will be reviewed
5 through the Association's normal legislative process for appropriateness, taking into
6 consideration all elements therein, including classifications of employees and employers,
7 reasons for the leave, periods of leave recognized (whether paid or unpaid), obligations
8 on return from leave, and other factors involved in order to achieve reasonable objectives
9 recognizing the legitimate needs of employees and employers.

10
11 Our AMA recognizes the positive impact of paid safe leave on public health outcomes and
12 supports legislation that offers safe leave; and be it further

13
14 RESOLVED, that our AMA supports physician mothers who are caregivers to alleviate
15 physician burnout.

16
17 Resolution 305 received mixed, but favorable online testimony. The Council on Medical
18 Education offered amended language for the first resolve and suggested that the second
19 resolve be not adopted. Most of the testimony favored adoption with amended language
20 to make the policy more inclusive and consistent with AMA principles of equity. There was
21 also testimony to request the word "elderly" be omitted since not all parents may be
22 considered elderly. Reference Committee recommends that Resolution 305 be adopted
23 as amended with a change in title.

24
25 (6) RESOLUTION 306 - SUPPORT FOR PAID PRENATAL
26 LEAVE

27
28 RECOMMENDATION A:

29
30 Your Reference Committee recommends that the first
31 resolve of Resolution 306 be amended by addition and
32 deletion to read as follows:

33
34 RESOLVED, that our American Medical Association
35 supports policies that provide physician employees,
36 ~~particularly larger organizations and those with the capacity~~
37 ~~and resources,~~ with paid leave for routine prenatal care or
38 any medical care related to pregnancy in addition to other
39 existing forms of leave.

40
41 RECOMMENDATION B

42
43 Your Reference Committee recommends that the second
44 resolve of Resolution 306 be deleted.

1 ~~RESOLVED, that our AMA supports the creation of state~~
2 ~~sponsored programs that cover family and medical leave.~~

3
4 RECOMMENDATION C:

5
6 Your Reference Committee recommends that Resolution
7 306 be adopted as amended.

8
9 RECOMMENDATION D:

10
11 Your Reference Committee recommends a change in title to
12 read as follows:

13
14 SUPPORT FOR PAID LEAVE FOR PRENATAL CARE
15

16
17 **HOD ACTION: Resolution 306 adopted as amended.**

18
19 **ADOPTED LANGUAGE:**

20
21 **SUPPORT FOR PAID LEAVE FOR PRENATAL CARE**

22
23 **RESOLVED, that our American Medical Association supports policies that provide**
24 **physician employees with paid leave for routine prenatal care or any medical care**
25 **related to pregnancy in addition to other existing forms of leave.**
26

27
28 RESOLVED, that our American Medical Association supports policies that provide
29 employees, particularly larger organizations and those with the capacity and resources,
30 with paid leave for prenatal care or any medical care related to pregnancy in addition to
31 other existing forms of leave; and be it further

32 RESOLVED, that our AMA supports the creation of state sponsored programs that cover
33 family and medical leave.
34

35 Resolution 306 received mixed but favorable online testimony. While some testimony
36 favored adoption as written, others offered comments and amended language for
37 consideration. One testimony proffered an amended title that reads, "Support for Paid
38 Leave for Prenatal Care." Your Reference Committee agrees with the change in title. Your
39 Reference Committee recommends that Resolution 306 be adopted as amended with a
40 change in title.

1 (7) RESOLUTION 307 - INTEGRATING ARTIFICIAL
2 INTELLIGENCE (AI) LITERACY INTO UME, GME, AND
3 CME

4
5 RECOMMENDATION A:

6
7 Your Reference Committee recommends that the second
8 resolve of Resolution 307 be amended by addition and
9 deletion to read as follows:

10
11 RESOLVED, that our AMA collaborate with ~~LCME and~~
12 ~~ACGME~~ medical organizations to recognize AI literacy
13 elements ~~within accreditation and program requirements~~
14 where appropriate (Directive to Take Action);

15
16 RECOMMENDATION B:

17
18 Your Reference Committee recommends that the third
19 resolve of Resolution 307 be amended by addition to read
20 as follows:

21
22 RESOLVED, that our AMA support AI CME offerings to
23 upskill the current workforce

24
25 RECOMMENDATION C:

26
27 Your Reference Committee recommends that the fourth
28 resolve of Resolution 307 be adopted by addition and
29 deletion to read as follows:

30
31 RESOLVED, that our AMA ~~advocate~~ for funding and faculty-
32 ~~development~~ resources to implement and evaluate ~~such AI~~
33 ~~training initiatives~~ (Directive to Take Action);

34
35 RECOMMENDATION D:

36
37 Your Reference Committee recommends that the fifth
38 resolve of Resolution 307 be deleted.

39
40 ~~RESOLVED, that our AMA report back on progress,~~
41 ~~including uptake metrics, learner outcomes, and best~~
42 ~~practices for equitable implementation across diverse~~
43 ~~institutions.~~

44
45 RECOMMENDATION E:

46
47 Your Reference Committee recommends that Resolution
307 be adopted as amended.

1 RECOMMENDATION F:
23 Your Reference Committee recommends a change in title to
4 read as follows:
56 INTEGRATING AUGMENTED INTELLIGENCE (AI)
7 LITERACY INTO UME, GME, AND CME
89
10 **HOD ACTION: Resolution 307 adopted as amended.**11
12 **ADOPTED LANGUAGE:**13
14 **INTEGRATING AUGMENTED INTELLIGENCE (AI) LITERACY INTO UME, GME, AND**
15 **CME**16
17 **RESOLVED, that our American Medical Association develop and disseminate**
18 **model AI learning objectives and curricular toolkits aligned with existing AMA**
19 **policy and AAMC principles; and be it further**
2021 **RESOLVED, that our AMA collaborate with medical organizations to recognize AI**
22 **literacy elements where appropriate; and be it further**
2324 **RESOLVED, that our AMA support AI CME offerings to upskill the current**
25 **workforce; and be it further**
2627 **RESOLVED, that our AMA advocate for funding and faculty-development resources**
28 **to implement and evaluate AI training initiatives.**
2930
31 **RESOLVED, that our American Medical Association develop and disseminate model AI**
32 **learning objectives and curricular toolkits aligned with existing AMA policy and AAMC**
33 **principles; and be it further**
3435 **RESOLVED, that our AMA collaborate with LCME and ACGME to recognize AI literacy**
36 **elements within accreditation and program requirements where appropriate; and be it**
37 **further**38 **RESOLVED, that our AMA support CME offerings to upskill the current workforce; and be**
39 **it further**
4041 **RESOLVED, that our AMA advocate for funding and faculty-development resources to**
42 **implement and evaluate such training initiatives; and be it further**
4344 **RESOLVED, that our AMA report back on progress, including uptake metrics, learner**
45 **outcomes, and best practices for equitable implementation across diverse institutions.**
4647 Resolution 307 received mixed but mostly favorable online testimony. One testimony
48 favored not adoption, indicating that the resolution appears to seek a curriculum mandate.
49 Several testimonies made reference to the work the AMA is presently doing in this space,
50 including the recent establishment of the Center for Digital Health and AI. While some

1 testimony favored adoption, others offered amended language. The Council on Medical
2 Education recommended the following actions: the first resolve be adopted; the second,
3 third, and fourth resolves be amended; and the fifth resolve not be adopted. Other
4 testimony concurred with the Council. Your Reference Committee acknowledges the term
5 “augmented intelligence” (AI) as a conceptualization of artificial intelligence that focuses
6 on AI’s assistive role, emphasizing that its design enhances human intelligence rather
7 than replaces it. Thus, your Reference Committee recommends that Resolution 307 be
8 adopted as amended with a change in title.

9
10 (8) RESOLUTION 308 - ENHANCING THE PATHWAY FOR
11 BLACK MALE MEDICAL STUDENTS

12
13 RECOMMENDATION A:

14
15 Your Reference Committee recommends that the fifth
16 resolve of Resolution 308 be amended by addition to read
17 as follows:

18
19 RESOLVED, that our AMA encourage collaboration
20 between our AMA, medical schools, HBCUs, and
21 community organizations to increase pathways for Black
22 male students in medicine.

23
24 RECOMMENDATION B:

25
26 Your Reference Committee recommends that the second
27 and third resolves of Resolution 308 be deleted.

28
29 RECOMMENDATION C:

30
31 Your Reference Committee recommends that policies H-
32 305.925, D-200.982, D-200.980 and H-295.851 be
33 reaffirmed.

34
35 RECOMMENDATION D:

36
37 Your Reference Committee recommends that Resolution
38 308 be adopted as amended.
39

40
41 **HOD ACTION: Resolution 308 adopted as amended.**

42
43 **ADOPTED LANGUAGE:**

44
45 **RESOLVED, that, consistent with applicable laws, our American Medical**
46 **Association support the development and funding of comprehensive mentorship**
47 **programs connecting Black male pre-medical students with physician mentors,**
48 **guiding academic preparation, MCAT preparation, the medical school application**
49 **process, and career development; and be it further**

1 **RESOLVED, that, consistent with applicable laws, our AMA support the**
2 **development of leadership training programs for Black male physicians, equipping**
3 **them with the skills and knowledge to assume leadership roles in academic**
4 **medicine, healthcare administration, and public health; and be it further**
5

6 **RESOLVED, that our AMA encourage collaboration between our AMA, medical**
7 **schools, HBCUs, and community organizations to increase pathways for Black**
8 **male students in medicine.**
9

10 **Policies H-305.925, D-200.982, D-200.980 and H-295.851 be reaffirmed.**
11

12
13 RESOLVED, that, consistent with applicable laws, our American Medical Association
14 support the development and funding of comprehensive mentorship programs connecting
15 Black male pre-medical students with physician mentors, guiding academic preparation,
16 MCAT preparation, the medical school application process, and career development; and
17 be it further
18

19 RESOLVED, that, consistent with applicable laws, our AMA promote the expansion of loan
20 repayment programs specifically designed to incentivize physicians to practice in
21 underserved communities, where Black male populations are often concentrated; and be
22 it further
23

24 RESOLVED, that, consistent with applicable laws, our AMA develop faculty to promote
25 unbiased assessment of the performance of medical learners to reduce disparities in
26 medical school matriculation; and be it further
27

28 RESOLVED, that, consistent with applicable laws, our AMA support the development of
29 leadership training programs for Black male physicians, equipping them with the skills and
30 knowledge to assume leadership roles in academic medicine, healthcare administration,
31 and public health; and be it further
32

33 RESOLVED, that our AMA encourage collaboration between our AMA, medical schools,
34 HBCUs, and community organizations.
35

36 Resolution 308 received supportive online testimony. The Council on Medical Education
37 was in favor of the first and fourth resolves, but not the fifth resolve, and suggested that
38 policies be reaffirmed in lieu of the second and third resolves. One testimony concurred
39 with the Council. Other testimony was supportive of adoption, including additional
40 testimony from the author that stressed the value that Black men bring to the physician
41 workforce. Your Reference Committee concurs with the Council on the first four resolves.
42 Your Reference Committee supports retaining the fifth resolve, including the Council's
43 added language to make the purpose of the collaboration clearer. Your Reference
44 Committee recommends that Resolution 308 be adopted as amended.

45 (9) RESOLUTION 309 - REASONABLE WORKPLACE
46 ACCOMMODATIONS FOR RESIDENTS AND FELLOWS
47 DURING PREGNANCY

1 RECOMMENDATION A:
2

3 Your Reference Committee recommends that the first
4 resolve of Resolution 309 be amended by addition and
5 deletion to read as follows:
6

7 RESOLVED, that our American Medical Association ~~work~~
8 advocate that with relevant stakeholders parties to support
9 ~~the implementation of the following guidelines for all~~
10 ~~residency training programs:~~

11 ~~a) Programs should provide evidence-based~~
12 ~~accommodations for all pregnant physician trainees and~~
13 ~~physician staff, such as opting out of night shifts during the~~
14 ~~first and third trimesters and attending scheduled medical~~
15 ~~appointments, and should implement them in such a way~~
16 ~~that they do not place an increased intolerable burden of~~
17 ~~work on other physician trainees and physician staff; and b)~~
18 ~~Scheduling for pregnant physicians in the third trimester~~
19 ~~should prioritize rotations with easily cancellable/coverable~~
20 ~~shifts to minimize departmental disruption in the event of~~
21 ~~medical necessity or early delivery; (Directive to Take~~
22 ~~Action) and be it further~~

23
24 RECOMMENDATION B:
25

26 Your Reference Committee recommends that the second
27 resolve of Resolution 309 be amended by addition to read
28 as follows:

29 RESOLVED, that our AMA supports evidence-based
30 policies and procedures which prioritize the safety and well-
31 being of all pregnant physicians. (New HOD Policy)
32

33 RECOMMENDATION C:
34

35 Your Reference Committee recommends that Resolution
36 309 be adopted as amended.
37

38
39 **HOD ACTION: Resolution 309 adopted as amended.**

40
41 **ADOPTED LANGUAGE:**
42

43 **RESOLVED, that our American Medical Association advocate that relevant parties**
44 **provide evidence-based accommodations for all pregnant physician trainees and**
45 **physician staff and should implement them in such a way that they do not place an**
46 **intolerable burden of work on other physician trainees and physician staff, and**
47 **minimize departmental disruption in the event of medical necessity or early**
48 **delivery; and be it further**

1 **RESOLVED, that our AMA supports evidence-based policies and procedures which**
2 **prioritize the safety and well-being of all pregnant physicians.**
3

4
5 RESOLVED, that our American Medical Association (AMA) work with relevant
6 stakeholders to support the implementation of the following guidelines for all residency
7 training programs:

- 8 a. Programs should provide evidence-based accommodations for pregnant trainees,
9 such as opting out of night shifts during the first and third trimesters and attending
10 scheduled medical appointments, and should implement them in such a way that
11 they do not place an increased burden of work on other trainees; and
12 b. Scheduling for pregnant physicians in the third trimester should prioritize rotations
13 with easily cancellable/coverable shifts to minimize departmental disruption in the
14 event of medical necessity or early delivery; and be it further

15
16 RESOLVED, that our AMA supports evidence-based policies and procedures which
17 prioritize the safety and well-being of pregnant physicians.
18

19 Resolution 309 received mixed testimony. Online testimony noted concerns about the
20 over-prescriptive nature of the first resolve as well as concerns about exerting prioritization
21 in the second resolve, while other testimony favored the resolution. In-person testimony
22 was provided offering amendments by addition and deletion to address these concerns.
23 Other testimony favored these amendments. Your Reference Committee also supports
24 the amendments and offered additional amendments to each resolve to further clarify the
25 intent of the testimony. Thus, your Reference Committee recommends that Resolution
26 309 be adopted as amended.
27

28 (10) RESOLUTION 310 - REMEDYING THE HARMS OF
29 AMA'S ROLE IN THE FLEXNER REPORT
30

31 RECOMMENDATION A:
32

33 Your Reference Committee recommends that the first
34 resolve of Resolution 310 be amended by addition and
35 deletion to read as follows:
36

37 RESOLVED, that our American Medical Association (AMA)
38 partner with relevant public and private sector organizations
39 and ~~community stakeholders~~ relevant parties to promote
40 ~~make a transformative financial investment into~~ the opening
41 of new medical schools and sustainability of existing
42 medical schools affiliated with Historically Black Colleges &
43 Universities (HBCUs), Tribal Colleges & Universities
44 (TCUs), and other Minority Serving Institutions (MSIs);
45 ~~remedying the harms of the 1910 Flexner Report in regards~~
46 ~~to the diversity of the physician workforce, and advancing~~
47 ~~population health equity~~ (Directive to Take Action); and be it
48 further

1 RECOMMENDATION B:
2

3 Your Reference Committee recommends that the second
4 resolve of Resolution 310 be amended by addition and
5 deletion to read as follows:
6

7 RESOLVED, that our AMA prioritize our organization's
8 efforts to bolster diversity, equity, and inclusion across the
9 medical education continuum, as part of our strategic
10 commitments towards restorative justice to promote truth,
11 reconciliation, and healing in medicine and medical
12 education, and to address remedying the harms of the 1910
13 Flexner Report, diversifying the physician workforce, and
14 advancing population health equity.

15
16 RECOMMENDATION C:

17
18 Your Reference Committee recommends that Resolution
19 310 be adopted as amended.
20

21 RECOMMENDATION D:

22
23 Your Reference Committee recommends a change in title to
24 read as follows:
25

26 ADDRESSING THE HARMS OF AMA'S ROLE IN THE
27 FLEXNER REPORT
28

29
30 HOD ACTION: Alternate Resolution 310 adopted in lieu of 310.
31

32 ADOPTED LANGUAGE:

33
34 ADDRESSING THE HARMS OF AMA'S ROLE IN THE FLEXNER REPORT
35

36 RESOLVED, that our American Medical Association (AMA) partner with relevant
37 public and private sector organizations and relevant parties to advance restorative
38 efforts that address the harms of the 1910 Flexner Report by promoting and
39 supporting the development, opening, and/or reopening of medical schools in
40 historically marginalized and underserved communities, including those affiliated
41 with Historically Black Colleges & Universities (HBCUs), Tribal Colleges &
42 Universities (TCUs), and Minority-Serving Institutions (MSIs) through collaborative
43 feasibility assessments, resource development partnerships, and community-
44 guided planning processes, among others; and be it further
45

46 RESOLVED, that our AMA prioritize our organization's efforts to bolster diversity,
47 equity, and inclusion across the medical education continuum, including but not
48 limited to supporting structural pathways, culturally responsive curricula, and
49 accountability mechanisms that strengthen recruitment, retention, and
50 advancement of historically marginalized groups in medicine.

1
2
3 RESOLVED, that our American Medical Association (AMA) partner with relevant public
4 and private sector organizations and community stakeholders to make a transformative
5 financial investment into the opening of new medical schools and sustainability of existing
6 medical schools affiliated with Historically Black Colleges & Universities (HBCUs), Tribal
7 Colleges & Universities (TCUs), and other Minority Serving Institutions (MSIs), remedying
8 the harms of the 1910 Flexner Report in regards to the diversity of the physician workforce,
9 and advancing population health equity; and be it further

10
11 RESOLVED, that our AMA prioritize our organization's efforts to bolster diversity, equity,
12 and inclusion across the medical education continuum, as part of our strategic
13 commitments to remedying the harms of the 1910 Flexner Report, diversifying the
14 physician workforce, and advancing population health equity.

15
16 Resolution 310 received mixed online and in-person testimony. The Council on Medical
17 Education originally recommended this resolution not be adopted, explaining the first
18 resolve would be a conflict of interest since the AMA is a co-sponsor of the LCME that
19 accredits medical schools. Further, they expressed concern that the fiscal note would fall
20 outside of the AMA's current strategic plan and budget. This concern was further amplified
21 by the Board of Trustees who testified that the projected implementation costs,
22 approximately in excess of \$1B, exceed the organization's available financial resources.
23 The Council on Medical Education proffered amended language to support the spirit of the
24 resolution. Other testimony favored adoption of the original language. Your Reference
25 Committee agrees with the spirit of this resolution, the recognition of harms cause by the
26 AMA's role in the Flexner Report, as acknowledged in policy H-350.960, and the
27 importance of action towards restorative justice. However, Your Reference Committee is
28 also sensitive to the significant fiscal impact adoption of this resolution would have on the
29 organization. Your Reference Committee believes the amended language proffered by the
30 Council, with modifications, provides a pathway for AMA to continue making meaningful
31 contributions towards the development of a diverse workforce that can meet the needs of
32 the U.S. population while being fiscally solvent. Therefore, your Reference Committee
33 recommends that Resolution 310 be adopted as amended.

34
35 (11) RESOLUTION 311 - GENDER AND URIM DISPARITIES
36 IN SURGICAL TRAINING VOLUMES

37
38 RECOMMENDATION A:

39
40 Your Reference Committee recommends that the first
41 resolve of Resolution 311 be amended by addition and
42 deletion to read as follows:

43
44 RESOLVED, that our American Medical Association
45 recognizes gender- and underrepresented in medicine
46 URIM-based disparities in procedural and surgical case
47 training volumes as an equity issue in graduate medical
48 education, distinct from resident competency (New HOD
49 Policy); and be it further

1 RECOMMENDATION B:
2

3 Your Reference Committee recommends that the second
4 resolve of Resolution 311 be deleted.

5
6 ~~RESOLVED, that our AMA advocate for the Accreditation~~
7 ~~Council for Graduate Medical Education (ACGME) and~~
8 ~~specialty boards to collect and publish aggregate, de-~~
9 ~~identified surgical case volume data stratified by gender and~~
10 ~~URiM status (Directive to Take Action); and be it further~~

11
12 RECOMMENDATION C:
13

14 Your Reference Committee recommends the addition of a
15 new second resolve to read as follows:

16
17 RESOLVED, that our AMA encourage the Accreditation
18 Council for Graduate Medical Education (ACGME) and
19 specialty boards to collect aggregate, de-identified
20 procedural and surgical case volume data stratified by
21 gender and underrepresented in medicine status, and to
22 make these data available through a controlled-access
23 process to institutional leaders and residency and fellowship
24 programs (Directive to Take Action).

25
26 RECOMMENDATION D:
27

28 Your Reference Committee recommends that the third
29 resolve of Resolution 311 be amended by addition and
30 deletion to read as follows:

31
32 ~~RESOLVED, that our AMA encourage advocate that~~
33 ~~surgical residency and fellowship programs to implement~~
34 ~~monitoring mechanisms to promote equitable procedure~~
35 ~~procedural and surgical case allocation, while recognizing~~
36 ~~reaffirming that all graduates must meet established training~~
37 ~~requirements (Directive to Take Action); and be it further~~

38
39 RECOMMENDATION E:
40

41 Your Reference Committee recommends that the fourth
42 resolve of Resolution 311 be amended by addition and
43 deletion to read as follows:

44 ~~RESOLVED, that our AMA encourage support—the~~
45 ~~development and dissemination of best practices to~~
46 ~~include—including mentorship and initiatives, equitable~~
47 ~~case distribution systems, and supportive leave policies—to~~
48 ~~ensure fairness in procedural and surgical operative case~~
49 ~~experience across all surgical specialties (New HOD Policy)~~

1 RECOMMENDATION F:

2
3 Your Reference Committee recommends that Resolution
4 311 be adopted as amended.

5
6 RECOMMENDATION G:

7
8 Your Reference Committee recommends a change in title to
9 read as follows:

10
11 GENDER AND UNDERREPRESENTED IN MEDICINE
12 DISPARITIES IN PROCEDURAL AND SURGICAL
13 TRAINING VOLUMES
14

15
16 **HOD ACTION: Resolution 311 adopted as amended.**

17
18 **ADOPTED LANGUAGE:**

19
20 **GENDER AND UNDERREPRESENTED IN MEDICINE DISPARITIES IN PROCEDURAL
21 AND SURGICAL TRAINING VOLUMES**

22
23 **RESOLVED, that our American Medical Association recognizes gender- and
24 underrepresented in medicine-based disparities in procedural and surgical case
25 training volumes as an equity issue in graduate medical education, distinct from
26 resident competency; and be it further**

27
28 **RESOLVED, that our AMA encourage the Accreditation Council for Graduate
29 Medical Education (ACGME) and specialty boards to collect aggregate, de-identified
30 procedural and surgical case volume data stratified by gender and
31 underrepresented in medicine status, and to make these data available through a
32 controlled-access process to institutional leaders and residency and fellowship
33 programs; and be it further**

34
35 **RESOLVED, that our AMA encourage residency and fellowship programs to
36 implement mechanisms to promote equitable procedural and surgical case
37 allocation, while recognizing that all graduates must meet established training
38 requirements; and be it further**

39
40 **RESOLVED, that our AMA encourage the development and dissemination of best
41 practices to include mentorship and equitable case distribution systems to ensure
42 fairness in procedural and surgical case experience across all specialties.**
43

44
45 **RESOLVED, that our American Medical Association recognize gender- and URiM-based
46 disparities in surgical training volumes as an equity issue in graduate medical education,
47 distinct from resident competency (Directive to Take Action); and be it further**

48
49 **RESOLVED, that our AMA advocate for the Accreditation Council for Graduate Medical
50 Education (ACGME) and specialty boards to collect and publish aggregate, de-identified**

1 surgical case volume data stratified by gender and URiM status (Directive to Take Action);
2 and be it further

3
4 RESOLVED, that our AMA advocate that surgical residency and fellowship programs
5 implement monitoring mechanisms to promote equitable case allocation, while reaffirming
6 that all graduates meet established training requirements (Directive to Take Action); and
7 be it further

8
9 RESOLVED, that our AMA support the development and dissemination of best practices—
10 including mentorship initiatives, equitable case distribution systems, and supportive leave
11 policies—to ensure fairness in operative experience across all surgical specialties
12 (Directive to Take Action)

13
14 Resolution 311 received mixed, but favorable testimony. While some testimony supported
15 adoption, others offered amended language. Some testimony suggested inclusion of
16 “procedural” rather than only those performed during surgical training throughout the
17 resolution; Your Reference Committee concurred. In-person testimony offered alternate
18 language for the second resolve to address surgical case volume and others supported it.
19 Your Reference Committee also supported the alternate second resolve. Further, Your
20 Reference Committee offered amendments to the others three resolves as well as the title
21 to clarify points raised. Thus, Your Reference Committee recommends that Resolution
22 311 be adopted as amended with a change in title.

23
24 (12) RESOLUTION 313 - HARDSHIP FOR INTERNATIONAL
25 MEDICAL GRADUATES FROM PALESTINE

26
27 RECOMMENDATION A:

28
29 Your Reference Committee recommends that the first
30 resolve of Resolution 313 be amended by addition and
31 deletion to read as follows:

32
33 RESOLVED, that our American Medical Association
34 advocate with relevant parties stakeholders that advise
35 state medical boards to develop alternative pathways such
36 as a hardship waiver for primary source verification of
37 medical education for all licensing requirements for
38 physicians who graduated from medical schools in regions
39 of humanitarian crisis or conflict zones, including Palestine
40 until the current humanitarian crisis in Palestine is resolved;
41 and be it further

1 RECOMMENDATION B:
2

3 Your Reference Committee recommends that the second
4 resolve of Resolution 313 be amended by addition and
5 deletion to read as follows:
6

7 RESOLVED, that our AMA advocate with relevant parties
8 ~~stakeholders~~ to consider waiving the requirement that the
9 Statement of Need for visa application come directly from a
10 federal/central Ministry of Health office for physicians from
11 regions of humanitarian crisis or conflict zones, including
12 Palestinian physicians, who matched to residency or
13 fellowship in the U.S. until the resolution of the current
14 ~~humanitarian crisis in Palestine.~~

15
16 RECOMMENDATION C:

17
18 Your Reference Committee recommends that Resolution
19 313 be adopted as amended.

20
21 RECOMMENDATION D:

22
23 Your Reference Committee recommends a change in title to
24 read as follows:
25

26 HARDSHIP FOR INTERNATIONAL MEDICAL
27 GRADUATES IN HUMANITARIAN CRISIS OR CONFLICT
28 ZONES
29

30
31 **HOD ACTION: Resolution 313 referred.**
32

33
34 RESOLVED, that our American Medical Association (AMA) advocate with relevant
35 stakeholders that advise state medical boards to develop alternative pathways such as a
36 hardship waiver for primary source verification of medical education for all licensing
37 requirements for physicians who graduated from medical schools in Palestine until the
38 current humanitarian crisis in Palestine is resolved; and be it further

39 RESOLVED, that our AMA advocate with relevant stakeholders to consider waiving the
40 requirement that the Statement of Need for visa application come directly from a
41 federal/central Ministry of Health office for Palestinian physicians who matched to the
42 residency or fellowship in the U.S. until the resolution of the current humanitarian crisis in
43 Palestine.
44

45 Resolution 313 was not available in the ORC and only received in-person testimony.
46 Testimony was mixed, though all supported the spirit of the resolution and acknowledged
47 the moral imperative to support those experiencing hardships from humanitarian crises.
48 Some testimony noted existing policy, such as D-255.974, D-275.989, and a previous
49 Council report, Challenges to Primary Source Verification of International Medical

1 Graduates Resulting from International Conflict, and advocated for either reaffirmation or
2 amendment of policy to focus on humanitarian crises more generally rather than naming
3 specific groups. One individual suggested referral, but other testimony did not support this.
4 Additional testimony noted that AMA policy has precedent for naming specific groups,
5 such as Ukraine in past policy, and emphasized the significant challenges experienced by
6 Palestinian physicians, including the U.S. federal government's suspension of visas for
7 Palestinians specifically.

8
9 Some testimony expressed concerns about varying definitions of Palestine, though
10 Council on Medical Education testimony noted that the Educational Commission for
11 Foreign Medical Graduates maintains a definition for Palestine relevant to their verification
12 work. One amendment, supported by the resolution author, was offered to recognize
13 hardships for Palestinian physicians while not limiting policy to this group. The Council
14 noted that advocacy on these matters should not be limited by the end of an immediate
15 humanitarian crisis, as even after crises are resolved, there may still be hardships with
16 verification, or normal verification processes may resume even amidst crises. Your
17 Reference Committee supports the spirit of this resolution and discussed balancing the
18 immediate needs of this specific group with policy that stays evergreen in future situations.
19 Your Reference Committee offered a change in title to align with this amendment. Your
20 Reference Committee recommends that Resolution 313 be adopted as amended with a
21 change in title.

DRAFT

- 1 This concludes the report of Reference Committee C. I would like to thank Reference
- 2 Committee members Marygrace Elson, MD, MME, Amit Ghose, MD, Rohini Guin,
- 3 Raymond Lorenzoni, MD, Debra Perina, MD, and Cliff Sullivan, MD; staff persons Lena
- 4 Drake, Amber Ryan, MEd, and Tanya Lopez, MS; and all those who testified before the
- 5 Committee.

Marygrace Elson, MD, MME
American College of Obstetricians and
Gynecologists

Raymond Lorenzoni, MD
Connecticut

Amit Ghose, MD
Michigan

Debra Perina, MD
American College of Emergency Physicians

Rohini Guin, MD PhD candidate
Regional Medical Student
Renaissance School of Medicine, Stony
Brook University

H. Clifford Sullivan III, MD
American Society for Clinical Pathology

Rose Berkun, MD
Florida
Chair

DRAFT

DISCLAIMER

The following is a preliminary report of actions taken by the House of Delegates at its 2025 Interim Meeting and should not be considered final. Only the Official Proceedings of the House of Delegates reflect official policy of the Association.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (I-25)

Final Report of Reference Committee on Ethics and Bylaws

Mark Casanova, MD, Chair

RECOMMENDED FOR ADOPTION

- 1
- 2
- 3 1. BOT Report 08 – On the Ethics of Human Lifespan Prolongation
- 4 2. BOT Report 21 – Specialty Society Representation in the House of Delegates -
- 5 Five-Year Review
- 6 3. CEJA Report 01 – Amendment to Opinion 1.1.1 “Patient-Physician
- 7 Relationships”
- 8 4. CEJA Report 02 – Supporting Efforts to Strengthen Medical Staffs Through
- 9 Collective Actions and/or Unionization
- 10 5. CEJA Report 03 – Ethical Impetus for Research in Pregnant and Lactating
- 11 Individuals
- 12 6. Resolution 001 – Clarifying Conscientious Objection
- 13 7. Resolution 005 – Preserving Autonomy in the Patient-Physician Relationship -
- 14 ADOPTED
- 15 8. Resolution 006 – Amendment to AMA Bylaws to Enable Continuity of Leadership
- 16 - ADOPTED
- 17 9. Resolution 008 – Health Plan In-Network Steering of Pathology/Laboratory
- 18 Services - ADOPTED
- 19 10. Resolution 009 – Gender Equity in Disability Insurance for Physicians -
- 20 ADOPTED
- 21

RECOMMENDED FOR ADOPTION AS AMENDED

- 22
- 23
- 24 11. BOT Report 05 – Addressing the Unregulated Body Brokerage Industry
- 25 12. BOT Report 10 – Improving Usability of Electronic Health Records (EHRs) for
- 26 Transgender and Gender Diverse Patients
- 27 13. BOT Report 11 – Supporting Diversity in Research
- 28 14. BOT Report 19 – Addressing the Historical Injustices of Anatomical Specimen
- 29 Use
- 30 15. Resolution 003 – Report on Gender-Based Pay Equity in Medicine – ADOPTED
- 31 AS AMEND
- 32 16. Resolution 007 – Improving Protection for Reproductive Health Information
- 33 ADOPTED AS AMENDED

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17

RECOMMENDED FOR REFERRAL

- 17. CCB Report 02 – Bylaws Clarifications Subsequent to A-25 House of Delegates Meeting
- 18. CCB Report 03 – Credentialing of Temporary Delegates and Alternate Delegates Resolution 010 – Clarifying the Medical Student Section’s and Resident and Fellow Section’s Abilities to Fill Temporary Vacancies in Accordance with the AMA Bylaws
- 19. Resolution 002 – Ensuring Ethical Use of Wearable Recording Devices in Clinical Encounters

RECOMMENDED FOR NOT ADOPTION

- 20. CCB Report 01 – Bylaws Review Report – NOT ADOPT
- 21. Resolution 004 – Patient Options to Restrict Secondary Use of Their Healthcare Data

DRAFT

RECOMMENDED FOR ADOPTION

- 1
2
3
4 (1) BOT REPORT 08 – ON THE ETHICS OF HUMAN
5 LIFESPAN PROLONGATION

6
7 RECOMMENDATION:

8
9 Your Reference Committee recommends that BOT Report
10 08 be adopted and the remainder of the Report be filed.

11
12 **HOD ACTION: Recommendations in BOT Report 08 adopted and the remainder of
13 the report filed.**

14
15
16 The Board of Trustees recommends that Policy D-140.947 be rescinded as having been
17 accomplished by this report and the remainder of the report be filed.

18
19 No online testimony was proffered. Limited in-person testimony was in unanimous
20 support. Your Reference Committee recommends that the report be adopted.

- 21
22
23 (2) BOT REPORT 21 – SPECIALTY SOCIETY
24 REPRESENTATION IN THE HOUSE OF DELEGATES -
25 FIVE-YEAR REVIEW

26
27 RECOMMENDATION:

28
29 Your Reference Committee recommends that BOT Report
30 21 be adopted and the remainder of the Report be filed.

31
32 **HOD ACTION: Recommendations in BOT 21 adopted and the remainder of the
33 report filed.**

34
35
36 The Board of Trustees recommends that the following be adopted, and the remainder of
37 this report be filed:

38
39 1. The American College of Occupational and Environmental Medicine, American
40 Gastroenterological Association, American Geriatrics Society, American Orthopaedic
41 Association, American Psychiatric Association, American Roentgen Ray Society,
42 American Society of Nuclear Cardiology, Society of Cardiovascular Computed
43 Tomography, and Society of Hospital Medicine retain representation in the American
44 Medical Association House of Delegates. (Directive to Take Action)

45
46 2. Having failed to meet the requirements for continued representation in the AMA
47 House of Delegates as set forth in the AMA Bylaw B-8.5.2 The Triological Society be

1 placed on probation and be given one year to work with AMA membership staff to
2 increase their AMA membership. (Directive to Take Action)

3
4 Limited in-person testimony was in unanimous support. Your Reference Committee
5 recommends that the report be adopted.

6
7
8 (3) CEJA REPORT 01 – AMENDMENT TO OPINION 1.1.1
9 “PATIENT-PHYSICIAN RELATIONSHIPS”

10
11 RECOMMENDATION:

12
13 Your Reference Committee recommends that CEJA
14 Report 01 be adopted and the remainder of the Report be
15 filed.

16
17 **HOD ACTION: Recommendations in CEJA Report 01 be adopted and the remainder
18 of the report filed.**

19
20 **ADOPTED LANGUAGE:**

21
22 **The practice of medicine, and its embodiment in the clinical encounter between a
23 patient and a physician, is fundamentally a moral activity that arises from the
24 imperative to care for patients and to alleviate suffering. The relationship that
25 emerges between a patient and a physician must be based on trust. The
26 physician’s obligation to be trustworthy entails additional ethical duties such as a
27 commitment to act for the good of patients; to uphold respect for patients as
28 persons; to develop good communication skills; and to be professionally
29 competent. This trust is fostered by physicians’ ethical responsibilities to place
30 patients’ welfare above the physician’s own self-interest or obligations to others,
31 to use sound medical judgment on patients’ behalf, and to advocate for their
32 patients’ welfare. When external influences negatively impact this trust, or the
33 patient-physician relationship directly, physicians individually and collectively
34 should advocate for changes to ameliorate the situation and promote a more
35 hospitable environment in which patient-physician relationships may flourish.**

36
37 **A patient-physician relationship commences when a physician begins to serve a
38 patient’s medical needs. The contexts that may lead to a patient-physician
39 relationship vary: they generally occur as a response to a request by a patient or a
40 patient’s surrogate, but can also include certain contractual, legally mandated, or
41 emergency settings without the explicit request or consent of the patient.**

42
43 **While the patient-physician relationship may involve one patient and one
44 physician, in today’s complex health care system, such relationships often
45 involve multiple members of a care team, patient family members, and surrogates.
46 The core values of the patient-physician relationship, however, remain
47 unchanged. How these values are implemented will depend on many factors,
48 including the setting, the needs of the patient, the duration of the relationship, and
49 the training, expertise, and experience of the physician, and will necessarily**

1 **reflect the myriad ways that patients and physicians interact. While every patient-**
2 **physician relationship will be different and will change over time, the fundamental**
3 **importance of establishing and sustaining trust through respect for persons, good**
4 **communication, and professional competency will always be crucial at every**
5 **layer, node, and time of the relationship. It is the duty of physicians, therefore, to**
6 **uphold these values and support patients and the primacy of the patient-physician**
7 **relationship to the best of their ability in all practice settings and at all times.**
8

9
10
11 Your Council on Ethical and Judicial Affairs recommends that Opinion 1.1.1, "Patient
12 Physician Relationships" be amended by addition and deletion and the remainder of this
13 report be filed.

14
15 The practice of medicine, and its embodiment in the clinical encounter between a patient
16 and a physician, is fundamentally a moral activity that arises from the imperative to care
17 for patients and to alleviate suffering. ~~The relationship between a patient and a physician~~
18 ~~is based on trust, which gives rise to~~ The relationship that emerges between a patient
19 and a physician must be based on trust. The physician's obligation to be trustworthy
20 entails additional ethical duties such as a commitment to act for the good of patients; to
21 uphold respect for patients as persons; to develop good communication skills; and to be
22 professionally competent. This trust is fostered by physicians' ethical responsibilities to
23 place patients' welfare above the physician's own self-interest or obligations to others, to
24 use sound medical judgment on patients' behalf, and to advocate for their patients'
25 welfare. When external influences negatively impact this trust, or the patient-physician
26 relationship directly, physicians individually and collectively should advocate for changes
27 to ameliorate the situation and promote a more hospitable environment in which patient-
28 physician relationships may flourish.

29
30 A patient-physician relationship ~~exists~~ commences when a physician begins to serve a
31 patient's medical needs. ~~Generally, the relationship is entered into by mutual consent~~
32 ~~between physician and patient (or surrogate). However, in certain circumstances a~~
33 ~~limited patient-physician relationship may be created without the patient's (or~~
34 ~~surrogate's) explicit agreement. Such circumstances include: The contexts that may lead~~
35 ~~to a patient-physician relationship vary: they generally occur as a response to a request~~
36 ~~by a patient or a patient's surrogate, but can also include certain contractual, legally~~
37 ~~mandated, or emergency settings without the explicit request or consent of the patient.~~

38
39 While the patient-physician relationship may involve one patient and one physician in
40 today's complex health care system, such relationships often involve multiple members
41 of a care team, patient family members and surrogates. The core values of the patient-
42 physician relationship, however, remain unchanged. How these values are implemented
43 will depend on many factors, including the setting, the needs of the patient, the duration
44 of the relationship, and the training, expertise, and experience of the physician, and will
45 necessarily reflect the myriad ways that patients and physicians interact. While every
46 patient-physician relationship will be different and will change over time, the fundamental
47 importance of establishing and sustaining trust through respect for persons, good
48 communication, and professional competency will always be crucial at every layer, node,
49 and time of the relationship. It is the duty of physicians, therefore, to uphold these values

1 and support patients and the primacy of the patient-physician relationship to the best of
 2 their ability in all practice settings and at all times.

3 ~~a When a physician provides emergency care or provides care at the request of the~~
 4 ~~patient's treating physician. In these circumstances, the patient's (or surrogate's)~~
 5 ~~agreement to the relationship is implicit.~~

6
 7 ~~b When a physician provides medically appropriate care for a prisoner under court order,~~
 8 ~~in keeping with ethics guidance on court-initiated treatment.~~

9
 10 ~~c When a physician examines a patient in the context of an independent medical~~
 11 ~~examination, in keeping with ethics guidance. In such situations, a limited patient-~~
 12 ~~physician relationship exists.~~

13
 14 (Modify HOD/CEJA Policy)

15
 16 Online testimony was limited and mixed. In-person testimony was also limited and
 17 mixed. CEJA testified that online calls for referral expressed a desire for the
 18 recommendation to address terminating a physician-patient relationship; however, CEJA
 19 explained that these concerns are addressed in a separate opinion in the *Code of*
 20 *Medical Ethics*, Opinion 1.1.5, "Terminating a Patient-Physician Relationship". Limited
 21 testimony raised the question of the prospective patient, which is addressed in *Code of*
 22 *Medical Ethics*, Opinion 1.1.2. The majority of testimony was in favor of adoption. Your
 23 Reference Committee recommends that the report be adopted.

24
 25
 26 (4) CEJA REPORT 02 – SUPPORTING EFFORTS TO
 27 STRENGTHEN MEDICAL STAFFS THROUGH
 28 COLLECTIVE ACTIONS AND/OR UNIONIZATION

29
 30 RECOMMENDATION:

31
 32 Your Reference Committee recommends that CEJA
 33 Report 02 be adopted and the remainder of the report filed.

34
 35 **HOD ACTION: Recommendations in CEJA Report 02 referred.**

36
 37
 38
 39 The Council on Ethical and Judicial Affairs recommends that the following
 40 recommendations be adopted and the remainder of the report be filed:

- 41
 42 1. That Opinion 1.2.10 be amended by addition and deletion with a change in title
 43 as follows:

44
 45 Advocacy and Collective Actions by Physicians ~~Political Action by Physicians~~

46
 47 Like all Americans, physicians enjoy the right to advocate for change in law and policy,
 48 in the public arena, and within their institutions. Indeed, physicians have an ethical
 49 responsibility to seek change when they believe the requirements of law, or policy, or

1 practice are contrary to the best interests of patients. However, advocacy actions should
2 not put the wellbeing of patients in jeopardy.

3 Collective action is one means by which physicians can advocate for patients, the health
4 of communities, the profession, and their own health. Physicians have a responsibility to
5 avoid disruption to patient care when engaging in any collective action. When
6 considering collective actions that have the potential to be disruptive, whether aimed at
7 changing the policies of government, the private sector, or their own institutions, there
8 are additional considerations that should be addressed. These include avoiding harm to
9 patients, minimizing the impact of actions on patient access to care, maintaining trust in
10 the patient-physician relationship, fulfilling the responsibility to improve patient care,
11 avoiding mental and physical harms to physicians, promoting physician wellbeing,
12 upholding the values and integrity of the profession, and considering alternative
13 measures that could reasonably be expected to achieve similar results with less
14 potential effect on patient and physician wellbeing.

15
16 When considering participation ~~Physicians who participate in~~ advocacy activities,
17 including collective actions:

18
19 a. ~~Ensure that the health of patients is not jeopardized, and that patient care is not~~
20 ~~compromised. Physicians should recognize that, in pursuing their primary commitment to~~
21 ~~patients, physicians can, and at times may have an obligation to, engage in collective~~
22 ~~political action to advocate for changes in law and institutional policy aimed at promoting~~
23 ~~patient care and wellbeing.~~

24
25 b. ~~Avoid using disruptive means to press for reform. Strikes and other collective actions~~
26 ~~may reduce access to care, eliminate or delay needed care, and interfere with continuity~~
27 ~~of care and should not be used as a bargaining tactic. In rare circumstances, briefly~~
28 ~~limiting personal availability may be appropriate as a means of calling attention to the~~
29 ~~need for changes in patient care. Physicians should be aware that some actions may put~~
30 ~~them or their organizations at risk of violating antitrust laws or laws pertaining to medical~~
31 ~~licensure or malpractice. Physicians may also engage in collective action to advocate for~~
32 ~~changes within their institutions, including changes in patient care practices, physician~~
33 ~~work conditions, health and wellbeing, and/or institutional culture that negatively affect~~
34 ~~patient care.~~

35
36 c. Physicians should refrain from collective action that would likely jeopardize the health
37 of patients or compromise patient care.

38
39 d. Physicians may consider engaging in disruptive forms of collective action that do not
40 compromise patient care only as a last resort, with the primary objective to improve
41 patient care and outcomes by calling attention to and/or making needed changes in
42 practices, protocols, incentives, expectations, structures, and/or institutional culture.

43
44 e. Disruptive actions, including strikes, that could directly compromise patient care
45 should be avoided and should not be used solely for physician self-interest.

46
47 f. Physicians should avoid forming workplace or other alliances, such as unions,
48 with ~~workers~~ colleagues and others who do not share physicians' primary and overriding
49 commitment to patients.

50

1 ~~g. Physicians should refrain from using undue influence or pressure colleagues punitive~~
2 ~~or coercive means to force others to participate in advocacy activities or collective~~
3 ~~actions, or to penalize others and should not punish colleagues, overtly or covertly, for~~
4 ~~deciding not to participate in such activities.~~

5
6 2. That Policy H-405.946(2) be rescinded as having been accomplished by this report.
7 (Rescind AMA Policy)

8
9 Online testimony was mixed between calls for referral and adoption. In-person testimony
10 was mixed, with a majority in favor of adoption. Your Reference Committee recommends
11 that the report be adopted.

12
13
14 (5) CEJA REPORT 03 – ETHICAL IMPETUS FOR
15 RESEARCH IN PREGNANT AND LACTATING
16 INDIVIDUALS

17
18 RECOMMENDATION:

19
20 Your Reference Committee recommends that CEJA
21 Report 03 be adopted and the remainder of the Report be
22 filed.

23
24
25 **HOD ACTION: Recommendations in CEJA Report 03 adopted and the remainder of**
26 **the report filed.**

27
28
29 The Council on Ethical and Judicial Affairs recommends that following being adopted
30 and the remainder of the report be filed:

31
32 1. Research involving pregnant and lactating individuals, including but not limited to,
33 research regarding interventions intended to benefit pregnant or lactating individuals
34 and/or their fetuses or nursing infants, must balance the health and safety of individuals
35 who participate and the well-being of their fetuses or nursing infant against the desire to
36 develop new and innovative therapies. Although it is important to carefully consider
37 potential fetal risks involved when pregnant and lactating individuals participate in
38 research, it is critical to realize that large scale exclusion from participation by these
39 individuals has also precluded potential benefits and in some cases resulted in harm for
40 this group. The paucity of data on safe and effective medical treatment during pregnancy
41 and breastfeeding has resulted in physicians and patients choosing between pursuing
42 medical interventions with uncertain risks to themselves and their fetuses or nursing
43 infants, or foregoing the interventions altogether, which might itself cause harm due to
44 undertreatment of medical conditions.

45
46 Understanding both the potential risks of participation and of non-participation,
47 physicians conducting research must obtain the informed, voluntary consent of pregnant
48 or lactating individuals, and adhere to general principles for ethical conduct of research

1 as in all human participant's research. In addition, physicians conducting research
2 should:

3
4 (a) Include pregnant and lactating individuals in research for which they would otherwise
5 be eligible in order to establish a greater knowledge base, produce relevant data, and
6 promote respect for individuals.

7
8 (b) Consider excluding pregnant and lactating individuals only when a study poses a
9 substantial risk of significant harm to them or their fetuses or nursing infants, and:

10
11 i. specify why the research excludes pregnant and lactating individuals;

12
13 ii. seek alternative research methodologies to rectify gaps in knowledge.

14
15 (c) Where scientifically appropriate and available, base studies that include pregnant and
16 lactating individuals on well-designed, ethically sound, existing research with nonhuman
17 animals or nongravid human participants to better assess potential risks.

18
19 (d) Minimize risks to the fetus or nursing infant to the greatest extent possible, especially
20 when the research is not conducted primarily to investigate potential benefit for fetuses
21 or nursing infants, but rather for the development of important biomedical knowledge that
22 cannot be obtained by any other means. (New HOD/CEJA Policy)

23
24 2. AMA Policy D-140.949 be rescinded as having been accomplished by this report
25 (Rescind AMA Policy)

26
27 Online testimony was in unanimous support. The report was not extracted at the in-
28 person hearing. Your Reference Committee recommends that the report be adopted.

29
30
31 (6) RESOLUTION 001 – CLARIFYING CONSCIENTIOUS
32 OBJECTION

33
34 RECOMMENDATION:

35
36 Your Reference Committee recommends that Resolution
37 001 be adopted.

38
39 **HOD ACTION: Resolution 001 adopted.**

40
41
42 RESOLVED, that our American Medical Association study the use of conscientious
43 objection to refuse care to patients based upon their membership in particular groups,
44 including when such refusal does not meet the legal standard of invidious discrimination,
45 and return recommendations strengthening present policy against this practice
46 (Directive to Take Action); and be it further

47
48 RESOLVED, that our AMA ask the Council on Ethical and Judicial Affairs to consider
49 amending the AMA Code of Medical Ethics--including, but not limited to, its relevant

1 Principles--to ensure that a physician's right to choose their patients is appropriately
2 limited by their duty to provide equitable access to care (Directive to Take Action); and
3 be it further

4
5 RESOLVED, that our AMA (i) support efforts to include protections for patients, as they
6 are delineated in the AMA Code of Medical Ethics, in state- and federal-level policies
7 codifying conscientious objection and (ii) oppose policies protecting conscientious
8 objection which do not also provide these protections to patients. (New HOD Policy)

9
10 Online testimony was mixed, with a majority in opposition. In-person testimony was
11 generally in favor of adoption. Your Reference Committee recommends that the
12 resolution be adopted.

DRAFT

1 (7) RESOLUTION 005 – PRESERVING AUTONOMY IN THE
2 PATIENT-PHYSICIAN RELATIONSHIP

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RECOMMENDATION:

Your Reference Committee recommends that Resolution
005 be adopted.

9 **HOD ACTION: Resolution 005 adopted.**

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11
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13 RESOLVED, that our American Medical Association study relevant sections of the *Code*
14 *of Medical Ethics* to address outside political and administrative influences on the patient
15 physician relationship and its impact on shared decision making in the clinical setting.
16 (Directive to Take Action)

17
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Online testimony was in near unanimous support. The resolution was not extracted at
the in-person hearing. Your Reference Committee recommends that the resolution be
adopted.

23 (8) RESOLUTION 006 – AMENDMENT TO AMA BYLAWS
24 TO ENABLE CONTINUITY OF LEADERSHIP

25
26
27
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31

RECOMMENDATION:

Your Reference Committee recommends that Resolution
006 be adopted.

32 **HOD ACTION: Resolution 006 adopted.**

33
34

35 RESOLVED, that our American Medical Association amend AMA Bylaw 7.1.2 to allow
36 the Resident and Fellow Section (RFS) Immediate Past Chair to serve in the position
37 even if they have graduated from the RFS. (Modify Current HOD Policy)

38
39
40
41

Online testimony was in near unanimous support. The resolution was not extracted at
the in-person hearing. Your Reference Committee recommends that the resolution be
adopted.

1 (9) RESOLUTION 008 – HEALTH PLAN IN-NETWORK
2 STEERING OF PATHOLOGY/LABORATORY SERVICES
3

4 RECOMMENDATION:
5

6 Your Reference Committee recommends that Resolution
7 008 be adopted.
8
9

10 **HOD ACTION: Resolution 008 adopted.**
11

12
13
14 RESOLVED, that our American Medical Association support state and federal legislative
15 efforts to expressly prohibit in-network steering by health insurance plans, or by
16 laboratory benefit managers under contract with such plans, to "preferred" or
17 "designated" in-network laboratories or pathologists, thereby excluding other in-network
18 pathology and laboratory providers (New HOD Policy); and be it further
19

20 RESOLVED, that our AMA advocate in partnership with state medical societies and
21 medical specialty societies to protect ordering physician discretion to refer pathology and
22 laboratory specimens to any in-network pathologist or in-network laboratory of their
23 choice, based upon relevant medical considerations in the best interest of patient care,
24 consistent with AMA Code of Medical Ethic. (Directive to Take Action)
25

26 Online testimony was in unanimous support. The resolution was not extracted at the in-
27 person hearing. Your Reference Committee recommends that the resolution be adopted.
28

29
30 (10) RESOLUTION 009 – GENDER EQUITY IN DISABILITY
31 INSURANCE FOR PHYSICIANS
32

33 RECOMMENDATION:
34

35 Your Reference Committee recommends that Resolution
36 009 be adopted.
37
38

39 **HOD ACTION: Resolution 009 adopted.**
40

41
42 RESOLVED, that our American Medical supports gender-neutral disability insurance
43 premiums for physicians. (New HOD Policy)
44

45 Online testimony was evenly mixed between support and calls for referral. In-person
46 testimony was strongly against referral and in favor of adoption. Your Reference
47 Committee recommends that the resolution be adopted.

RECOMMENDED FOR ADOPTION AS AMENDED

(11) *BOT REPORT 05 – ADDRESSING THE UNREGULATED
BODY BROKERAGE INDUSTRY

RECOMMENDATION A:

Your Reference Committee recommends that BOT Report 05 be amended by addition and deletion of the first section of H-460.890 as follows:

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

RECOMMENDATION B:

That subsection 1(f) of H-460.890 be amended by addition as follows:

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

RECOMMENDATION C:

That BOT Report 05 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommendations in BOT Report 05 adopted as amended and the remainder of the report filed.

ADOPTED LANGUAGE:

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

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

***b. Registration:* A registration process is imperative for ensuring accurate and transparent informed consent during the body donation decision process. Pertinent information which should be conveyed during the**

1 registration process includes any disposition and distribution of bodies or
 2 body parts, including the locations, possible uses of the body or body
 3 parts (i.e., military, education, forensic, etc.), and financial aspects of body
 4 donation. Additionally, the registration process should outline the body
 5 donor eligibility and suitability criteria.

6
 7 **c. Custody:** A transparent custody process is imperative for ensuring the
 8 ethical stewardship and management of the body entrusted to the end user
 9 (e.g., researchers, educators, clinicians).

10
 11 **d. Tracking:** A tracking system should be put in place to ensure the proper
 12 governance, oversight, and infrastructure (including registration and
 13 informed consent) during the use of donated bodies. Tracking systems
 14 should include a mechanism for monitoring body donation policies and
 15 procedures and a reporting mechanism for violations of these policies.

16
 17 **e. Use:** Bodies should be used in a respectful, dignified, and ethical manner
 18 for education and research purposes.

19
 20 **f. Disposition:** Final disposition of the body should be made in accordance
 21 with the wishes of the donor and their families when feasible.

22
 23 **g. Memorialization:** A respectful memorial ceremony for the family in which
 24 the body donor is honored for their “altruism and commitment to education
 25 and research” should be held at the conclusion of the use of the body as
 26 well as governing oversight of the body donation policies.

27
 28 **2. Supports federal and state legislation consistent with body donation best
 29 practices that require all body donation programs adopt and implement policies
 30 which uphold informed consent, transparency, and accountability during the
 31 process of human body donation and use.**

32
 33 **3. Encourages state medical societies to advocate for legislation consistent with
 34 body donation best practices (Modify Current Policy)**

35
 36
 37 The Board of Trustees recommends that the following be adopted in lieu of Resolution
 38 212-I-24 and the remainder of the report be filed.

39
 40 1. That Policy H-460.890, Improving Body Donation Regulation,” be amended by
 41 addition and deletion as follows:

42
 43 1. Our AMA recognizes the need for ethical, and transparent, regulations for body and
 44 body part donation regulations consistent with body donation best practices including:

45
 46 a. Outreach: This covers all communications with body donors and their families,
 47 beginning with the initial engagement to request donations. Ethical outreach is premised
 48 on transparency and accountability, free from any form of coercion or enticement.
 49

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

8
9 c. Custody: A transparent custody process is imperative for ensuring the ethical
10 stewardship and management of the body entrusted to the end user (e.g., researchers,
11 educators, clinicians).

12
13 d. Tracking: A tracking system should be put in place to ensure the proper governance,
14 oversight, and infrastructure (including registration and informed consent) during the use
15 of donated bodies. Tracking systems should include a mechanism for monitoring body
16 donation policies and procedures and a reporting mechanism for violations of these
17 policies.

18
19 e. Use: Bodies should be used in a respectful, dignified, and ethical manner for
20 education and research purposes.

21
22 f. Disposition: Final disposition of the body should be made in accordance with the
23 wishes of the donor and their families.

24
25 g. Memorialization: A respectful memorial ceremony for the family in which the body
26 donor is honored for their “altruism and commitment to education and research” should
27 be held at the conclusion of the use of the body as well as governing oversight of the
28 body donation policies.

29
30 2. Supports federal and state legislation consistent with body donation best practices
31 that require all body donation programs adopt and implement policies which uphold
32 informed consent, transparency, and accountability during the process of human body
33 donation and use.

34
35 3. Encourages state medical societies to advocate for legislation consistent with body
36 donation best practices. (Modify Current HOD Policy)

37
38 Online testimony was in near unanimous support. Your Reference Committee found a
39 minor error in the report’s recommendation, which failed to strike out and underline
40 language that should be part of the addition and deletion formatting, and proffered an
41 amendment to correct it. In-person testimony was limited. An amendment was proffered
42 to provide greater flexibility in meeting the wishes of family members. Your Reference
43 Committee recommends that the report be adopted as amended.

1 (12) BOT REPORT 10 – IMPROVING USABILITY OF
2 ELECTRONIC HEALTH RECORDS (EHRS) FOR
3 TRANSGENDER AND GENDER DIVERSE PATIENTS
4

5 RECOMMENDATION A:
6

7 Your Reference Committee recommends that BOT Report
8 10 be amended by addition and deletion in
9 recommendations 3 and 4 as follows:
10

11 3. Our AMA acknowledge the evolving nature of
12 language and engage appropriate collaborators
13 ~~stakeholders~~ to ensure the continued relevance
14 and accuracy of terminology used across AMA
15 resources and advocacy. (New HOD Policy)
16

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

27 RECOMMENDATION B:
28

29 That BOT Report 10 be adopted as amended and the
30 remainder of the report be filed.
31
32

33 **HOD ACTION: Recommendations in BOT Report 10 adopted as amended and the**
34 **remainder of the report filed.**
35

36 **ADOPTED LANGUAGE:**
37

- 38 1. **Our AMA reaffirm Policy H-315.967, “Promoting Inclusive Gender, Sex, and**
39 **Sexual Orientation Options on Medical Documentation.” (Reaffirm HOD**
40 **Policy)**
41
- 42 2. **Our AMA support the use of the term “chosen name” over “preferred**
43 **name,” recognizing its importance to transgender and gender-diverse**
44 **patients. (New HOD Policy)**
45
- 46 3. **Our AMA acknowledge the evolving nature of language and engage**
47 **appropriate collaborators to ensure the continued relevance and accuracy**
48 **of terminology used across AMA resources and advocacy. (New HOD**
49 **Policy)**

- 1
2 **4. Our AMA continue to support efforts by EHR vendors, health systems, and**
3 **physician practices, and work with relevant collaborators (e.g., the**
4 **ASTP/ONC, LGBTQIA+ advocacy groups, and minors' privacy experts), to**
5 **improve EHR usability for transgender and gender-diverse patients, with**
6 **attention to strong privacy protections, and report back on this progress by**
7 **I-26. (New HOD Policy)**
8
-

9
10
11 The Board of Trustees recommends that the following be adopted in lieu of Resolution
12 004-I-24 and the remainder of the report be filed:

- 13
14 1. Our AMA reaffirm Policy H-315.967, "Promoting Inclusive Gender, Sex, and
15 Sexual Orientation Options on Medical Documentation." (Reaffirm HOD Policy)
16
17 2. Our AMA support the use of the term "chosen name" over "preferred name,"
18 recognizing its importance to transgender and gender-diverse patients. (New
19 HOD Policy)
20
21 3. Our AMA acknowledge the evolving nature of language and engage appropriate
22 stakeholders to ensure the continued relevance and accuracy of terminology
23 used across AMA resources and advocacy. (New HOD Policy)
24
25 4. Our AMA continue to support efforts by EHR vendors, health systems, and
26 physician practices, and work with relevant stakeholders (e.g., the ASTP/ONC,
27 LGBTQIA+ advocacy groups, and minors' privacy experts), to improve EHR
28 usability for transgender and gender-diverse patients, with attention to strong
29 privacy protections, and report back on this progress by I-26. (New HOD Policy)
30

31 Online testimony was in near unanimous support. An amendment was proffered to
32 replace the use of "stakeholders" in recommendations 3 and 4, given the negative
33 connotation to many Indigenous peoples, with "partners" or "collaborators". The minimal
34 in-person testimony was in unanimous support of the report as amended. Your
35 Reference Committee recommends that the report be adopted as amended.
36
37

38 (13) BOT REPORT 11 – SUPPORTING DIVERSITY IN
39 RESEARCH

40
41 RECOMMENDATION A:

42
43 Your Reference Committee recommends that the first
44 recommendation in BOT Report 11 be amended by
45 addition and deletion as follows:

- 46
47 1. That our American Medical Association support
48 ~~the use of language interpreters and translators, at~~
49 ~~a cost not to be funded by the physician, the~~

1 development of a framework to fund language
2 interpreters and translators at no cost to individual
3 physicians or practices in clinical trials and health
4 research participation to promote equitable data
5 collection and outcomes. (New HOD Policy)

6
7 RECOMMENDATION B:

8
9 That BOT 11 be adopted as amended and the remainder
10 of the report be filed.

11
12
13 **HOD ACTION: First recommendation in BOT Report 11 amended by addition and**
14 **deletion as follows:**

15
16 1. That our American Medical Association
17 support ~~the use of language interpreters and~~
18 ~~translators, at a cost not to be funded by the~~
19 ~~physician, the use of language interpreters and~~
20 ~~translators, the development of a framework to~~
21 ~~fund language interpreters and translators at no~~
22 ~~cost to individual physicians or practices~~
23 clinical trials and health ~~research~~ participation
24 to promote equitable data collection and
25 outcomes. (New HOD Policy)

26
27 BOT Report adopted as amended.

28
29 **ADOPTED LANGUAGE:**

- 30
31 1. That our American Medical Association support the use of language
32 interpreters and translators at no cost to individual physicians or practices
33 in clinical trials and health research participation to promote equitable data
34 collection and outcomes. (New HOD Policy)
- 35
36 2. That our AMA encourage Institutional and Research Review Boards (IRBs)
37 to develop and publish standardized guidelines for interpreter services to
38 ensure appropriate enrollment and ongoing participation of clinical
39 research participants with Limited English Proficiency and Deaf or Hard of
40 Hearing people. (New HOD Policy)
- 41
42 3. That our AMA encourage Institutional and Research Review Boards (IRBs)
43 to develop and publish transparent guidelines for improving the diversity
44 of research participants, including (1) that eligibility criteria be as inclusive
45 as possible, (2) that written justification for exclusion be provided for
46 review, and (3) that additional accommodations for potential enrollees be
47 considered. (New HOD Policy)
- 48

- 1 **4. That our AMA support greater inclusion in clinical trials and health**
2 **research of all peoples and groups that are underrepresented or excluded**
3 **from such research to promote greater study generalization, health equity,**
4 **and justice. (New HOD Policy)**
5
 - 6 **5. That our AMA support community-centered engagement before, during,**
7 **and after clinical trials and health research to foster and sustain public**
8 **trust in medicine and science. (New HOD Policy)**
9
 - 10 **6. That our AMA encourage that all study protocols involving human research**
11 **participants include appropriate funding to support the inclusion of**
12 **underrepresented and excluded populations. (New HOD Policy)**
13
-

14
15
16 The Board of Trustees recommends that the following be adopted in lieu of Resolution
17 007-I-24 and the remainder of this report be filed:

- 18
19 1. That our American Medical Association support the use of language interpreters
20 and translators, at a cost not to be funded by the physician, in clinical trials and
21 health research participation to promote equitable data collection and outcomes.
22 (New HOD Policy)
23
- 24 2. That our AMA encourage Institutional and Research Review Boards (IRBs) to
25 develop and publish standardized guidelines for interpreter services to ensure
26 appropriate enrollment and ongoing participation of clinical research participants
27 with Limited English Proficiency and Deaf or Hard of Hearing people. (New HOD
28 Policy)
29
- 30 3. That our AMA encourage Institutional and Research Review Boards (IRBs) to
31 develop and publish transparent guidelines for improving the diversity of research
32 participants, including (1) that eligibility criteria be as inclusive as possible, (2)
33 that written justification for exclusion be provided for review, and (3) that
34 additional accommodations for potential enrollees be considered. (New HOD
35 Policy)
36
- 37 4. That our AMA support greater inclusion in clinical trials and health research of all
38 peoples and groups that are underrepresented or excluded from such research
39 to promote greater study generalization, health equity, and justice. (New HOD
40 Policy)
41
- 42 5. That our AMA support community-centered engagement before, during, and after
43 clinical trials and health research to foster and sustain public trust in medicine
44 and science. (New HOD Policy)
45
- 46 6. That our AMA encourage that all study protocols involving human research
47 participants include appropriate funding to support the inclusion of
48 underrepresented and excluded populations. (New HOD Policy)
49

1 Online testimony was in unanimous support. In-person testimony was in strong support,
2 with two amendments proffered. Your Reference Committee recommends that the report
3 be adopted as amended.
4

5
6 (14) BOT REPORT 19 – ADDRESSING THE HISTORICAL
7 INJUSTICES OF ANATOMICAL SPECIMEN USE
8

9 RECOMMENDATION A:

10
11 Your Reference Committee recommends that the first
12 recommendation in BOT 19 be amended by addition and
13 deletion as follows:
14

- 15 1. Our AMA supports the guidelines set forth by the
16 American Association for Anatomy's 2024 task
17 force report Human Body Donation Programs Best
18 Practices and Recommended Standards for
19 human body donation programs. (New HOD Policy)
20

21 RECOMMENDATION B:

22
23 That recommendation two be amended by addition and
24 deletion as follows:
25

- 26 2. That section 67 of H-140.820 be rescinded as
27 having been accomplished by this report.
28

29 RECOMMENDATION C:

30
31 That BOT 19 be adopted as amended and the remainder
32 of the report be filed.
33
34

35 **HOD ACTION: BOT Report 19 adopted as amended.**

36
37 **ADOPTED LANGUAGE:**

- 38
39 **1. Our AMA supports the guidelines set forth by the American Association for**
40 **Anatomy's 2024 task force report Human Body Donation Program Best**
41 **Practices and Recommended Standards. (New HOD Policy)**
42
43 **2. That section 7 of H-140.820 be rescinded as having been accomplished by**
44 **this report**
45

46
47 The Board of Trustees recommends that the following be adopted and the remainder of
48 the report be filed.
49

- 1 1. Our AMA supports the guidelines set forth by the American Association for
2 Anatomy's 2024 best practices and recommended standards for human body
3 donation programs. (New HOD Policy)
- 4 2. That section 6 of H-140.820 be rescinded as having been accomplished by this
5 report

6
7 Online testimony was in unanimous support. In-person testimony was in strong support,
8 with two amendments proffered, one to clarify a clerical mistake and another to
9 incorporate all the language from the entire American Academy of Anatomy 2024 report.
10 Your Reference Committee recommends that the report be adopted as amended.

11
12
13 (15) RESOLUTION 003 – REPORT ON GENDER-BASED PAY
14 EQUITY IN MEDICINE

15
16 RECOMMENDATION A:

17
18 Your Reference Committee recommends that Resolution
19 003 be amended by addition and deletion as follows:

20
21 RESOLVED, that our American Medical
22 Association study and report at ~~HOD-2026 I-26~~ the
23 current pay structures and existing gender-based
24 ~~disparities between male and female physicians, in~~
25 physician pay; and be it further and review policies
26 ~~to ensure equitable compensation for all~~
27 physicians. (Directive to Take Action)

28
29 RECOMMENDATION B:

30
31 That a second resolve be added by addition as follows:

32
33 RESOLVED, That our American Medical
34 Association propose data-driven guidance to end
35 gender-based pay disparities and create strategies
36 to achieve transparency and equitable
37 compensation across medical practice settings.
38 (Directive to Take Action)

39
40 RECOMMENDATION C:

41
42 That Resolution 003 be adopted as amended.
43
44
45
46
47
48
49

1 **HOD ACTION: Resolution 003 adopted as amended.**

2
3 **ADOPTED LANGUAGE:**

4
5 **RESOLVED, that our American Medical Association study and report at I-26 the**
6 **current pay structures and existing gender-based disparities in physician pay;**
7 **and be it further**

8
9 **RESOLVED, That our American Medical Association propose data-driven**
10 **guidance to end gender-based pay disparities and create strategies to achieve**
11 **transparency and equitable compensation across medical practice settings.**
12 **(Directive to Take Action)**

13
14
15
16 **RESOLVED, that our American Medical Association study and report at HOD 2026 the**
17 **current pay structures and existing disparities between male and female physicians, and**
18 **review policies to ensure equitable compensation for all physicians. (Directive to Take**
19 **Action)**

20
21 Online testimony was mixed, with the majority in support. In-person testimony was in
22 general support of the report and a proffered amendment to add data-driven guidelines
23 to help end gender-based pay disparities. A second proffered amendment to extend the
24 timeline for report back received mixed support. Your Reference Committee
25 recommends that the resolution be adopted as amended.

26
27
28 (16) **RESOLUTION 007 – IMPROVING PROTECTION FOR**
29 **REPRODUCTIVE HEALTH INFORMATION**

30
31 **RECOMMENDATION A:**

32
33 Your Reference Committee recommends that Resolution
34 007 be amended by addition and deletion as follows:

35
36 **RESOLVED, that our American Medical**
37 **Association support ~~the prohibition against~~**
38 **legislation and regulations prohibiting the use or**
39 **disclosure of protected health information (PHI) to**
40 **conduct a criminal, civil, or administrative**
41 **investigations ~~into~~ or to impose criminal, civil, or**
42 **administrative liability for the mere act of seeking,**
43 **obtaining, providing, or facilitating reproductive**
44 **health care; and be it further (New HOD Policy)**

45
46 **RECOMMENDATION B:**

47
48 That a second resolve be added by addition as follows:

49

1 RESOLVED, that our AMA advocate to ensure that
2 the release of protected health information of a
3 decedent to forensic pathologists be unimpeded by
4 unnecessary administrative burdens. (Directive to
5 Take Action)

6
7 RECOMMENDATION C:

8
9 That Resolution 007 be adopted as amended.

10
11
12 **HOD ACTION: Resolution 007 adopted as amended.**

13
14 **ADOPTED LANGAUGE:**

15
16 **RESOLVED, that our American Medical Association support legislation and**
17 **regulations prohibiting the use or disclosure of protected health information (PHI)**
18 **to conduct a criminal, civil, or administrative investigations or to impose criminal,**
19 **civil, or administrative liability for the mere act of seeking, obtaining, providing, or**
20 **facilitating reproductive health care; and be it further**

21
22 **RESOLVED, that our AMA advocate to ensure that the release of protected health**
23 **information of a decedent to forensic pathologists be unimpeded by unnecessary**
24 **administrative burdens. (New HOD Policy)**

25
26
27
28 RESOLVED, that our American Medical Association support the prohibition against the
29 use or disclosure of protected health information (PHI) to conduct a criminal, civil, or
30 administrative investigation into or impose criminal, civil, or administrative liability for the
31 mere act of seeking, obtaining, providing, or facilitating reproductive health care. (New
32 HOD Policy)

33
34 Online testimony was in near unanimous support. In-person testimony was in near
35 unanimous support of an amendment proffered by the authors. One additional minor
36 amendment was proffered. Your Reference Committee recommends that the resolution
37 be adopted as amended.

RECOMMENDED FOR REFERRAL

(17) CCB REPORT 02 – BYLAWS CLARIFICATIONS
SUBSEQUENT TO A-25 HOUSE OF DELEGATES
MEETING

RECOMMENDATION A:

Your Reference Committee recommends that section 5.3.9
be referred.

RECOMMENDATION B:

That CCB Report 02 be referred in part and the remainder
of the report be adopted and filed.

HOD ACTION: CCB Report 02 referred in part and remainder of report adopted and filed.

ADOPTED LANGUAGE:

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

- a. Possess the United States degree of doctor of medicine (MD) or doctor of osteopathic medicine (DO);**
- b. Work or reside in the United States and possess a recognized international medical degree equivalent to the United States MD or DO; or**
- c. Are medical students in educational programs provided by a college of medicine or osteopathic medicine accredited by the Liaison Committee on Medical Education or the Commission on Osteopathic College Accreditation leading to the MD or DO degree. This includes those students who are on an approved sabbatical, provided that the student will be in good standing upon returning from the sabbatical.**

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

1--Membership

1.1 Categories.

1
2 Categories of membership in the American Medical Association (AMA) are: Active
3 Members, Affiliate Members, Honorary Members, and International Members.

4
5 **1.1.1 Active Members.**

6
7 **1.1.1.1 Active Members.** Active members must meet one of the following
8 requirements:

9
10 a. Possess the United States degree of doctor of medicine (MD) or doctor of osteopathic
11 medicine (DO), ~~or a recognized international equivalent;~~

12
13 b. Work or reside in the United States and possess a recognized international medical
14 degree equivalent to the United States MD or DO; or

15
16 ~~b.~~ c. Are medical students in educational programs provided by a college of medicine
17 or osteopathic medicine accredited by the Liaison Committee on Medical Education or
18 the Commission on Osteopathic College Accreditation leading to the MD or DO degree.
19 This includes those students who are on an approved sabbatical, provided that the
20 student will be in good standing upon returning from the sabbatical.

21
22 **1.1.4 International Members.**

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

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

27
28 b. Possession of a valid license in good standing in the country of graduation or
29 practice location documented by one of the following:

30
31 (i) verification that the applicant is an international member of a national medical
32 specialty society seated in the House of Delegates that has a procedure to verify the
33 applicant's educational credentials;

34
35 (ii) certification from the national medical association in the country of practice
36 attesting to the applicant's valid authorization to practice medicine without limitation; or

37
38 (iii) certification from the registry or licensing authority of the country of practice
39 attesting to the applicant's valid license in good standing.

40
41 **5—Board of Trustees**

42
43 ***

44
45 **5.3 Duties and Privileges.** In addition to the rights and duties conferred or imposed
46 upon the Board of Trustees by law and custom and elsewhere in the Constitution and
47 Bylaws, the Board of Trustees shall:

48
49 **5.3.1 Management.** Manage or direct the management of the property and conduct
50 the affairs, work and activities of the AMA consistent with the policy actions and

1 directives adopted by the House of Delegates, except as may be otherwise provided in
2 the Constitution or these Bylaws.

3
4 **5.3.1.1** The Board is the principal governing body of the AMA and it exercises broad
5 oversight and guidance for the AMA with respect to the management systems and risk
6 management program of the AMA through its oversight of the AMA's Executive Vice
7 President.

8
9 **5.3.1.2** Board of Trustees actions should be based on policies and directives approved
10 by the House of Delegates. In the absence of specifically applicable House policies or
11 directives and to the extent feasible, the Board shall determine AMA positions based on
12 the tenor of past policy and other actions that may be related in subject matter.

13 ***

14 **5.3.3 Fulfillment of House of Delegates Charge.** Review all resolutions and
15 recommendations adopted by the House of Delegates to determine how to fulfill the
16 charge from the House. Resolutions and recommendations pertaining to the expenditure
17 of funds also shall be reviewed. If it is decided that the expenditure is inadvisable, the
18 Board shall report, at its earliest convenience, to the House the reasons for its decisions.

19
20 **5.3.3.1** In determining expenditure advisability, the Board will consider the scope of the
21 proposed expenditure and whether it is consistent with the AMA's vision, goals, and
22 priorities. Where the Board recommends that a proposed expenditure is not prudent and
23 is inadvisable, the Board will present alternative actions, if feasible, in its report to the
24 House.

25
26 ***

27
28 **5.3.9 Establishment and Appointment of Committees.** Establish Appoint
29 such committees as necessary to carry out the purposes of the AMA and appoint
30 committee membership.

31
32 **5.3.9.1** An advisory committee will be constituted for purposes of education and
33 advocacy.

34
35 **5.3.9.1.1** It will have a governing council and a direct reporting relationship to the Board.

36
37 **5.3.9.1.2** An advisory committee will not have representation in the House of Delegates.

38
39 **5.3.9.1.3** An advisory committee will operate under a charter that will be subject to
40 review and renewal by the Board at least every four years.

41
42 **5.3.9.2** An ad hoc committee will be constituted as a special committee, workgroup or
43 taskforce.

44
45 **5.3.9.2.1** It will operate for a specific purpose and for a prescribed period of time.

46
47 Online testimony was unanimously in favor of a partial referral of section 5.3.9, citing
48 concerns that the proposed amendment to 5.3.9 introduces a potential conflict with the
49 bylaws, specifically section 2.13.6. Limited in-person testimony was mixed, with one call
50 for referral, one for adoption, and one in favor of the preliminary report recommendation

- 1 of partial adoption. Your Reference Committee recommends that section 5.3.9 be
- 2 referred and the remainder of the report be adopted.

DRAFT

1 (18) CCB REPORT 03 – CREDENTIALING OF TEMPORARY
2 DELEGATES AND ALTERNATE DELEGATES
3

4 *RESOLUTION 010 – CLARIFYING THE MEDICAL
5 STUDENT SECTION'S AND RESIDENT AND FELLOW
6 SECTION'S ABILITIES TO FILL TEMPORARY
7 VACANCIES IN ACCORDANCE WITH THE AMA BYLAWS
8

9 RECOMMENDATION:

10 Your Reference Committee recommends that CCB Report
11 03 with Resolution 010 be referred.
12
13
14

15 **HOD ACTION: CCB Report 03 with Resolution 010 referred.**
16
17
18

19 The Council on Constitution and Bylaws recommends that the following Bylaws
20 amendments and deletions (highlighted in RED) be adopted, and that the remainder of
21 the report be filed. Adoption requires the affirmative vote of two-thirds of the members of
22 the House of Delegates present and voting following a one-day layover.
23

24 **2—House of Delegates**

25
26 **2.0.1 Composition and Representation....**
27

28 **2.0.1.1 Qualification of Members of the House of Delegates.** Members of the House
29 of Delegates must be active members of the AMA and of the entity they represent.
30

31 **2.0.1.2 Rights and Privileges.** Delegates have the privilege of the floor of the House of
32 Delegates which includes the ability to submit resolutions, discuss and make motions on
33 items of business and vote in elections.
34

35 **[subsequent section will be renumbered accordingly]**
36

37 **2.1 Constituent Associations....**
38

39 ***
40

41 **2.1.3 Certification-Credentialing.** The president or chief executive officer of each
42 constituent association, or ~~the president's~~ their designee, shall ~~provide~~ certify to the AMA
43 Office of House of Delegates Affairs with the names and contact information of their
44 delegates and alternate delegates from their respective associations. Certification must
45 occur at least 45 days prior to ~~each~~ the Annual or Interim Mm meeting of the House of
46 Delegates. These appropriately identified individuals shall be duly credentialed for that
47 meeting only.
48

1 **2.1.4 Term.** Delegates from constituent associations shall be selected for two-year
2 terms and assume office on the date set by the constituent association, provided that
3 such seats are authorized pursuant to these Bylaws. Constituent associations entitled to
4 more than one delegate shall select them so that half the number, as near as may be,
5 are selected each year. One-year terms may be provided but only to the extent and for
6 such time as is necessary to accomplish this proportion.

7
8 **2.1.5 Vacancies.** The delegate selected to fill a vacancy shall assume office
9 immediately after selection and serve for the remainder of that term.

10
11 **2.1.5~~6~~ Resident/Fellow Physician and Medical Student Delegates.** A constituent
12 association may designate one or more of its delegate and alternate delegate seats to
13 be filled by a resident/fellow physician member or a medical student member.

14
15 **2.1.6.1 Term.** Such resident/fellow physician or medical student delegate or alternate
16 delegate shall serve for a one-year term ~~beginning as of the date of certification of the~~
17 ~~delegate or alternate delegate by the constituent association to the AMA.~~

18
19 **2.1.6.2 No Restriction on Selection.** Nothing in this bylaw shall preclude a
20 resident/fellow physician or medical student member from being selected to fill a full 2-
21 year term as a delegate or alternate delegate from a constituent association as provided
22 in Bylaw 2.1.34.

23
24 *****2.2 National Medical Specialty Societies....**

25
26 ***

27
28 **2.2.3 Certification Credentialing.** The president or chief executive officer of each
29 specialty society, or ~~the president's their~~ designee, shall provide certify to the AMA
30 Office of House of Delegates Affairs with the names and contact information of their
31 delegates and alternate delegates from their respective societies. Certification must
32 occur at least 45 days prior to each the Annual or Interim Mmeeting of the House of
33 Delegates. These appropriately identified individuals shall be duly credentialed for that
34 meeting only.

35
36 **2.2.4 Term.** Delegates from specialty societies shall be selected for two-year terms,
37 and shall assume office on the date set by the specialty society provided that such seats
38 are authorized pursuant to these Bylaws. Specialty societies entitled to more than one
39 delegate shall select them so that half the number, as near as may be, are selected
40 each year. One-year terms may be provided but only to the extent and for such time as
41 is necessary to accomplish this proportion.

42
43 **2.2.5 Resident/Fellow Physician and Medical Student Delegates.** A specialty
44 association may designate one or more of its delegate and alternate delegate seats to
45 be filled by a resident/fellow physician member or a medical student member.

46
47 **2.2.5.1 Term.** Such resident/fellow physician or medical student delegate or alternate
48 delegate shall serve for a one-year.

49

1 **2.2.5.2 No Restriction on Selection.** Nothing in this bylaw shall preclude a
2 resident/fellow physician or medical student member from being selected to fill a full 2-
3 year term as a delegate or alternate delegate from a specialty association as provided in
4 Bylaw 2.2.3.
5

6 **2.2.56 Vacancies.** The delegate selected to fill a vacancy shall assume office
7 immediately after selection and serve for the remainder of that term.
8

9 **2.3 Medical Student Regional Delegates and Alternate Delegates.** In addition to the
10 delegate and alternate delegate representing the Medical Student Section, medical
11 student regional delegates and regional alternate delegates shall be apportioned and
12 elected as provided in this bylaw.
13

14 **2.3.1 Qualifications.** Medical student regional delegates and alternate delegates must
15 be active medical student members of the AMA. In addition, medical student regional
16 delegates and alternate delegates must be members of and have received written
17 endorsement from their endorsing constituent association where their educational
18 program is located. The region in which the endorsing society is located determines the
19 student's region, and a medical student may only serve as a regional delegate, alternate
20 delegate or any temporary delegate or alternate delegate form of substitute (pursuant to
21 Bylaws 2.8.35 and 2.10.42) only for that region.

22 **2.3.2 Apportionment.** The total number of ~~M~~medical ~~S~~student ~~r~~Regional delegates and
23 alternate delegates is based on one delegate and one alternate delegate for each 2,000
24 active medical student members of the AMA, as recorded by the AMA on December 31
25 of each year. Each Medical Student Region, as defined by delineated in the rules of the
26 Medical Student Section, is entitled to one delegate and one alternate delegate for each
27 2,000 active medical student members of the AMA in an educational program located
28 within the jurisdiction of the ~~Medical Student Region~~. Any remaining ~~M~~medical ~~S~~student
29 ~~Section r~~Regional delegates and alternate delegates shall be apportioned one delegate
30 and one alternate delegate per region(s) with the greatest number of active AMA
31 medical student members in excess of a multiple of 2,000. If two regions have the same
32 number of active AMA medical student members, ties will be broken by lottery by the
33 MSS Medical Student Section Governing Council.
34

35 **2.3.2.1 Effective Date.** In January of each year the AMA shall notify the chair of the
36 Medical Student Section Governing Council of the number of seats in the House of
37 Delegates to which each Medical Student Region is entitled. Such apportionment shall
38 take effect on January 1 of the following year and shall remain effective for one year.
39

40 **2.3.3 Election.** Medical student regional delegates and alternates shall be elected by
41 the Medical Student Section in accordance with procedures adopted by the Medical
42 Student Section and approved by the Board of Trustees. ~~Each elected delegate and~~
43 ~~alternate delegate must receive written endorsement from their constituent association in~~
44 ~~accordance with procedures adopted by the Medical Student Section and approved by~~
45 ~~the Board of Trustees.~~ Regional dDelegates and alternate delegates shall be elected in
46 conjunction with at the Business Meeting of the Medical Student Section associated with
47 prior to the Interim Meeting of the House of Delegates. Regional dDelegates and
48 alternate delegates shall assume their office be seated at the next Annual Meeting of the
49 House of Delegates.
50

1 **2.3.4 Certification Credentialing.** The ~~C~~chair of the Medical Student Section
2 Governing Council, or the ~~C~~chair's designee, shall ~~provide~~ certify to the AMA Office of
3 House of Delegates Affairs with the names and contact information of the delegates and
4 alternate delegates for each Medical Student Region elected in accordance with 2.3.3 by
5 December 31 of each year. These appropriately identified individuals shall be duly
6 credentialed for each House of Delegates meeting occurring within their term as defined
7 in 2.3.5. Certification of delegates and alternate delegates must occur at least 45 days
8 prior to the Annual Meeting of the House of Delegates.

9 **2.3.5 Term.** Medical ~~s~~Student ~~r~~Regional delegates and alternate delegates shall be
10 elected for one-year terms ~~and shall assume office on the date set by the Medical~~
11 ~~Student Section Governing Council.~~

12
13 **2.3.6 Vacancies.** A medical student who fills a vacancy for a medical student regional
14 delegate or alternate delegate must have been elected from the same medical student
15 region as the vacating student. The delegate or alternate delegate selected to fill a
16 vacancy shall assume office immediately after selection and serve for the remainder of
17 that term.

18
19 **2.4 Delegates from the Resident and Fellow Sectional Delegates and Alternate**
20 **Delegates.** In addition to the delegate and alternate delegate representing the Resident
21 and Fellow Section, resident and fellow physician sectional delegates and alternate
22 delegates shall be apportioned and elected in a manner as provided in this bylaw.

23
24 **2.4.1 Qualifications.** Resident and fellow sectional Ddelegates and alternate delegates
25 from the Resident and Fellow Section must be active members of the Resident and
26 Fellow Section of the AMA. In addition, resident and fellow sectional physician delegates
27 and alternate delegates must be members of and have written endorsement from a their
28 endorsing society or organization currently seated in the HOD, in a capacity appropriate
29 to their level of training.

30
31 **2.4.2 Apportionment.** The apportionment of resident and fellow sectional delegates
32 from the Resident and Fellow Section is one delegate for each 2,000 active resident and
33 fellow physician members of the AMA, as recorded by the AMA on December 31 of each
34 year.

35
36 **2.4.2.1 Effective Date.** In January of each year, the AMA shall notify the chair of the
37 Resident and Fellow Section Governing Council of the number of seats in the House of
38 Delegates to which the Resident and Fellow Section is entitled. Such apportionment
39 shall take effect on January 1 of the following year and shall remain effective for one
40 year.

41
42 **2.4.3 Election.** Resident and fellow sectional Ddelegates and alternate delegates shall
43 be elected by the Resident and Fellow Section in accordance with procedures adopted
44 by the Section and approved by the Board of Trustees. Resident and fellow sectional
45 delegates and alternate delegates shall be elected at the Business Meeting of the
46 Resident and Fellow Section prior to the Interim Meeting of the House of Delegates.
47 Elected resident and fellow sectional delegates and alternate delegates shall assume
48 their office at the next Annual Meeting of the House of Delegates. Each delegate and
49 alternate delegate must receive written endorsement from a society or organization

1 ~~currently seated in the House of Delegates and in accordance with procedures adopted~~
2 ~~by the Resident and Fellow Section and approved by the Board of Trustees.~~

3
4 **2.4.4 Certification Credentialing.** The ~~C~~chair of the Resident and Fellow Section
5 Governing Council, or the ~~C~~chair's designee, shall ~~provide~~ ~~certify to~~ the AMA Office of
6 House of Delegates Affairs the names and contact information of the resident and fellow
7 sectional delegates and alternate delegates elected in accordance with 2.4.3 by
8 December 31 of each year for the Resident and Fellow Section. These appropriately
9 identified individuals shall be duly credentialed for each House of Delegates meeting
10 within their term as defined in 2.4.5. Certification of delegates and alternate delegates
11 must occur at least 45 days prior to the Annual Meeting of the House of Delegates.

12
13 **2.4.5 Term.** Resident and fellow sectional Ddelegates and alternate delegates ~~from the~~
14 ~~Resident and Fellow Section~~ shall be elected for one-year terms ~~and shall assume office~~
15 ~~on the date set by the Resident and Fellow Section Governing Council.~~

16
17 **2.4.6 Vacancies.** A resident or fellow who fills a vacancy for a resident and fellow
18 sectional delegate or alternate delegate must have been elected by the Resident and
19 Fellow Section. The delegate or alternate delegate sselected to fill a vacancy shall
20 assume office immediately after ~~selection and serve for the remainder of the term~~

21 ***
22 **2.6 Other Delegates.** Each of the following is entitled to a delegate: AMA Sections;
23 the Surgeons General of the United States Army, United States Navy, United States Air
24 Force, and United States Public Health Service; ~~the~~ Chief Medical Director of the
25 Department of Veterans Affairs; the National Medical Association; the American Medical
26 Women's Association; the American Osteopathic Association; and professional interest
27 medical associations granted representation in the House of Delegates.

28
29 **2.6.1 Certification Credentialing.** The president, chief executive officer, chair, or other
30 authorized individual of each entity described above shall ~~provide~~ ~~certify to~~ the AMA
31 Office of House of Delegates Affairs with the names and contact information of their
32 respective delegate and alternate delegate at least 45 days prior to each ~~the Annual or~~
33 ~~Interim M~~meeting of the House of Delegates.

34
35 **2.6.2 Term.** Delegates ~~from~~ these entities shall be selected for 2-year terms, and shall
36 assume office on the date set by the entity. Certification Credentialing of delegates and
37 alternate delegates must occur at least 45 days prior to the Annual or Interim Meeting of
38 the House of Delegates.

39
40 **2.6.3 Vacancies.** The delegate selected to fill a vacancy shall assume office
41 immediately after selection and serve for the remainder of that term.

42
43 ***

44 **2.8 Alternate Delegates.** Each organization represented in the House of Delegates
45 may select an alternate delegate for each of its delegates entitled to be seated in the
46 House of Delegates.

47
48 **2.8.1 Qualifications.** Alternate delegates must be active members of the AMA and of
49 the entity they represent.

50

1 **2.8.2 Certification Credentialing.** ~~Alternate delegates, with the exception of medical~~
2 ~~student regional and resident and fellow sectional alternate delegates, shall be certified~~
3 ~~credentialed to the AMA in the same manner as delegates at least 45 days prior to each~~
4 ~~meeting of the House of Delegates.~~

5
6 **2.8.3 Term.** Alternate delegates shall be selected for a 2-year term, and shall assume
7 office on the date set by the organization, unless otherwise provided in these Bylaws.
8

9 **2.8.4 Vacancies.** Alternate delegates selected to fill a vacancy shall assume office
10 immediately after selection and shall serve for the remainder of that term.
11

12 **2.8.5 Rights and Privileges.** ~~At the request of their corresponding delegate, a~~
13 ~~alternate delegate may temporarily be seated for them substitute for a delegate, on the~~
14 ~~floor of the House of Delegates, at the request of the delegate by complying with the~~
15 ~~procedures established by the Committee on Rules and Credentials. The alternate~~
16 ~~delegate must display their corresponding delegate's temporary credential and may then~~
17 ~~assume their privilege of the floor. While substituting for a delegate, the alternate~~
18 ~~delegate may speak and debate on the floor of the House, offer an amendment to a~~
19 ~~pending matter, make motions, and vote.~~

20
21 **2.8.6 Status.** The alternate delegate is not a "member of the House of Delegates" as
22 that term is used in these Bylaws. Accordingly, an alternate delegate may not introduce
23 resolutions into the House of Delegates, nor vote in any election conducted by the
24 House of Delegates. An alternate delegate is not eligible for nomination or election as
25 Speaker or Vice Speaker of the House of Delegates. The alternate delegate must
26 immediately relinquish their position on the floor of the House of Delegates upon the
27 request of their ir corresponding delegate for whom they are alternate delegate is
28 substituting temporarily seated.
29

30 **2.10 Registration and Seating of Delegates.**

31
32 **2.10.1 Notification.** In January of each year, the AMA shall notify each organization of
33 the number of seats in the House of Delegates to which it is entitled during the current
34 year.
35

36 ~~**2.10.2 Credentials.** A delegate or alternate delegate may only be seated if there is~~
37 ~~certification on file stating that the delegate or alternate delegate has been properly~~
38 ~~selected to serve in the House of Delegates.~~

39
40 ~~**2.10.3 Lack of Credentials.** A delegate or alternate delegate may be seated without~~
41 ~~the certificate defined in Bylaw 2.10.2 provided proper identification as the delegate or~~
42 ~~alternate delegate selected by the respective entity is established, and so certified to the~~
43 ~~AMA.~~
44

45 **2.10.2**

46 ~~**2.10.4 Substitute Temporary Delegate.** When a credentialed delegate or alternate~~
47 ~~delegate is unable to attend a meeting of the House of Delegates, or a portion thereof,~~
48 ~~the president, the president's designee or the chief executive officer, or chair other~~
49 ~~authorized individual of the entity the vacating delegate represents, or their designee,~~
50 ~~may appoint credential a temporary substitute delegate or temporary substitute alternate~~

1 delegate, who shall be eligible to serve as such a temporary delegate or temporary
2 alternate delegate in the House of Delegates at that meeting only.

3
4 **2.10.2.1 Temporary Delegates or Alternate Delegates for the AMA Sections.**

5 When a delegate from an AMA Section, other than the medical student regional and
6 resident and fellow sectional delegates, is unable to attend a meeting of the House of
7 Delegates, or a portion thereof, the alternate delegate from that section may be
8 credentialed as the temporary delegate. When an alternate delegate, other than the
9 medical student regional and resident and fellow sectional alternate delegates, from an
10 AMA Section is unable to attend a meeting of the House of Delegates, or a portion
11 thereof, a temporary alternate delegate may be selected and subsequently credentialed
12 from among the members of the section governing council.

13
14 **2.10.2.2 Temporary Medical Student Regional Alternate Delegate.** A medical
15 student meeting the requirements in Bylaw 2.3.1 who fills a temporary unfilled seat for a
16 medical student regional alternate delegate must have been elected at a special election
17 with an endorsement from a constituent association within the same medical student
18 region as the absent medical student. Temporary medical student regional alternate
19 delegates may only serve at the meeting for which they were credentialed.

20
21 **2.10.2.3 Temporary Resident and Fellow Sectional Alternate Delegates.** A
22 resident or fellow meeting the requirements in Bylaw 2.4.1 who fills a temporary unfilled
23 seat for a resident and fellow sectional alternate delegate must be elected in a special
24 election. Temporary resident and fellow sectional alternate delegates may only serve at
25 the meeting for which they were credentialed.

26
27 **2.10.4.1—Temporary Substitute Delegate.** A delegate whose credentials have been
28 accepted by the Committee on Rules and Credentials and whose name has been placed
29 on the roll of the House of Delegates shall remain a delegate until final adjournment of
30 that meeting of the House of Delegates. However, if the delegate is not able to remain in
31 attendance, that delegate's place may be taken during the period of absence by an
32 alternate delegate, or a substitute alternate delegate selected in accordance with Bylaw
33 2.10.4 if an alternate delegate is not available. The person who takes the place of the
34 delegate must have certification on file and shall be known as a temporary substitute
35 delegate. Such temporary substitute delegate shall have all of the rights and privileges of
36 a delegate while serving as a temporary substitute delegate, including the right to vote in
37 the House of Delegates and to vote in any election conducted by the House of
38 Delegates. The temporary substitute delegate shall not be eligible for nomination or
39 election as Speaker or Vice Speaker of the House of Delegates.

40
41 [Subsequent bylaw provisions 2.10.5, 2.10.6 and 2.10.7 will be renumbered as
42 2.10.3,2.10.4 and 2.10.5]

43
44 ****

45
46 **2.10.6**

47 **2.10.8 Medical Student Seating.** Each medical student regional delegate shall be
48 seated with the student's endorsing constituent association. Alternate delegates or
49 temporary substitute medical student regional delegates or alternate delegates shall be

1 assigned to the original regional delegate's seat location during the time they are seated
2 for the original delegate.

3
4 **2.10.7**

5 **2.10.9 Resident and Fellow Seating.** Each ~~delegate from the R~~resident and ~~F~~fellow
6 ~~Section sectional~~ delegate shall be seated with ~~the physician's their~~ endorsing society or
7 organization. ~~In the case where a delegate has been endorsed by multiple entities, the~~
8 ~~delegate must choose, prior to the election, with which delegation the delegate wishes to~~
9 ~~be seated.~~ Alternate delegates or temporary substitute resident and fellow sectional
10 delegates and alternate delegates shall be assigned to the original delegate's seat
11 location during the time they are seated for the original delegate.

12 (Modify Bylaws)

13
14 RESOLVED, that our American Medical Association Bylaws be amended to explicitly
15 affirm the ability of the Resident and Fellow Section to appoint substitute resident and
16 fellow sectional delegates and alternate delegates as well as temporary substitute
17 resident and fellow sectional delegates in accordance with procedures adopted by the
18 Section as all other delegations to the House of Delegates are able to and without being
19 held to a higher threshold of election (Modify Bylaws); and be it further

20
21 RESOLVED, that our AMA Bylaws be amended to explicitly affirm the ability of the
22 Medical Student Section to appoint substitute medical student regional delegates and
23 alternate delegates as well as temporary substitute medical student regional delegates
24 in accordance with procedures adopted by the Section as all other delegations to the
25 House of Delegates are able to and without being held to a higher threshold of election.
26 (Modify Bylaws)

27
28 Your Reference Committee heard extensive online and in-person testimony regarding
29 the merits, pros, cons, and potential parliamentary and legal constraints. As CCB Report
30 03 and Resolution 010 are fundamentally inseparable, your Reference Committee
31 conferred with counsel (OGC), and it was decided to combine them for consideration.
32 The general consensus of the Reference Committee was to attempt to reach a remedy
33 that would both meet the needs of the interested parties and not cause internal policy
34 conflict. Through extensive discussion, a direct pathway was not obvious without referral
35 of both items back to CCB for extensive review. The expectation is that Resolution 010
36 be incorporated into the revised CCB Report 03 to address the concerns of all those who
37 testified, including those regarding internal bylaws conflicts.

38
39
40 (19) RESOLUTION 002 – ENSURING ETHICAL USE OF
41 WEARABLE RECORDING DEVICES IN CLINICAL
42 ENCOUNTERS

43
44 RECOMMENDATION:

45
46 Your Reference Committee recommends that Resolution
47 002 be referred.

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HOD ACTION: Resolution 002 referred.

RESOLVED, that our American Medical Association consider developing new ethical guidance to address the use of personal or wearable recording devices—including eyeglass-mounted cameras—by physicians and patients in clinical encounters, including provisions that:

a) Require informed patient consent prior to any recording,

b) Prohibit covert or undisclosed use of such devices in clinical care,\

c) Recommend that such non-clinical visual recording devices not be worn during physical examinations of the breast, pelvic, genital, or rectal areas, regardless of recording status.

(Directive to take Action); and be it further

RESOLVED, that our AMA work with appropriate entities and organizations to develop model institutional policies on the ethical use, disclosure, and documentation of wearable and ambient personal recording technologies in health care settings. (Directive to Take Action)

Online testimony was mixed, with the majority calling for referral. Calls for referral expressed concerns about patient safety, privacy, and security as well as a desire for the AMA to provide more in-depth recommendations. The resolution was not extracted at the in-person hearing. Your Reference Committee recommends that the resolution be referred.

RECOMMENDED FOR NOT ADOPTION

(20) CCB REPORT 01 – BYLAWS REVIEW REPORT

RECOMMENDATION:

Your Reference Committee recommends that CCB Report 01 be not adopted.

HOD ACTION: CCB Report 01 not adopted.

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

3—Officers

3.6 Vacancies.

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

6—Councils

6.6 Council on Long Range Planning and Development.

6.6.2 Membership.

6.6.2.1 Ten active members of the AMA. Five members shall be appointed by the Speaker of the House of Delegates as follows: Two members shall be appointed from the membership of the House of Delegates, 2two members shall be appointed from the membership of the House of Delegates or from the AMA membership at-large, and one member appointed shall be a resident/fellow physician. Four members shall be appointed by the Board of Trustees from the membership of the House of Delegates or from the AMA membership at-large. One member appointed shall be a medical student member appointed by the Board of Trustees from a minimum of two-nominees submitted

1 ~~by the Medical Student Section Governing Council of the Medical Student Section with~~
2 ~~the concurrence of the Board of Trustees. The Board of Trustees may request additional~~
3 ~~nominations from the Medical Student Section Governing Council before making the~~
4 ~~appointment.~~

6.6.5 Vacancies.

7 **6.6.5.1 Members Other than the Resident/Fellow Physician and Medical Student**
8 **Member.** Any vacancy among the members of the Council other than the resident/fellow
9 physician member and the medical student member shall be filled by appointment by
10 either the Speaker of the House of Delegates or by the Board of Trustees as provided in
11 Bylaw 6.6.2. The new member shall be appointed for a four-year term.

12
13 **6.6.5.2 Resident/Fellow Physician Member.** If the resident/fellow physician member
14 of the Council ceases to complete the term for which appointed, the remainder of the
15 term shall be deemed to have expired. The successor shall be appointed by the Speaker
16 of the House of Delegates for a two-year term.

17
18 **6.6.5.3 Medical Student Member.** If the medical student member of the Council
19 ceases to complete the term for which appointed, the Board of Trustees may appoint a
20 successor to fill the remainder of the unexpired term from a minimum of two nominees
21 submitted by the Medical Student Section Governing Council. The Board of Trustees
22 may request additional nominations from the Medical Student Section Governing Council
23 before making the appointment.

6.7 Council on Legislation.

6.7.2 Membership.

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28
29 **6.7.2.1** Twelve active members of the AMA, one of whom shall be a resident/fellow
30 physician, and one of whom shall be a medical student. These members of the Council
31 shall be appointed by the Board of Trustees. The medical student member shall be
32 appointed by the Board of Trustees from a minimum of two
33 nominees ~~nominations~~ submitted by the Medical Student Section Governing Council. The
34 Board of Trustees may request additional nominations from the Medical Student Section
35 Governing Council before making the appointment.

6.7.3 Term.

36
37
38
39 **6.7.3.1** Members of the Council on Legislation shall be appointed for terms of one year,
40 beginning at the conclusion of the Annual Meeting. Except as provided in Bylaw 6.11, if
41 the resident/fellow physician member ceases to be a resident/fellow physician at any
42 time prior to the expiration of the term for which appointed, the service of such
43 resident/fellow physician member on the Council shall thereupon terminate, and the
44 position shall be declared vacant. Except as provided in Bylaw 6.11, if the medical
45 student member ceases to be enrolled in an educational program the service of such
46 medical student member on the Council shall thereupon terminate, and the position shall
47 be declared vacant.

48 ***
49
50

1 **6.7.5** Vacancies. Any vacancy, with the exception of a vacancy in the medical student
2 position, occurring on the Council ~~shall~~ may be filled for the remainder of the unexpired
3 term at the next meeting of the Board of Trustees. Completion of an unexpired term shall
4 not count toward maximum tenure on the Council.

5 6.7.5.1 Medical Student Member. If the medical student member ceases to complete
6 the term for which appointed, the Board may appoint a medical student member from a
7 minimum of two nominees submitted by the Medical Student Section Governing Council
8 to fill the remainder of the one-year term. The Board of Trustees may request additional
9 nominations from the Medical Student Section Governing Council before making the
10 appointment.

11
12 **6.8 Election - Council on Constitution and Bylaws, Council on Medical**
13 **Education, Council on Medical Service, and Council on Science and Public Health.**

14
15 **6.8.1 Nomination and Election.** Members of these Councils, except the medical
16 student member, shall be elected by the House of Delegates. The Chair of the Board of
17 Trustees will present announced candidates, who shall be entered into nomination by
18 the Speaker at the opening session of the meeting at which elections take place.
19 Nominations may also be made from the floor by a member of the House of Delegates at
20 the opening session of the meeting at which elections take place.

21
22 **6.8.2 Medical Student Member.** Medical student members of these Councils shall be
23 appointed by the Board of Trustees from a minimum of two nominees submitted by the
24 Medical Student Section Governing Council ~~of the Medical Student Section with the~~
25 ~~concurrence of the Board of Trustees.~~ The Board of Trustees may request additional
26 nominations from the Medical Student Section Governing Council before making the
27 appointments.

28
29 **6.9 Term and Tenure - Council on Constitution and Bylaws, Council on Medical**
30 **Education, Council on Medical Service, and Council on Science and Public Health.**

31
32 **6.9.1 Term.**

33
34 **6.9.1.3 Medical Student Member.** The medical student member of these Councils
35 shall be appointed for a term of one year. Except as provided in Bylaw 6.11, if the
36 medical student member ceases to be enrolled in an educational program at any time
37 prior to the expiration of the term for which elected, the service of such medical student
38 member on the Council shall thereupon terminate, and the position shall be declared
39 vacant.

40
41 **6.9.2 Tenure.** Members of these Councils may serve no more than eight years. The
42 limitation on tenure shall take priority over a term length for which the member was
43 elected. Medical student members who are appointed shall assume office at the close of
44 the Annual Meeting with the exception of a medical student who is appointed to fill a
45 vacancy.

46
47 **6.9.3 Vacancies.**

48
49 **6.9.3.1 Members other than the Resident/Fellow Physician and Medical Student**
50 **Member.** Any vacancy among the members of these Councils other than the

1 resident/fellow physician and medical student member shall be filled at the next Annual
2 Meeting of the House of Delegates. The successor shall be elected by the House of
3 Delegates for a four-year term.

4
5 **6.9.3.2 Resident/Fellow Physician Member.** If the resident/fellow physician member
6 of these Councils ceases to complete the term for which elected, the remainder of the
7 term shall be deemed to have expired. The successor shall be elected by the House of
8 Delegates for a two-year term.

9
10 **6.9.3.3 Medical Student Member.** If the medical student member of these Councils
11 ceases to complete the term for which appointed, the Board may appoint a medical
12 student member from a minimum of two nominees submitted by the Medical Student
13 Section Governing Council to fill the remainder of the one-year term. The Board of
14 Trustees may request additional nominations from the Medical Student Section
15 Governing Council before making the appointment.

16
17 **6.11 Term of Resident/Fellow Physician or Medical Student Member.** A
18 resident/fellow physician member of a Council who completes residency or fellowship
19 within 90 days prior to an Annual Meeting shall be permitted to serve on the Council until
20 the completion of the Annual Meeting. A medical student member of a Council who
21 graduates from an educational program during their term shall be permitted to serve on
22 the Council for up to 200 days after graduation but not extending past the completion of
23 the Annual Meeting following graduation. Service on a Council as a resident/fellow
24 physician and/or medical student member shall not be counted in determining maximum
25 Council tenure.
26 (Modify Bylaws)

27
28 Online testimony was mixed, with a majority calling for referral. In-person testimony was
29 in strong support for non-adoption. Your Reference Committee recommends that the
30 report be not adopted.

31
32
33 (21) RESOLUTION 004 – PATIENT OPTIONS TO RESTRICT
34 SECONDARY USE OF THEIR HEALTHCARE DATA

35
36 RECOMMENDATION:

37
38 Your Refence Committee recommends that Resolution 004
39 be not adopted.

40
41
42 **HOD ACTION: Resolution 004 referred.**
43
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1 RESOLVED, that our American Medical Association support healthcare data privacy
2 practices that provide patients with options to withdraw or restrict secondary uses of their
3 data, including the ability to retroactively withdraw their data from de-identified data sets.
4 (New HOD Policy)
5

6 The majority of online testimony was in favor of referral for study. In-person testimony
7 was mixed, with the majority in favor of non-adoption. Your Reference Committee
8 recommends that the resolution be not adopted.

DRAFT

Madam Speaker, this concludes the report of Reference Committee on Ethics and Bylaws. I would like to thank Dr. Dale Mandel, Dr. Nancy Ellerbroek, Dr. Jason Jameson, Dr. Jennifer Piel, Dr. Tashera Perry, and Dr. Brigitta Robinson and all those who testified before the committee.

Tashera Perry, MD
Indiana State Medical Association

Brigitta Robinson, MD
Colorado Medical Society

Jason Jameson, MD
American Urological Association

Jennifer Piel, MD
American Academy of Psychiatry
and the Law

Dale Mandel, MD
Pennsylvania Medical Society

Nancy Ellerbroek, MD
American College of Radiology

Mark Casanova, MD
Texas Medical Association
Chair

Amendments:

If you wish to propose an amendment to an item of business, use the following QR code or the following link: <https://forms.office.com/r/13Y1p3bQq9>



DRAFT

DISCLAIMER

The following is a preliminary report of actions taken by the House of Delegates at its 2025 Interim Meeting and should not be considered final. Only the Official Proceedings of the House of Delegates reflect official policy of the Association.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (I-25)

Final Report of Reference Committee F

Robert A. Gilchick, MD, MPH, Chair

RECOMMENDED FOR ADOPTION

1. Council on Long Range Planning and Development Report 1 – Private Practice Physicians Section Five-Year Review
2. Report of the House of Delegates Committee on the Compensation of the Officers
3. Board of Trustees Report 23 – Accreditation Council for Continuing Medical Education Observer Status in the House of Delegates

RECOMMENDED FOR ADOPTION AS AMENDED

4. Speakers' Report 2 – Election Committee Review of Election Rules for Clarification

RECOMMENDED FOR ADOPTION IN LIEU OF

5. Resolution 603 – Upholding Professional Integrity and Ethical Leadership through Continued Publication of the AMA Journal of Ethics
Resolution 604 – Sustaining Ethical Leadership Through Continued Support of the AMA Journal of Ethics

RECOMMENDED FOR REFERRAL

6. Resolution 601 – Reimagining and Modernizing the U.S. Healthcare Delivery System

Amendments

If you wish to propose an amendment to an item of business, use the following QR code or click: <https://forms.office.com/r/13Y1p3bQq9>



***Your Reference Committee recommendation has changed from the Preliminary Report.**

1 **RECOMMENDED FOR NOT ADOPTION**

2

3 7. Council on Long Range Planning and Development Report 2 – Evaluation of the
4 Structure of the AMA House of Delegates

5

6 8. Speakers' Report 1 – Online Reference Committees

7

8 9. Resolution 602 – Standardizing the Appointment Process for AMA Councils

DRAFT

RECOMMENDED FOR ADOPTION

- 1 (1) COUNCIL ON LONG RANGE PLANNING AND
2 DEVELOPMENT REPORT 1 - PRIVATE PRACTICE
3 PHYSICIANS SECTION FIVE-YEAR REVIEW
4

5 RECOMMENDATION:
6

7 Your Reference Committee recommends that the Recommendation in Council on Long
8 Range Planning and Development Report 1 be adopted and the remainder of the Report
9 be filed.

11 **HOD ACTION:**

12 **Council on Long Range Planning and Development Report 1 adopted and**
13 **remainder of report filed.**
14

16
17 The Council on Long Range Planning and Development recommends that our American
18 Medical Association renew delineated section status for the Private Practice Physicians
19 Section through 2030 with the next review no later than the 2030 Interim Meeting and that
20 the remainder of this report be filed. (Directive to Take Action)

21
22 Testimony in response to CLRPD Report 1 was supportive.
23

24 Your Reference Committee noted concerns related to member engagement and
25 governance were raised in the testimony, but your Reference Committee believes that the
26 Private Practice Physicians Section (PPPS) leadership can continue to work through these
27 matters internally. Moreover, the Council on Long Range Planning and Development's
28 positive review and the favorable testimony supports renewal of delineated status for the
29 PPPS.
30

31 Your Reference Committee recommends that the Council on Long Range Planning and
32 Development Report 1 be adopted.

1 (2) REPORT OF THE HOUSE OF DELEGATES COMMITTEE
2 ON THE COMPENSATION OF THE OFFICERS
3

4 RECOMMENDATION:
5

6 Your Reference Committee recommends that the
7 Recommendation in the Report of the House of Delegates
8 Committee on the Compensation of the Officers be adopted
9 and the remainder of the Report be filed.

11 **HOD ACTION:**

12 **Report of the House of Delegates Committee on the Compensation of the Officers**
13 **adopted and remainder of report filed.**
14
15

- 16
- 17 1. That there be no additional changes to the Officers' compensation for the period
18 beginning July 1, 2025, through June 30, 2026. (Directive to Take Action.)
 - 19 2. That the remainder of the report be filed.
20

21 No testimony was received.
22

23 Your Reference Committee recommends that the Report of the House of Delegates
24 Committee on the Compensation of the Officers be adopted.
25

26

27 (3) BOARD OF TRUSTEES REPORT 23 - ACCREDITATION
28 COUNCIL FOR CONTINUING MEDICAL EDUCATION
29 OBSERVER STATUS IN THE HOUSE OF DELEGATES
30

31 RECOMMENDATION:
32

33 Your Reference Committee recommends that the
34 Recommendation in Board of Trustees Report 23 be
35 adopted and the remainder of the Report be filed.
36

37 **HOD ACTION:**

38 **Board of Trustees Report 23 adopted and remainder of report filed.**
39
40

41

42 The Board of Trustees recommends that the Accreditation Council for Continuing Medical
43 Education be admitted as an Official Observer in the House of Delegates, and that the
44 remainder of this report be filed.
45

46 Only supportive testimony was received. Therefore, your Reference Committee
47 recommends that Board of Trustees Report 23 be adopted.

RECOMMENDED FOR ADOPTION AS AMENDED**(4) SPEAKERS' REPORT 2 - ELECTION COMMITTEE
REVIEW OF ELECTION RULES FOR CLARIFICATION****RECOMMENDATION A:**

Your Reference Committee recommends that the Recommendation in Speakers' Report 2 be amended by addition and deletion to read as follows:

1. A formal election complaint must be filed in writing by a HOD delegate or alternate delegate via the election website before the commencement of the election session at which the candidate is currently seeking election.
2. A campaign presentation is a written or verbal presentation about a campaign or a solicitation of votes for an AMA election during to a non-sponsoring group meeting. A candidate may attend and participate in the business of a non-campaign-related meeting or event of a non-sponsoring group or non-endorsing group, but the candidate shall not engage in campaigning of any kind. nor shall their attendance at the meeting include recognition or acknowledgment as a candidate prior to, during, or following such meeting or event.

RECOMMENDATION B:

Your Reference Committee recommends that the Recommendation in Speakers' Report 2 be adopted as amended and the remainder of the Report be filed.

HOD ACTION:

Speakers' Report 2 adopted as amended and the remainder of report filed.

ADOPTED LANGUAGE:

1. **A formal election complaint must be filed in writing by a HOD delegate or alternate delegate via the election website before the commencement of the election session at which the candidate is currently seeking election.**
 2. **A campaign presentation is a written or verbal presentation about a campaign or a solicitation of votes for an AMA election to a non-sponsoring group. A candidate may attend and participate in the business of a non-campaign-related meeting or event of a non-sponsoring group or non-endorsing group, but the candidate shall not engage in campaigning of any kind.**
-

1 Your Speakers recommend that the following clarifications be made to the AMA election
2 policies and the remainder of the report be filed:

- 3
- 4 1. A formal election complaint must be filed in writing by a HOD delegate or alternate
5 delegate via the election website before the commencement of the election session at
6 which the candidate is currently seeking election.
- 7
- 8 2. A campaign presentation is a written or verbal presentation about a campaign or a
9 solicitation of votes for an AMA election during a non-sponsoring group meeting.

10
11 Speakers' Report 2 sought to offer clarification on the election complaint process,
12 campaign-related presentations, and sponsoring groups. Limited testimony raised
13 additional points related to the parameters for an election session and the expectations of
14 a candidate during meetings held by a non-sponsoring group.

15
16 Testimony called for the addition of "non-endorsing groups" to the amended language in
17 an effort to provide support for candidates who wish to "address their own sponsoring and
18 endorsing societies of which they are a member."

19
20 Additional testimony supported removal of restrictive language that would mitigate the
21 unintended consequence of incurring a campaign violation while maintaining flexibility for
22 candidates attending non-campaign-related meetings.

23
24 In response to these points, and after consultation with your Speakers to better understand
25 the intent of their recommendations to preserve equitable campaign opportunities for all
26 candidates, your Reference Committee proffered amended language to provide added
27 clarification.

28
29 Your Reference Committee maintains its recommendation that Speakers' Report 2 be
30 adopted as amended.

RECOMMENDED FOR ADOPTION IN LIEU OF

- 1 (5) RESOLUTION 603 - UPHOLDING PROFESSIONAL
2 INTEGRITY AND ETHICAL LEADERSHIP THROUGH
3 CONTINUED PUBLICATION OF THE AMA JOURNAL OF
4 ETHICS
5 RESOLUTION 604 - SUSTAINING ETHICAL LEADERSHIP THROUGH
6 CONTINUED SUPPORT OF THE AMA JOURNAL OF ETHICS

7
8 RECOMMENDATION:

9
10 Your Reference Committee recommends that Alternate
11 Resolution 603 be adopted in lieu of Resolutions 603 and
12 604:

13
14 UPHOLDING PROFESSIONAL INTEGRITY AND
15 ETHICAL LEADERSHIP

16
17 RESOLVED, that our American Medical Association commit
18 to sustaining accessible, physician-led education and
19 discourse on the ethical challenges in medicine (New HOD
20 Policy); and be it further

21
22 RESOLVED, that our AMA publicize opportunities for
23 medical ethics engagement and learning across the
24 association (Directive to Take Action).
25

26
27 **HOD ACTION:**

28 **Alternate Resolution 603 adopted as amended in lieu of Resolutions 603 and 604.**

29
30 **ADOPTED LANGUAGE:**

31 **UPHOLDING PROFESSIONAL INTEGRITY AND ETHICAL LEADERSHIP**

- 32
33 **1. Our AMA is committed to sustaining accessible, physician-led education and**
34 **discourse on the ethical challenges in medicine.**
35
36 **2. Our AMA will develop and publicize opportunities for medical ethics**
37 **engagement and learning across the association.**
38
39 **3. Our AMA will continue to advance and fund opportunities for editorial**
40 **fellowships in ethics for trainees and early-career physicians commensurate to**
41 **the AMA Journal of Ethics Editorial Fellowship.**
42
43 **4. Our AMA will report back on its progress and advancement for medical ethics**
44 **engagement and editorial fellowships for trainees and early-career physicians**
45 **at Annual 2026.**
46
-

1 Resolution 603 –

2 RESOLVED, that our American Medical Association reaffirm its commitment to sustaining
3 accessible, physician-led education and discourse on the ethical challenges in medicine
4 (New HOD Policy); and be it further

5
6 RESOLVED, that our AMA maintain current funding and operations of the *AMA Journal of*
7 *Ethics* through at least the end of fiscal year 2027 (Directive to Take Action); and be it
8 further

9
10 RESOLVED, that our AMA study and report back with recommendations on how our
11 organization can maintain leadership in medical ethics education, including an
12 investigation of more sustainable or alternative publishing models for the *AMA Journal of*
13 *Ethics* (Directive to Take Action); and be it further

14
15 RESOLVED, that our AMA support the continued work, dissemination, and publication of
16 the *AMA Journal of Ethics*. (New HOD Policy)

17
18 Resolution 604 –

19 RESOLVED, that our American Medical Association (AMA) support the continued work,
20 dissemination, and publication of the *AMA Journal of Ethics* to address ethical challenges
21 in healthcare; and be it further

22
23 RESOLVED, that our AMA reaffirm its commitment to sustaining accessible, physician-
24 led ethics education and discourse.

25
26 Mixed testimony was received for Resolutions 603 and 604. Testimony noted concerns
27 that medical students and resident physicians may lose access to educational or
28 publishing opportunities when the *AMA Journal of Ethics* ceases publication in December
29 2025.

30
31 Additional testimony indicated that factors such as low readership and limited awareness
32 for the *Journal of Ethics* affirms the opportunity to utilize other platforms while continuing
33 the AMA's mission to maintain a standard for medical ethics. Testimony reflected the need
34 to promote more effective use of the AMA's resources. Further, these opportunities could
35 support our members' engagement in ethical discourse while promoting professional
36 development.

37
38 Your Reference Committee heard testimony from our Board of Trustees that our newly
39 founded Center for Digital Health and AI will prioritize and resource ethics as a core pillar
40 of our strategy and operations. Additionally, the rights for all content developed and
41 scheduled for publication in 2026 will revert to the authors of that content, and they will be
42 free to publish that content as they wish.

43
44 Overall, testimony supported the need to maintain the AMA's ethics work, especially in
45 light of AI, private equity, and other emerging issues that may impact the practice of
46 medicine.

47
48 Based on the testimony presented, your Reference Committee recommends that Alternate
49 Resolution 603 be adopted in lieu of Resolutions 603 and 604.

RECOMMENDED FOR REFERRAL

1 (6) RESOLUTION 601 - REIMAGINING AND MODERNIZING
2 THE U.S. HEALTHCARE DELIVERY SYSTEM

3
4 RECOMMENDATION:

5
6 Your Reference Committee recommends that Resolution
7 601 be referred.
8

9
10 **HOD ACTION:**

11 **Resolution 601 referred for decision.**
12

13
14 RESOLVED, that our American Medical Association will convene a multidisciplinary Task
15 Force, under the direction of the Board of Trustees, that may include physicians and
16 trainees, allied health professionals, leaders from hospitals and health systems, public
17 and private payers, health economists, ethicists, patient advocates, and other relevant
18 parties from across the health sector, to develop a legislative roadmap to reform the U.S.
19 healthcare delivery system, drawing from and building upon existing AMA policy, and
20 positioning our AMA as a convener of a broader national coalition to advance this vision;
21 and that this roadmap will be structured around the following components:

- 22
- 23 1. Foundational Principles: The roadmap will specifically incorporate the following
24 principles:
 - 25 a. Equitable access to affordable, high-quality healthcare for all as a basic human
26 right;
 - 27 b. Physician autonomy and the primacy of the patient-physician relationship;
 - 28 c. Physician-led care as the foundation of clinical decision-making and healthcare
29 delivery;
 - 30 d. Freedom of patients and physicians to choose care settings and models of
31 practice;
 - 32 e. Physician practice sustainability through fair and predictable payment;
 - 33 f. Science-based innovation that improves healthcare value and efficiency; and
 - 34 g. Prevention, public health, and health equity as central pillars of a sustainable
35 healthcare system;
 - 36
 - 37 2. Scope of Review: In developing the roadmap, the task force will consider issues
38 related to healthcare delivery and financing, including, but is not limited to, the
39 following systemic problems and potential solutions:
 - 40 a. Physician payment and workforce sustainability;
 - 41 b. Comprehensive valuation of physician work;
 - 42 c. Incentives that support timely, patient-centered care and uphold clinical judgment;
 - 43 d. Administrative, financial, and clinical interference by intermediaries;
 - 44 e. Uninsurance, underinsurance, and other cost-sharing issues;
 - 45 f. Universal coverage, including preventive services and public health;
 - 46 g. Equity in care delivery;
 - 47 h. Protection of physician-patient shared decision-making;

- 1 i. Market consolidation, vertical integration, and profiteering;
- 2 j. Drug pricing and access to evidence-based therapies; and
- 3 k. Transparency and reporting of the true cost of care;
- 4
- 5 3. Environmental Scan: To inform the roadmap, the task force will conduct a
- 6 comprehensive review of existing global and domestic healthcare programs and
- 7 reform proposals to evaluate their strengths and weaknesses based on how each
- 8 framework centers patients, upholds clinical judgment, and promotes healthcare
- 9 system and physician practice sustainability; and
- 10
- 11 4. Reporting and Engagement: The task force will:
- 12 a. Report at least annually to the AMA House of Delegates on its findings and
- 13 progress;
- 14 b. Provide recommendations to the AMA Board of Trustees on areas requiring further
- 15 policy development to support this work;
- 16 c. Regularly convene focus groups within and outside of the AMA House of
- 17 Delegates to review draft elements of the roadmap as they are being developed;
- 18 and
- 19 d. Deliver a final comprehensive legislative roadmap to reform the U.S. healthcare
- 20 delivery system for consideration by the AMA House of Delegates.
- 21 (Directive to Take Action)
- 22

23 Testimony was mixed in response to Resolution 601 and underscored the complexity of
24 the matter, as well as the range of perspectives among those testifying. Proponents
25 emphasized that the resolution addresses key weaknesses in the current healthcare
26 system (e.g., fragmentation and underpayment) and fosters a vision for reform.
27 Conversely, testimony in opposition cautioned that the resolution may be overly
28 prescriptive and questioned whether a single Task Force could effectively manage the
29 breadth of issues identified. Several recommended clarifying the guiding principles of a
30 Task Force, particularly the commitment to science-based evidence in healthcare
31 innovation.

32
33 Testimony stressed the importance of strong physician representation, physician-led care,
34 and the preservation of shared decision-making.

35
36 Some individuals also warned of potential divisions within the medical community and the
37 challenges inherent in developing a new policy framework, suggesting that integrating
38 existing policies might be a more practical solution. Testimony also pointed out the large
39 fiscal note assigned to the resolution. The overall discussion reflected a shared dedication
40 to collaborative, evidence-driven approaches for addressing the complex challenges of
41 the U.S. healthcare system.

42
43 In response to the testimony presented, our AMA Board of Trustees indicated your
44 Reference Committee's preliminary recommendation for referral for report is welcomed,
45 and would allow for careful consideration of factors such as:

- 46
- 47 • The respective roles of existing AMA entities responsible for driving efforts in this area,
48 including the Council on Legislation, the Council on Medical Service, and the House
49 of Delegates.

- 1 • How the substantial body of existing AMA policy guides our AMA efforts toward health
2 system modernization.
3
- 4 • The opportunities for, and challenges of, developing partnerships with non-physician
5 entities for these efforts.
6
- 7 Your Reference Committee maintains its recommendation that Resolution 601 be referred
8 for report. As was stated during testimony, our AMA needs to develop and lead with a plan
9 for reforming our healthcare system.

DRAFT

RECOMMENDED FOR NOT ADOPTION

1 (7) COUNCIL ON LONG RANGE PLANNING AND
2 DEVELOPMENT REPORT 2 - EVALUATION OF THE
3 STRUCTURE OF THE AMA HOUSE OF DELEGATES
4

5 RECOMMENDATION:
6

7 Your Reference Committee recommends that the
8 Recommendation in Council on Long Range Planning and
9 Development Report 2 not be adopted and the remainder of
10 the Report be filed.
11

12 **HOD ACTION:**

13 **Council on Long Range Planning and Development Report 2 not adopted and report**
14 **filed.**
15
16

17
18 The Council on Long Range Planning and Development recommends that the delegate
19 apportionment for the AMA House of Delegates be paused at 2025 levels through year-
20 end 2026 and that this report be filed.

21
22 Testimony was predominately opposed to the recommendation contained in CLRPD
23 Report 2 indicating that a proposed pause in increased delegate apportionment may
24 undermine democratic principles as well as efforts related to membership growth.
25 Additional testimony noted that smaller delegations may be placed at a disadvantage due
26 to a pause. Your Reference Committee noted some larger delegations expressed similar
27 concerns.
28

29 The limited supportive testimony indicated that implementing a pause for one year may
30 provide an opportunity to address logistical concerns associated with House of Delegates
31 (HOD) meetings. Testimony further reflected that the CLRPD listening session at the 2025
32 Interim meeting may facilitate an in-depth discussion and identify potential solutions for
33 future consideration.
34

35 Your Reference Committee acknowledges and appreciates the CLRPD's efforts in
36 preparing this report; however, your Reference Committee supports that the
37 recommendation contained in the Council on Long Range Planning and Development
38 Report 2 not be adopted.

1 (8) SPEAKERS' REPORT 1 - ONLINE REFERENCE
2 COMMITTEES

3
4 RECOMMENDATION:

5
6 Your Reference Committee recommends that the
7 Recommendation in Speakers' Report 1 not be adopted and
8 the remainder of the Report be filed.

9
10
11 **HOD ACTION:**

12 **Speakers' Report 1 not adopted and report filed.**

13
14
15 Your Speakers recommend that Policy G-600.045, "Online Reference Committee
16 Hearings in the House of Delegates," be amended by addition and deletion and the
17 remainder of the report be filed:

- 18
19 1. Our American Medical Association will convene Online Reference Committee
20 Hearings prior to each House of Delegates meeting. These hearings shall open 10
21 days following the resolution submission deadline and remain open for ~~24~~ 14 days.

22
23 Testimony in response to Speakers' Report 1 reflected appreciation for the opportunity to
24 provide feedback and emphasized the importance of thoughtful engagement in the
25 policymaking process.

26
27 The majority of those who testified opposed implementing any immediate changes to the
28 Online Reference Committee (ORC) process. Several expressed concerns that reducing
29 the ORC duration at this time could constrain participation and impede the thorough review
30 of resolutions. Testimony further highlighted that the ORC process constitutes a recent
31 and significant procedural change, and that delegations are continuing to adapt to its
32 implementation. Overall, the testimony reflected a collective commitment to enhancing the
33 ORC process over time, with careful consideration of the diverse needs and capacities of
34 all delegations.

35
36 Your Reference Committee recommends that Speakers' Report 1 not be adopted.

1 (9) RESOLUTION 602 - STANDARDIZING THE
2 APPOINTMENT PROCESS FOR AMA COUNCILS
3

4 RECOMMENDATION:
5

6 Your Reference Committee recommends that Resolution
7 602 not be adopted.
8

9
10 **HOD ACTION:**
11 **Resolution 602 not adopted.**
12

13
14 RESOLVED, that our American Medical Association develop a phased implementation
15 plan – including selection criteria, procedural steps, and necessary bylaw amendments –
16 to establish a House of Delegates-elected Nominating Committee responsible for the
17 appointment and reappointment of all Council members, subject to final approval by the
18 Board of Trustees. (Directive to Take Action)

19
20 Testimony was overwhelmingly opposed to Resolution 602, noting that the proposed
21 process compromises the democratic nature for selecting AMA Council members.
22 Concerns associated with establishing a nominating committee include:
23

- 24 • Bias could be introduced into the appointment process, which could compromise
25 fairness and consideration of diverse perspectives.
26
- 27 • Centralizing the appointment of Council members could erode accountability and
28 engagement for our AMA Board of Trustees and the HOD.
29
- 30 • Interactions between HOD members and Council candidates could be hampered
31 by the process change; thus, limiting discourse on key issues.
32

33 Although limited testimony noted the potential merit of a nominating committee, the overall
34 sentiment was that a universal appointment process is not appropriate for our AMA
35 Councils. Therefore, your Reference Committee recommends that Resolution 602 not be
36 adopted.

- 1 This concludes the report of Reference Committee F. I would like to thank Emily D. Briggs,
- 2 MD, MPH, Richard A. Geline, MD, Hillary Johnson-Jahangir, MD, PhD, Jayme N. Looper,
- 3 MD, MSE, Jayesh B. Shah, MD, MHA, Yasser F. Zeid, MD, MHA, and all those who
- 4 testified before the Committee.

Emily D. Briggs, MD, MPH
American Academy of Family
Physicians

Jayme N. Looper, MD, MSE (Alternate)
American Society of Anesthesiologists

Richard A. Geline, MD (Alternate)
Illinois

Jayesh B. Shah, MD, MHA
Texas

Hillary Johnson-Jahangir, MD, PhD
American Academy of Dermatology
Association

Yasser F. Zeid, MD, MHA
Texas

Robert A. Gilchick, MD, MPH
American College of Preventive
Medicine
Chair

DRAFT

DISCLAIMER

The following is a preliminary report of actions taken by the House of Delegates at its 2025 Interim Meeting and should not be considered final. Only the Official Proceedings of the House of Delegates reflect official policy of the Association.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (I-25)

Final Report of Reference Committee J

Mary Campagnolo, MD MBA, Chair

RECOMMENDED FOR ADOPTION

1. Board of Trustees Report 18 – Published Metrics for Hospitals and Hospital Systems
2. Resolution 802 – Patient Choice of Physician
3. Resolution 804 – Medicare Advantage Filing Limit
4. Resolution 809 – Ensuring Patient Safety and Physician Oversight in the Integration of Hospital Inpatient Virtual Nursing
5. Resolution 811 – Non-Medical Switching
6. Resolution 812 – Discontinue Review Choice Demonstration Project for Inpatient Rehabilitation Hospital Admissions
7. Resolution 814 – Mandate for Insurance Companies to Assist in the Transition of Patients to Alternative Participating Physicians Upon Contract Termination
8. Resolution 821 – Improving Access to Emergency Ophthalmologic Surgical Care
9. Resolution 828 – Creating a Public Scorecard on Insurer Delays in Care and Payment Caused by Prior Authorization
10. Resolution 829 – Publicize Insurer Financial Gains from Delayed Care and Payment Caused by Prior Authorization
11. Resolution 830 - Preserve Coverage for Peripheral Nerve Blockade in Chronic Pain

RECOMMENDED FOR ADOPTION AS AMENDED

12. Council on Medical Service Report 1 – Health Savings Account Reform
13. Council on Medical Service Report 2 – Telehealth Licensure
14. Council on Medical Service Report 3 – Payment Models to Sustain Rural Hospitals
15. Council on Medical Service Report 4 – Payment for Biosimilars
16. Resolution 805 – Shared Medical Appointments
17. Resolution 806 – Insurance Coverage for Colonoscopy Preparation Cost
18. *Resolution 807 – Protecting Hospitals and Patients from Inappropriate Denials of Inpatient Admissions
19. Resolution 808 – No Prior Authorization for Inexpensive Medications
20. Resolution 810 – Opposing Unilateral Downcoding of Physician Services by Insurance Companies
21. Resolution 815 – Mandating Health Insurers to Provide a Real-Time Online Tool for Coverage and Payment Policies, Integrated into Electronic Health Records (EHRs)

- 1 22. Resolution 816 – Prohibit Arbitrary Time Limits on Preauthorizations
- 2 23. Resolution 817 – Prohibiting Insurers from Denying Payment for Procedures
- 3 Based on Site of Service
- 4 24. Resolution 819 – Update the Status of Virtual Credit Card Policy, EFT Fees, and
- 5 Lack of Enforcement of Administrative Simplification Requirements by CMS*
- 6 25. Resolution 822 – Improving Home or Community-Based Services Waiver Waiting
- 7 List Management
- 8 26. Resolution 823 – Accountability in the Use of Augmented Intelligence for Prior
- 9 Authorization
- 10 27. Resolution 824 – Equitable Payment and Increased Access for In-Office Pediatric
- 11 Lead Screening and Testing
- 12 28. Resolution 825 – Ensuring Coverage for In-Office Point-of-Care (POC) Testing in
- 13 Outpatient Medical Practices
- 14 29. Resolution 826 - Increase National Immunization Rates by Advocating for
- 15 Equitable Vaccine Payments
- 16 30. Resolution 827 – Opposition to Prior Authorization in Medicare Fee-for-Service,
- 17 Burdensome Administrative Requirements

18
19 **REFER FOR DECISION**

- 20
21 31. Resolution 820 - Establishing an AMA “First Responder Team” for Real-Time
22 Physician Advocacy Against Adverse Insurance Company Actions

23
24 **RECOMMENDED FOR REAFFIRMATION IN LIEU OF**

- 25
26 32. Resolution 813 – Increased Regulation of For-Profit Healthcare Insurance
27 33. Resolution 818 – Universal Out-of-Network Benefits

RECOMMENDED FOR ADOPTION

1 (1) BOT REPORT 18 – PUBLISHED METRICS FOR
2 HOSPITALS AND HOSPITAL SYSTEMS
3

4 RECOMMENDATION:
5

6 Your Reference Committee recommends that the
7 Recommendations in Board of Trustees Report 18 be
8 adopted and the remainder of the report be filed.
9

10
11 **HOD ACTION: Board of Trustees Report 18 is adopted and remainder of Report filed.**
12

13
14 The Board of Trustees recommends that the following be adopted and the remainder of
15 the report be filed:
16

17 1. Our American Medical Association supports the use of metrics that hospitals and
18 hospital systems can use to improve physicians' experience, engagement, and work
19 environment in a manner accessible to physicians. (New HOD Policy)
20

21 2. That Policy D-215.979, "Published Metrics for Hospitals and Hospital Systems," be
22 rescinded as being accomplished by this report. (Rescind HOD Policy)
23

24 Your Reference Committee heard supportive testimony on Board of Trustees Report 18.
25 Testimony indicated that physician burnout remains alarmingly high and that the report
26 appropriately advances evidence-based, system-level metrics to assess burnout.
27 Therefore, your Reference Committee recommends that the recommendations in Board
28 of Trustees Report 18 be adopted and the remainder of the report be filed.
29

30 (2) RESOLUTION 802 – PATIENT CHOICE OF PHYSICIAN
31

32 RECOMMENDATION:
33

34 Your Reference Committee recommends that
35 Resolution 802 be adopted.
36

37
38 **HOD ACTION: Resolution 802 is adopted.**
39

40
41 RESOLVED, that our American Medical Association continue its support of the patient-
42 physician relationship and the patient's choice of physician by reaffirming existing AMA
43 policies, "Preservation of Physician-Patient Relationships and Promotion of Continuity of
44 Patient Care H-160.901" and "Physician Penalties for Out-of-Network Services H-
45 180.952." (Reaffirm HOD Policy)
46

1 Testimony on Resolution 802 was both in support of reaffirmation and in support of the
2 resolution as written. The resolution itself called for reaffirmation of AMA policy. Either
3 path leads to the same destination, therefore your Reference Committee recommends
4 that Resolution 802 be adopted.

5
6 (3) RESOLUTION 804 – MEDICARE ADVANTAGE FILING
7 LIMIT

8
9 RECOMMENDATION:

10
11 Your Reference Committee recommends that
12 Resolution 804 be adopted.

14 **HOD ACTION: Resolution 804 is adopted.**

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

23 Testimony was supportive of adoption of Resolution 804 as written. Several delegations
24 provided testimony in favor of the resolution highlighting that it supports administrative
25 simplification and fairness in Medicare Advantage plans. Testimony agreed on the
26 importance of parity between traditional Medicare and Medicare Advantage and
27 supported standardizing the time limits for filing claims to the 12-month time frame of
28 traditional Medicare. Therefore, your Reference Committee recommends that Resolution
29 804 be adopted.

31 (4) RESOLUTION 809 – ENSURING PATIENT SAFETY AND
32 PHYSICIAN OVERSIGHT IN THE INTEGRATION OF
33 HOSPITAL INPATIENT VIRTUAL NURSING

35 RECOMMENDATION:

36
37 Your Reference Committee recommends that
38 Resolution 809 be adopted.

41 **HOD ACTION: Resolution 809 is adopted.**

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

1
2 RESOLVED, that our AMA recognizes that organized medical staffs, as leaders in
3 hospital medicine who have a duty to protect patient safety within their institutions,
4 should work collaboratively to ensure physician-led, high-quality, patient-centered care in
5 the integration of inpatient virtual nursing, (New HOD Policy)
6

7 Your Reference Committee heard supportive testimony on Resolution 809. Testimony
8 noted that this resolution addresses the emerging practice of inpatient virtual nursing,
9 highlights growing concern about the rapid deployment of these systems, and
10 underscores the importance of physician oversight and medical staff involvement in the
11 implementation of these systems. There was a question raised about physicians' role in
12 inpatient virtual nursing but it was clarified that this resolution does not suggest that the
13 AMA overstep into nursing policy but instead this resolution would promote patient-
14 focused, physician-led care. Additional testimony asked that the forthcoming study called
15 for by adoption of Resolution 809 includes a look at the potential bias of these
16 arrangements against low-income individuals, including those covered by Medicaid.
17 Your Reference Committee recommends that Resolution 809 be adopted.

18
19 (5) RESOLUTION 811 – NON-MEDICAL SWITCHING

20
21 RECOMMENDATION:

22
23 Your Reference Committee recommends that
24 Resolution 811 be adopted.
25

26
27 **HOD ACTION: Resolution 811 is adopted.**
28

29
30 RESOLVED, that our American Medical Association opposes the practice of non-
31 medical switching by pharmacy benefit managers and health insurers, except when
32 clinically justified and approved by the prescribing physician (New HOD Policy); and be it
33 further

34
35 RESOLVED, that our American Medical Association study and report back at I-26 on the
36 clinical and economic impact of non-medical switching on patient outcomes, medication
37 adherence, and overall healthcare utilization, and disseminate these findings to
38 policymakers and the public. (Directive to Take Action)
39

40 Testimony on Resolution 811 was universally supportive. Testimony explained the
41 importance of ensuring that physicians, not pharmacy benefit managers or payers, are
42 the ones prescribing drugs to patients. Testimony explained the hurdles that can result
43 from non-medical switching like increased side effects, reduced treatment adherence,
44 and poor health outcomes. An amendment was proffered that would result in monitoring,
45 rather than studying, this topic. However, the vast majority of support was in favor of
46 adopting the resolution as written. Therefore, your Reference Committee recommends
47 Resolution 811 be adopted.

1 (6) RESOLUTION 812 – DISCONTINUE REVIEW CHOICE
2 DEMONSTRATION PROJECT FOR INPATIENT
3 REHABILITATION HOSPITAL ADMISSIONS
4

5 RECOMMENDATION:
6

7 Your Reference Committee recommends that
8 Resolution 812 be adopted.
9

10
11 **HOD ACTION: Resolution 812 is adopted.**
12

13
14 RESOLVED, that our American Medical Association oppose CMS's expansion of the
15 Inpatient Rehabilitation Facility Review Choice Demonstration Project and advocate that
16 the project be immediately discontinued. (Directive to Take Action)
17

18 Testimony on Resolution 812 was supportive of adoption. One delegation expressed
19 that the precedent of discontinuing a Center for Medicare and Medicaid Innovation
20 (CMMI) program could set. However, the authors of the resolution explained that this
21 program is not a CMMI demonstration project and situations of fraud have already been
22 demonstrated in the existing program. The delegation that originally voiced concerns
23 testified that their concerns were dissuaded by the response. Other testimony on this
24 item was strongly supportive and outlined the harm that this program causes. Therefore,
25 your Reference Committee recommends Resolution 812 be adopted.
26

27 (7) RESOLUTION 814 – MANDATE FOR INSURANCE
28 COMPANIES TO ASSIST IN THE TRANSITION OF
29 PATIENTS TO ALTERNATIVE PARTICIPATING
30 PHYSICIANS UPON CONTRACT TERMINATION
31

32 RECOMMENDATION:
33

34 Your Reference Committee recommends that
35 Resolution 814 be adopted.
36

37
38 **HOD ACTION: Resolution 814 is adopted.**
39

40
41 RESOLVED, that our American Medical Association advocate through legislation or
42 regulations that private and public health insurers be mandated on the event of a treating
43 physician terminating participation with that insurer to provide assistance to affected
44 patients in transitioning to other in-network physicians, including providing a list of
45 alternative participating physicians who can continue to provide care to the patient
46 (Directive to Take Action); and be it further
47

48 RESOLVED, that our American Medical Association advocate through legislation or
49 regulations that private and public health insurers be mandated to provide resources to

1 ensure continuity of care for patients who are mid-treatment or require ongoing care with
2 the exiting physician without penalties to the physician, including offering extended
3 benefits or out-of-network coverage when necessary (Directive to Take Action); and be it
4 further

5
6 RESOLVED, that our American Medical Association advocate through legislation or
7 regulations that private and public health insurers be mandated to provide an online
8 payment policy tool that has a uniform interface that works across all insurers and
9 physicians, ensuring consistent and streamlined access to coverage information for
10 physicians and patients. (Directive to Take Action)

11
12 Your Reference Committee heard limited testimony on Resolution 814. This resolution
13 was originally recommended for reaffirmation. However, one delegation provided
14 testimony against reaffirmation and in support of the original resolution. Another
15 delegation provided testimony against reaffirmation and in support of the resolution, but
16 only if it was amended. Testimony stated that it is important for the AMA to advocate on
17 this issue, as many health plans are not assisting patients in transitioning to other in-
18 network physicians when needed. Further testimony questioned the feasibility of the
19 third resolve clause and recommended it be deleted. Your Reference Committee did not
20 find the argument for feasibility compelling and believes the language is important to
21 retain in the resolution. Therefore, your Reference Committee recommends that
22 Resolution 814 be adopted.

23
24 (8) RESOLUTION 821 – IMPROVING ACCESS TO
25 EMERGENCY OPHTHALMOLOGIC SURGICAL CARE

26
27 RECOMMENDATION:

28
29 Your Reference Committee recommends that
30 Resolution 821 be adopted.

31
32
33 **HOD ACTION: Resolution 821 is adopted.**
34

35
36 RESOLVED, that our American Medical Association supports policies aimed at
37 enhancing access to emergency ophthalmic care—including vitreoretinal surgical
38 services and traumatic open globe injuries— through initiatives such as improved
39 operating room availability, facility reimbursement reforms, and changes to hospital
40 privileging that exclude economic criteria to facilitate timely surgical care (New HOD
41 Policy); and be it further

42
43 RESOLVED, that our AMA advocates to reduce payer barriers, including prior
44 authorization and inadequate Medicaid and Medicare reimbursement, that hinder access
45 to surgical ophthalmologic emergency care including vitreoretinal surgery and traumatic
46 open globe injuries (Directive to Take Action); and be it further

47
48 RESOLVED, that our AMA advocate for reducing geographic and socioeconomic
49 barriers to timely ophthalmologic emergency care—including both surgical vitreoretinal

1 services and traumatic open globe injuries—in alignment with AMA health equity
2 policies, with emphasis on rural and underserved communities. (Directive to Take
3 Action)

4
5 Your Reference Committee heard testimony in strong support of Resolution 821 and the
6 need to ensure timely access to sight-saving emergency ophthalmologic care, including
7 vitreoretinal surgeries and treatment of traumatic open globe injuries. A proffered
8 amendment asked for the addition of a new resolve clause advocating that hospitals
9 maintain 24/7 emergency availability of ophthalmologic care; however, this amendment
10 did not garner sufficient support as the vast majority of testimony strongly supported the
11 resolution as written. Thus, your Reference Committee recommends that Resolution 821
12 be adopted.

13
14 (9) RESOLUTION 828 – CREATING A PUBLIC
15 SCORECARD ON INSURER DELAYS IN CARE AND
16 PAYMENT CAUSED BY PRIOR AUTHORIZATION

17
18 RECOMMENDATION:

19
20 Your Reference Committee recommends that
21 Resolution 828 be adopted.

22
23
24 **HOD ACTION: Resolution 828 is adopted.**

25
26
27 RESOLVED, that our American Medical Association continue to lead the advocacy effort
28 and assist state medical associations with the implementation of timely, non-aggregated
29 public reporting by private and public plans that engage in prior authorization related to
30 the services subject to prior authorization, the number of services approved, denied and
31 overturned on appeal, and the timeframes for responding to requests for authorization
32 and paying physician claims (Directive to Take Action); and be it further

33
34 RESOLVED, that our AMA work with interested organizations in the development and
35 publication of public and private plan scorecards related to prior authorization approvals,
36 denials, appeals, and the timeframes for responding to requests for authorization and
37 processing physician payments to better inform patients, physicians, and purchasers of
38 insurance. (Directive to Take Action)

39
40 Testimony was unanimously supportive of Resolution 828. Testimony indicated that the
41 resolution is an extension of recent Centers for Medicare & Medicaid Services regulation
42 requiring reporting of prior authorization metrics for Medicare Advantage and Exchange
43 plans to private, employer-based, and ERISA-regulated plans. Further, it was suggested
44 that the scorecards outlined by this resolution could provide a broader, more consistent
45 framework for reporting and comparing performance. Due to the entirely supportive
46 testimony, your Reference Committee recommends Resolution 828 be adopted.

1 (10) RESOLUTION 829 – PUBLICIZE INSURER FINANCIAL
2 GAINS FROM DELAYED CARE AND PAYMENT
3 CAUSED BY PRIOR AUTHORIZATION
4

5 RECOMMENDATION:
6

7 Your Reference Committee recommends that
8 Resolution 829 be adopted.
9

10
11 **HOD ACTION: Resolution 829 is adopted.**
12

13
14 RESOLVED, that our American Medical Association support efforts to investigate and
15 publicize the financial benefit and profit to commercial insurers, and Medicare and
16 Medicaid health plans that inappropriately use prior authorization to unnecessarily delay
17 care for patients and payments to physicians. (New HOD Policy)
18

19 Testimony was generally supportive of Resolution 829. Testimony indicated the
20 publication of prior authorization data can inform patients and employers and, potentially,
21 incentivize insurers to improve their practices. One delegation supported the resolution
22 but suggested it may lack definitional clarity, questioned how an investigation of this kind
23 could be operationalized, and encouraged the AMA to proceed in a thoughtful way. Due
24 to the supportive testimony, your Reference Committee recommends Resolution 829 be
25 adopted.
26

27 (11) RESOLUTION 830 – PRESERVE COVERAGE FOR
28 PERIPHERAL NERVE BLOCKADE IN CHRONIC PAIN
29

30 RECOMMENDATION:
31

32 Your Reference Committee recommends that
33 Resolution 830 be adopted.
34

35
36 **HOD ACTION: Resolution 830 is adopted.**
37

38
39 RESOLVED, that our American Medical Association advocate for the withdrawal of the
40 draft Local Coverage Determinations issued by Medicare Administrative Contractors that
41 restrict coverage of peripheral nerve blockade procedures for chronic pain (Directive to
42 Take Action).; and be it further
43

44 RESOLVED, that our AMA advocate to the Centers for Medicare & Medicaid Services
45 (CMS) and the Medicare Administrative Contractors to preserve—and, where supported
46 by evidence, expand—coverage of peripheral nerve blockade and all associated
47 therapies (Directive to Take Action).; and be it further
48

1 RESOLVED, that our AMA reaffirm and apply existing AMA policy—H-185.931
2 “Workforce and Coverage for Pain Management” and H-120.922 “Improved Access and
3 Coverage to Non-Opioid Modalities to Address Pain”—to oppose efforts that limit the use
4 of peripheral nerve blockade and associated interventional pain procedures as evidence-
5 based treatment options. (Reaffirm HOD Policy)

6
7 Testimony on Resolution 830 was entirely supportive. Testimony explained the
8 importance of peripheral nerve blocks (PNBs) for patients that may not have other pain
9 relief options. Testimony highlighted the importance of PNBs for opioid abuse
10 prevention, in situations when circumstances preclude the use of other medication-
11 based pain relief, and to ensure full spectrum of pain management is offered to patients.
12 One testifier also explained the importance of maintaining coverage of PNBs to facilitate
13 training of the procedures. Therefore, your Reference Committee recommends that
14 Resolution 830 be adopted.

DRAFT

RECOMMENDED FOR ADOPTION AS AMENDED

1 (12) CMS REPORT 1 – HEALTH SAVINGS ACCOUNT
2 REFORM

3
4 RECOMMENDATION A:

5
6 Your Reference Committee recommends that
7 Recommendation 6 in Council on Medical Service Report
8 1 be amended by addition to read as follows:

9
10 6) That our AMA amend Policy H-165.828 by addition and
11 deletion to read as follows:

12
13 HEALTH INSURANCE AFFORDABILITY, H-165.828

14
15 (3) Our AMA (i) encourages the development of
16 demonstration projects to allow individuals eligible for
17 cost-sharing subsidies, who forego these subsidies by
18 enrolling in a bronze plan, to have access to a health
19 savings account (HSA) partially funded by an amount
20 determined to be equivalent to the cost-sharing subsidy;
21 and (ii) supports individual market bronze and silver
22 plans, regardless of actual deductible amount, being
23 treated as HSA-qualified high-deductible health plans,
24 with appropriate guardrails in place (e.g., safe harbor
25 provisions) to ensure low-income enrollees in these plans
26 do not suffer undue financial hardships. (Modify Current
27 HOD Policy)

28
29 RECOMMENDATION B:

30
31 Your Reference Committee recommends that Council
32 on Medical Service Report 1 be amended by addition of
33 a new Recommendation to read as follows:

34
35 Our AMA supports the principle that HSAs are
36 complementary to and do not replace health insurance
37 coverage or other efforts to improve affordability of
38 health insurance such as ACA premium tax credits.
39 (New HOD Policy)

40
41 RECOMMENDATION C:

42
43 Your Reference Committee recommends that the
44 Recommendations in Council on Medical Service Report
45 1 be adopted as amended and the remainder of the report
46 filed.
47

1
2 **HOD ACTION: Council on Medical Service Report 1 is adopted as amended and**
3 **remainder of report filed.**

4
5 **ADOPTED LANGUAGE:**

- 6
7 1) That our American Medical Association (AMA) support permitting health
8 savings account (HSA) contributions from family members, employers, or
9 other designated individuals and not limiting HSA contributions to the owner
10 of the high-deductible health plan, provided that annual Internal Revenue
11 Service contribution limits are not exceeded.
12
13 2) That our AMA support contributions to HSAs by individuals who are Medicare
14 enrollees with support for external research and/or demonstration projects to
15 determine how best those distributions can be spent, with special
16 consideration for low-resource Medicare enrollees.
17
18 3) That our AMA amend Policy H-165.852 by addition to read as follows:
19
20 **HEALTH SAVINGS ACCOUNTS, H-165.852(7)**
21
22 (7) legislation promoting the establishment and the use of HSAs and allowing
23 the tax-free use of such accounts for health care expenses, including health,
24 dental, vision, hearing, and long-term care insurance premiums and other costs
25 of long-term care, be strongly supported as an integral component of AMA
26 efforts to achieve universal access and coverage and freedom of choice in
27 health insurance.
28
29 4) That our AMA supports external research and/or demonstration projects on the
30 feasibility and tax integrity of transferring HSA funds between spouses and
31 other family members.
32
33 5) That our AMA supports Affordable Care Act (ACA) premium tax credits
34 designed to allow individuals to contribute to HSAs through the application of
35 unused or residual credit amounts.
36
37 6) That our AMA amend Policy H-165.828 by addition and deletion to read as
38 follows:
39
40 **HEALTH INSURANCE AFFORDABILITY, H-165.828 (3)**
41 (3) Our AMA (i) encourages the development of demonstration projects to allow
42 individuals eligible for cost-sharing subsidies, who forego these subsidies by
43 enrolling in a bronze plan, to have access to a health savings account (HSA)
44 partially funded by an amount determined to be equivalent to the cost-sharing
45 subsidy; and (ii) supports individual market bronze and silver plans, regardless
46 of actual deductible amount, being treated as HSA-qualified high-deductible
47 health plans, with appropriate guardrails in place (e.g., safe harbor provisions)
48 to ensure low-income enrollees in these plans do not suffer financial hardships.
49

- 1 7) That our AMA supports education on the use of HSAs to Medicare
2 beneficiaries and purchasers of ACA marketplace plans, including those
3 purchasing bronze plans and how that plan compares to purchasing a silver
4 plan with subsidies.
5
- 6 8) That our AMA supports the principle that HSAs are complementary to and do
7 not replace health insurance coverage or other efforts to improve affordability
8 of health insurance such as ACA premium tax credits
9
- 10 9) That our AMA reaffirm Policy H-290.972, Health Savings Accounts in the
11 Medicaid Program, which outlines several principles for states considering
12 offering beneficiaries HSAs.
13
- 14 10) That our AMA reaffirm Policy H-165.833, Amend the Patient Protection and
15 Affordable Care Act, which states that as part of the AMA's organizational goal
16 of amending and improving the Affordable Care Act, the AMA will advocate to
17 expand the use of HSAs as a means to provide health insurance.
18
- 19 11) That our AMA reaffirm Policy H-385.912, Direct Primary Care, which states that
20 the use of a health savings account to access direct primary care (DPC)
21 providers and/or to receive care from a direct primary care medical home
22 constitutes and bona fide medical expense, and that particular sections of the
23 IRS code related to qualified medical expenses should be amended to
24 recognize the use of HSA funds for DPC and DPC medical home models as a
25 qualified medical expense. Furthermore, H-385.912 states that the AMA will
26 seek federal legislation or regulation to amend appropriate sections of the IRS
27 code to specify that DPC access or DPC medical homes are not health "plans"
28 and that the use of HSA funds to pay for DPC provider services in such setting
29 constitutes a qualified medical expense, enabling patients to use HSAs to help
30 pay for DPC and to enter DPC periodic-fee agreements without IRS
31 interference or penalty.
32

33 The following additional resolve language was referred:

34
35 Our AMA advocates for using the expanded Affordable Care Act premium tax
36 credits as a vehicle for improving health insurance affordability rather than
37 converting those subsidies to health savings accounts or other cash savings
38 accounts.
39

40
41 The Council on Medical Service recommends that the following recommendations be
42 adopted in lieu of Resolution 803-I-24 and the remainder of the report be filed:
43

- 44 1) That our American Medical Association (AMA) support permitting health savings
45 account (HSA) contributions from family members, employers, or other designated
46 individuals and not limiting HSA contributions to the owner of the high-deductible health
47 plan, provided that annual Internal Revenue Service contribution limits are not
48 exceeded. (New HOD Policy)
49

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

5
6 3) That our AMA amend Policy H-165.852 by addition to read as follows:

7
8 HEALTH SAVINGS ACCOUNTS, H-165.852

9
10 It is the policy of the AMA that: (7) legislation promoting the establishment and
11 the use of HSAs and allowing the tax-free use of such accounts for health care
12 expenses, including health, dental, vision, hearing, and long-term care insurance
13 premiums and other costs of long-term care, be strongly supported as an integral
14 component of AMA efforts to achieve universal access and coverage and
15 freedom of choice in health insurance. (Modify Current HOD Policy)

16
17 4) That our AMA supports external research and/or demonstration projects on the
18 feasibility and tax integrity of transferring HSA funds between spouses and other family
19 members. (New HOD Policy)

20
21 5) That our AMA supports Affordable Care Act (ACA) premium tax credits designed to
22 allow individuals to contribute to HSAs through the application of unused or residual
23 credit amounts. (New HOD Policy)

24
25 6) That our AMA amend Policy H-165.828 by addition and deletion to read as follows:

26
27 HEALTH INSURANCE AFFORDABILITY, H-165.828

28
29 (3) Our AMA (i) encourages the development of demonstration projects to allow
30 individuals eligible for cost-sharing subsidies, who forego these subsidies by
31 enrolling in a bronze plan, to have access to a health savings account (HSA)
32 partially funded by an amount determined to be equivalent to the cost-sharing
33 subsidy; and (ii) supports individual market bronze and silver plans being treated
34 as HSA-qualified high-deductible health plans. (Modify Current HOD Policy)

35
36 7) That our AMA supports education on the use of HSAs to Medicare beneficiaries and
37 purchasers of ACA marketplace plans, including those purchasing bronze plans and how
38 that plan compares to purchasing a silver plan with subsidies. (New HOD Policy)

39
40 8) That our AMA reaffirm Policy H-290.972, Health Savings Accounts in the Medicaid
41 Program, which outlines several principles for states considering offering beneficiaries
42 HSAs. (Reaffirm HOD Policy)

43
44 9) That our AMA reaffirm Policy H-165.833, Amend the Patient Protection and Affordable
45 Care Act, which states that as part of the AMA's organizational goal of amending and
46 improving the Affordable Care Act, the AMA will advocate to expand the use of HSAs as
47 a means to provide health insurance. (Reaffirm HOD Policy)

48
49 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

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

11
12 Testimony on Council on Medical Service Report 1 was mixed. Several delegations and
13 individuals spoke in favor both of the original recommendations in CMS 1 and in favor of
14 the amended language suggested by the Reference Committee. Additional testimony
15 highlighted concern with recent developments in Congress and within the Administration
16 related to health savings accounts (HSAs) and enhanced ACA premium tax credits. The
17 Council on Medical Service noted that this was not considered during the writing of the
18 report given the timeline of these discussions. Additionally, the Council reiterated that
19 the focus of CMS 1 was directly addressing the referred resolution from I-24.
20

21 In online testimony, there was a question raised regarding the benchmarking of silver
22 level plans if they were to be redefined as HSA eligible high-deductible health plans
23 (HDHP), which the Council addressed. The Council clarified that the recommendations
24 in its report would expand flexibility and usability of HSAs for those wanting that type of
25 health care coverage but would not change eligibility for premium tax credits for others,
26 specifically those tied to the second-lowest cost silver plans. The Council proposed an
27 amendment to Recommendation 6, which the Reference Committee believes addresses
28 the concerns raised. In-person testimony supported this and there was no testimony
29 against these amendments.
30

31 The Reference Committee understands why the recent developments regarding HSAs
32 and ACA premium tax credits were not considered by the Council in their original
33 recommendations and appreciates the concerns that were raised during in-person
34 testimony. There were several amendments offered and your Reference Committee
35 believes an additional recommendation to the original Council recommendations is the
36 best path forward, to preserve the initial work from the Council in addressing the referred
37 resolution while also addressing potential policy changes from Congress and/or the
38 Administration. Your Reference Committee recommends that recommendations in
39 Council on Medical Service Report 1 be adopted as amended and the remainder of the
40 report be filed.

41
42 (13) CMS REPORT 2 – TELEHEALTH LICENSURE

43
44 RECOMMENDATION A:

45
46 Your Reference Committee recommends that
47 Recommendation 1 of Council on Medical Service
48 Report 2 be amended by addition to read as follows:
49

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

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

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

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

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

27 d. Exemption from licensure requirements for
28 physicians assessing or screening out-of-state patients
29 for acceptance of a referral to a center for excellence
30 or to a physician with specific expertise in the patient's
31 condition, as selected by the referring physician and
32 patient.

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

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

42 1.The trial meets relevant federal, state, and ethical
43 standards as well as those outlined in AMA policy;

44 2.The assessments are not intended to establish or
45 replace care for the patient outside of the context of the
46 trial; and

47 3.Physicians planning to use telehealth identify a
48 physician licensed in the patient's state to address in-
49 person care needs that may arise from the clinical trial.

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

8
9 RECOMMENDATION B:

10
11 Your Reference Committee recommends that the
12 Recommendations in Council on Medical Service
13 Report 2 be adopted as amended and the remainder
14 of the report be filed.

15
16
17 **HOD ACTION: Council on Medical Service Report 2 is adopted as amended and**
18 **remainder of report filed.**

19
20 **AMENDED LANGUAGE:**

21
22 **1. That our AMA amend Policy H-480.969[1] by addition to read:**

23
24 **(1) It is the policy of our American Medical Association (AMA) that medical boards**
25 **of states and territories should require a full and unrestricted license in that state**
26 **for the practice of telemedicine, unless there are other appropriate state-based**
27 **licensing methods, with no differentiation by specialty, for physicians who wish to**
28 **practice telemedicine in that state or territory. This license category should**
29 **adhere to the following principles:**

- 30 **a. Exemption from such a licensure requirement for physician-to-physician**
31 **consultations.**
32 **b. Exemption from such a licensure requirement for telemedicine practiced across**
33 **state lines in the event of an emergent or urgent circumstance, the definition of**
34 **which for the purposes of telemedicine should show substantial deference to the**
35 **judgment of the attending and consulting physicians as well as to the views of the**
36 **patient.**
37 **c. Allowances, by exemption or other means, for out-of-state physicians providing**
38 **continuity of care to a patient, where there is an established ongoing relationship**
39 **and previous in-person visits, for services incident to an ongoing care plan or one**
40 **that is being modified.**
41 **d. Exemption from licensure requirements for physicians assessing or screening**
42 **out-of-state patients for acceptance of a referral to a center for excellence or to a**
43 **physician with specific expertise in the patient's condition, as selected by the**
44 **referring physician and patient.**
45 **e. Exemption from licensure requirements for physicians screening out-of-state**
46 **patients for acceptance into a clinical trial that meets relevant federal, state, and**
47 **ethical standards as well as those outlined in AMA policy.**
48 **f. Exemption from licensure requirements for physicians conducting assessments**
49 **of out-of-state patients that are required as part of a clinical trial, provided that:**
50

- 1 **1.The trial meets relevant federal, state, and ethical standards as well as**
2 **those outlined in AMA policy;**
3 **2.The assessments are not intended to establish or replace care for the**
4 **patient outside of the context of the trial; and**
5 **3.Physicians planning to use telehealth identify a physician licensed in the**
6 **patient’s state to address in-person care needs that may arise from the**
7 **clinical trial.**
8 **g. Application requirements that are non-burdensome, issued in an expeditious**
9 **manner, have fees no higher than necessary to cover the reasonable costs of**
10 **administering this process, and that utilize principles of reciprocity with the**
11 **licensure requirements of the state in which the physician in question practices.**
12
13 **2. That Policies D-480.960 and D-480.964 be reaffirmed.**
14
-

15
16 The Council on Medical Service recommends that the following be adopted and the
17 remainder of the report be filed:
18

- 19 1. That our AMA amend Policy H-480.969[1] by addition to read:
20 (1) It is the policy of our American Medical Association (AMA) that medical
21 boards of states and territories should require a full and unrestricted license in
22 that state for the practice of telemedicine, unless there are other appropriate
23 state-based licensing methods, with no differentiation by specialty, for physicians
24 who wish to practice telemedicine in that state or territory. This license category
25 should adhere to the following principles:
26 a. Exemption from such a licensure requirement for physician-to-physician
27 consultations.
28 b. Exemption from such a licensure requirement for telemedicine practiced
29 across state lines in the event of an emergent or urgent circumstance, the
30 definition of which for the purposes of telemedicine should show substantial
31 deference to the judgment of the attending and consulting physicians as well as
32 to the views of the patient.
33 c. Allowances, by exemption or other means, for out-of-state physicians providing
34 continuity of care to a patient, where there is an established ongoing relationship
35 and previous in-person visits, for services incident to an ongoing care plan or one
36 that is being modified.
37 d. Exemption from licensure requirements for physicians assessing or screening
38 out-of-state patients for acceptance of a referral to a center for excellence or to a
39 physician with specific expertise in the patient’s condition.
40 e. Exemption from licensure requirements for physicians screening out-of-state
41 patients for acceptance into a clinical trial that meets relevant federal, state, and
42 ethical standards as well as those outlined in AMA policy.
43 f. Exemption from licensure requirements for physicians conducting assessments
44 of out-of-state patients that are required as part of a clinical trial, provided that:
45 1.The trial meets relevant federal, state, and ethical standards as well as
46 those outlined in AMA policy;
47 2.The assessments are not intended to establish or replace care for the
48 patient outside of the context of the trial; and

1 3.Physicians planning to use telehealth identify a physician licensed in the
2 patient's state to address in-person care needs that may arise from the
3 clinical trial.

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

9
10 2.That our AMA reaffirm Policy D-480.960, which encourages states to allow an out-of-
11 state physician to use telehealth to provide continuity of care to existing patients if there
12 is a pre-existing and ongoing physician-patient relationship and a previous in-person
13 visit, and the care is incident to an existing care plan or one that is being modified.
14 (Reaffirm HOD Policy)

15
16 3.That our AMA reaffirm Policy D-480.964, which encourages states that are not part of
17 the Interstate Medical Licensure Compact (IMLC) to consider joining the Compact;
18 advocates for reduced application and state licensure(s) fees processed through the
19 IMLC; supports state efforts to expand physician licensure recognition across state lines
20 in accordance with the standards and safeguards outlined in AMA policy; and
21 encourages states to pass legislation enhancing patient access to and proper regulation
22 of telehealth services. (Reaffirm HOD Policy)

23
24 Testimony was supportive of Council on Medical Service Report 2 and its
25 recommendations permitting telehealth licensure exceptions for out-of-state complex
26 referrals and clinical trials. An amendment was proffered to add "as selected by the
27 referring physician" to Recommendation 1(1d), citing concerns about patients potentially
28 being solicited for "free second opinions" using telehealth, or an insurer transitioning
29 patients from their treating physicians to groups that have more advantageous contracts
30 with the insurer. Responding to this proposed change, the Council on Medical Service
31 asked that "and patients" be added to the amendment since decisions about complex
32 referrals should ideally be made jointly by physicians and patients. The Council also
33 pointed to existing AMA policy addressing comments on the supervision of
34 nonphysicians using telehealth across state lines (Policy H-160.937) and preserving
35 patient safeguards and a state's liability framework (Policy D-480.960). Your Reference
36 Committee supports the proffered amendment and recommends that the
37 recommendations in Council on Medical Service Report 2 be adopted as amended and
38 the remainder of the report be filed.

39
40 (14) CMS REPORT 3 – PAYMENT MODELS TO SUSTAIN
41 RURAL HOSPITALS

42
43 RECOMMENDATION A:

44
45 Your Reference Committee recommends that
46 Recommendation 2b of Council on Medical Service
47 Report 3 be amended by addition and deletion to read
48 as follows:

1 b. support educating physicians, ~~providers non-~~
2 physician practitioners, and patients on alternative
3 payment models for rural hospitals. (New HOD Policy)
4

5 RECOMMENDATION B:
6

7 Your Reference Committee recommends that
8 Recommendation 5 of Council on Medical Service
9 Report 3 be amended by addition and deletion to read
10 as follows:
11

12 5. That our AMA amend Policy D-465.998 by addition
13 to read as follows:
14

15 ADDRESSING PAYMENT AND DELIVERY IN
16 RURAL HOSPITALS, D-465.998

17 5. Our AMA supports educating patients, ~~and~~
18 physicians, ~~and non-physician practitioners~~ on the
19 impact of Medicare Advantage plans on rural hospitals
20 and encourages all payers to provide adequate
21 payment to support the financial stability of rural
22 hospitals. (Modify Current HOD Policy)
23

24 RECOMMENDATION C:
25

26 Your Reference Committee recommends that Council
27 on Medical Service Report 3 be amended by addition of
28 a new Recommendation to read as follows:
29

30 10. That our AMA work to vigorously oppose Medicaid
31 cuts as they significantly impact at-risk rural hospitals.
32 (New HOD Policy)
33

34 RECOMMENDATION D:
35

36 Your Reference Committee recommends that Council
37 on Medical Service Report 3 be amended by addition of
38 a new recommendation to read as follows:
39

40 11. That our AMA reaffirm Policy H-290.951 (Reaffirm
41 HOD Policy)
42

43 RECOMMENDATION E:
44

45 Your Reference Committee recommends that the
46 Recommendations in Council on Medical Service
47 Report 3 be adopted as amended and the remainder of
48 the report filed.
49

1
2 **HOD ACTION: Council on Medical Service Report 3 is adopted as amended and**
3 **remainder of report filed.**

4
5 **ADOPTED LANGUAGE:**

6
7 **1. That our American Medical Association (AMA) supports the following minimum**
8 **standards for alternative payment models to rural hospitals in order to enhance**
9 **their financial sustainability and ensure access to care:**

- 10 a. **Fixed Cost Payment: Rural hospitals should be paid an agreed upon and**
11 **fixed sum delivered on a predictable schedule that is not tied to patient**
12 **volume.**
13 b. **Adequate Payment Rates: All payers should ensure that payments made**
14 **for variable services are adequate to cover the full cost of care provision.**
15 c. **Patient Cost-Sharing: Any out-of-pocket payments made by patients**
16 **should be reasonable and affordable.**
17 d. **Accountability and Transparency: Care delivered should be of high-quality,**
18 **evidence-based, and part of a physician-led team.**
19 e. **Administrative Simplicity: Models should minimize administrative burdens.**

20
21 **2. That our AMA believes that rural hospitals are essential to the communities they**
22 **serve. To ensure that these hospitals have adequate support to remain open and**
23 **financially viable, our AMA will continue to work with interested national medical**
24 **specialty societies and state medical associations to:**

- 25 a. **support and monitor novel payment models for rural hospitals and**
26 **encourage uniform reporting; and**
27 b. **support educating patients, physicians, and non-physician practitioners on**
28 **alternative payment models for rural hospitals.**

29
30 **3. That our AMA supports that funds allocated for rural hospitals be used to**
31 **enhance or maintain rural health care.**

32
33 **4. That our AMA work to vigorously oppose Medicaid cuts as they significantly**
34 **impact at-risk rural hospitals.**

35
36 **5. Policy D-465.999 be amended to read:**

37
38 **Our AMA: (1) will call on the Centers for Medicare & Medicaid Services to support**
39 **individual states in their development of rural health networks; (2) support the**
40 **reintroduction of the state-designated Critical Access Hospital (CAH) “necessary**
41 **provider” designation; and (3) will pursue steps to require the federal government**
42 **to fully fund its obligations under the Medicare Rural Hospital Flexibility Program.**

43
44 **6. Policy D-465.998 be amended by addition of a new 5 to read:**

45 **5. Our AMA supports educating patients and physicians on the impact of Medicare**
46 **Advantage plans on rural hospitals and encourages all payers to provide**
47 **adequate payment to support the financial stability of rural hospitals.**

48
49 **6. That Policies H-465.994, H-465.982, H-290.951, and H-465.997 be reaffirmed.**

1
2 **7. That the second clause of Policy D-190.969 be rescinded.**
3

4
5 The Council on Medical Service recommends that the following be adopted and the
6 remainder of the report be filed:
7

8 1. That our American Medical Association (AMA) supports the following minimum
9 standards for alternative payment models to rural hospitals in order to enhance their
10 financial sustainability and ensure access to care:

- 11 a. Fixed Cost Payment: Rural hospitals should be paid an agreed upon and fixed
12 sum delivered on a predictable schedule that is not tied to patient volume.
13 b. Adequate Payment Rates: All payers should ensure that payments made for
14 variable services are adequate to cover the full cost of care provision.
15 c. Patient Cost-Sharing: Any out-of-pocket payments made by patients should be
16 reasonable and affordable.
17 d. Accountability and Transparency: Care delivered should be of high-quality,
18 evidence-based, and part of a physician-led team.
19 e. Administrative Simplicity: Models should minimize administrative burdens. (New
20 HOD Policy)
21

22 2. That our AMA believes that rural hospitals are essential to the communities they serve.
23 To ensure that these hospitals have adequate support to remain open and financially
24 viable, our AMA will continue to work with interested national medical specialty societies
25 and state medical associations to:

- 26 c. support and monitor novel payment models for rural hospitals and encourage
27 uniform reporting; and
28 d. support educating physicians, providers, and patients on alternative payment
29 models for rural hospitals. (New HOD Policy)
30

31 3. That our AMA supports that funds allocated for rural hospitals be used to enhance or
32 maintain rural health care. (New HOD Policy)
33

34 4. That our AMA amend Policy D-465.999 by addition and deletion to read as follows:
35 CRITICAL ACCESS HOSPITAL NECESSARY PROVIDER DESIGNATION, D-465.999
36 Our AMA: (1) will call on the Centers for Medicare & Medicaid Services to support
37 individual states in their development of rural health networks; (2) ~~opposes the~~
38 elimination-support the reintroduction of the state-designated Critical Access Hospital
39 (CAH) "necessary provider" designation; and (3) will pursue steps to require the federal
40 government to fully fund its obligations under the Medicare Rural Hospital Flexibility
41 Program. (Modify Current HOD Policy)
42

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

44 ADDRESSING PAYMENT AND DELIVERY IN RURAL HOSPITALS, D-465.998
45 5. Our AMA supports educating patients and physicians on the impact of Medicare
46 Advantage plans on rural hospitals and encourages all payers to provide adequate
47 payment to support the financial stability of rural hospitals. (Modify Current HOD Policy)
48

49 6. That our AMA reaffirm Policy H-465.994 which outlines support for continued work with
50 relevant and interested stakeholders to research, report, and improve rural health

1 through strategies including telemedicine and innovative workforce strategies. (Reaffirm
2 HOD Policy)

3
4 7. That our AMA reaffirm Policy H-465.982 which encourages states, and ensures AMA
5 support, to support efforts related to managed care in rural settings. (Reaffirm HOD
6 Policy)

7
8 8. That our AMA reaffirm Policy H-465.997 which outlines support for local and federal
9 efforts to improve rural health with initiatives that are holistic and community-based.
10 (Reaffirm HOD Policy)

11
12 9. That the second clause of Policy D-190.969 be rescinded as it is accomplished by this
13 report. (Rescind AMA Policy)

14
15 Testimony on Council on Medical Service Report 3 was supportive. Testimony echoed
16 the concerns for rural hospitals that are outlined in the report and emphasized the
17 importance of ensuring their survival. Additionally, testimony explained the importance of
18 ensuring that the impact of recent federal legislation on rural hospitals is mitigated as
19 much as possible. An amendment was proposed to add physician practices to the
20 recommendations, however as explained by the authors, your Reference Committee
21 believes this is out of the scope of the current report which focused exclusively on rural
22 hospitals.

23
24 A second minor amendment was suggested by a delegation, and supported by the
25 Council, to change “providers” to “non-physician practitioners” in the second
26 recommendation. Your Reference Committee agrees that this language switch is
27 important and recommends the amendment. To ensure language is consistent
28 throughout policy, your Reference Committee also recommends mirroring language in
29 the fifth recommendation of the report to include “non-physician practitioners.”

30
31 Finally, an amendment was proffered to add a new 10th recommendation outlining AMA
32 efforts to oppose cuts to Medicaid as the cuts will likely impact rural hospitals
33 significantly. The Council pointed out that there is existing AMA policy and a Board
34 report on this topic. However, your Reference Committee believes that the addition of
35 the proffered new recommendation strengthens the report’s recommendations and
36 therefore supports its inclusion. Additionally, your Reference Committee agreed with the
37 Council testimony that existing policy should be reaffirmed as new recommendation 11.
38 Therefore, your Reference Committee recommends that recommendations in Council on
39 Medical Service Report 3 be adopted as amended and the remainder of the report filed.

40
41 (15) CMS REPORT 4 – PAYMENT FOR BIOSIMILARS

42
43 RECOMMENDATION A:

44
45 Your Reference Committee recommends that
46 Recommendation 2 of Council on Medical Service Report
47 4 be amended by addition to read as follows:
48

- 1 2. That our AMA encourages public and private payers to implement
2 comprehensive payment structures that allow for fair and timely payment for
3 biologic/biosimilar drugs that:
- 4 a. Maintain patient access to biologic/biosimilar drugs prescribed by their
5 physician consistent with AMA Policy H-100.940;
 - 6 b. Account for physician/practice administrative and acquisition costs, including
7 but not limited to, obtaining, storing, and administering the drug through a
8 payment rate that covers these costs;
 - 9 c. Incentivize the use of biosimilars when safe, clinically appropriate, and agreed
10 upon by the patient and physician; and
 - 11 d. Ensure that patient out-of-pocket costs are affordable. (New HOD Policy)

12
13 RECOMMENDATION B:

14
15 Your Reference Committee recommends that the
16 Recommendations in Council on Medical Service Report 4
17 be adopted as amended and the remainder of the report
18 be filed.

19
20
21 **HOD ACTION: Council on Medical Service Report 4 is adopted as amended and**
22 **remainder of report filed.**

23
24 **ADOPTED LANGUAGE:**

- 25
26 **1. That our American Medical Association (AMA) supports the revision of the**
27 **Average Sales Price (ASP) calculation of biologic/biosimilar drugs to more**
28 **accurately represent the cost of drugs for the physician practice. (New HOD**
29 **Policy)**
- 30
31 **2. That our AMA encourages public and private payers to implement**
32 **comprehensive payment structures that allow for fair and timely payment for**
33 **biologic/biosimilar drugs that:**
- 34 **a. Maintain patient access to biologic/biosimilar drugs prescribed by their**
35 **physician consistent with AMA Policy H-100.940;**
 - 36 **b. Account for physician/practice administrative and acquisition costs,**
37 **including but not limited to, obtaining, storing, and administering the drug**
38 **through a payment rate that covers these costs;**
 - 39 **c. Incentivize the use of biosimilars when safe, clinically appropriate, and**
40 **agreed upon by the patient and physician; and**
 - 41 **d. Ensure that patient out-of-pocket costs are affordable. (New HOD Policy)**
- 42
43 **3. That Policies H-100.940, H-110.959, H-125.972, D-110.987 be reaffirmed.**

44
45
46 The Council on Medical Service recommends that the following be adopted in lieu of
47 Resolution 103-A-25, and the remainder of the report be filed:
48

- 1 1. That our American Medical Association (AMA) supports the revision of the Average
2 Sales Price (ASP) calculation of biologic/biosimilar drugs to more accurately represent
3 the cost of drugs for the physician practice. (New HOD Policy)
4
- 5 2. That our AMA encourages public and private payers to implement comprehensive
6 payment structures that allow for fair and timely payment for biologic/biosimilar drugs
7 that:
 - 8 a. Maintain patient access to biologic/biosimilar drugs prescribed by their physician;
 - 9 b. Account for physician/practice administrative and acquisition costs, including but
10 not limited to, obtaining, storing, and administering the drug;
 - 11 c. Incentivize the use of biosimilars when safe, clinically appropriate, and agreed
12 upon by the patient and physician; and
 - 13 d. Ensure that patient out-of-pocket costs are affordable. (New HOD Policy)
14
- 15 3. That our AMA supports calculating the ASP for biologic/biosimilar drugs under
16 Medicare Part B as the average price paid for a reference biologic and its
17 interchangeable biosimilars adjusted by the market share of each product while ensuring
18 payment is adequate to maintain the financial viability of physician practices. (New HOD
19 Policy)
20
- 21 4. That our AMA reaffirm Policy H-100.940, which supports incentivizing the use of
22 biosimilars when appropriate, eliminating acquisition costs/reimbursement disparities,
23 and patient education. (Reaffirm HOD Policy)
24
- 25 5. That our AMA reaffirm Policy H-110.959, which opposes drug payment methodologies
26 that result in physicians being paid less than cost of the drug and related clinical
27 services. (Reaffirm HOD Policy)
28
- 29 6. That our AMA reaffirm Policy H-125.972, which supports the education of physicians
30 on biosimilars and their involved processes as well as encourages data collection and
31 evaluation by the Food & Drug Administration. (Reaffirm HOD Policy)
32
- 33 7. That our AMA reaffirm Policy D-110.987, which presents guidelines supportive of the
34 regulation of pharmacy benefit managers in a manner that encourages transparency.
35 (Reaffirm HOD Policy)
36

37 Testimony on Council on Medical Service Report 4 was mixed, but generally supportive
38 of the report's intent. Testimony from some delegations voiced support for the report
39 recommendations as written explaining they offered realistic and incremental steps that
40 would help patients and physicians in the short and long term. Additionally, supportive
41 testimony outlined the importance of not only looking forward to new payment models
42 but to also addressing the current payment methodology, Average Sales Price (ASP)
43 calculations. Some delegations offered support with some amendments to the
44 recommendations that would outline AMA support for flat rate payment methodologies
45 and broaden the Council recommended calculation revision. Other testimony from
46 delegations and individuals outlined opposition to the ASP calculation generally and
47 suggested the removal of recommendations referencing this price calculation. The
48 Council acknowledged that while the ASP calculation is not perfect, it is the current
49 payment model and therefore revisions should be advocated for. The authors explained
50 that the recommendation offered covers the intent of the original referred resolution and

1 goes further. The Council expressed concern that the addition of a flat payment rate to
2 the second recommendation could harm future advocacy efforts by limiting support to
3 only flat payment methodology and not other innovative and helpful methods. To
4 address the concerns regarding Recommendation 3, the Council explained that the
5 suggested alternative calculation supports increases in biosimilar market competition,
6 supports physician transition to lower cost biosimilars when appropriate, and could lead
7 to brand-name biologic manufacturers being forced to reduce prices in order to maintain
8 market share. Additionally, the Council explained that Recommendations 1 and 3 work
9 to improve the current ASP model and Recommendation 2 aims to support future
10 alternative payment models that meet the set criteria. Finally, the Council reiterated that
11 language has been included throughout the recommendations to ensure that all payment
12 models are sufficient to sustain practices and include fair payment rates.

13
14 In-person testimony on Council on Medical Service Report 4 was generally supportive of
15 removing the reference to “flat payment” rates. Testifiers explained that this language
16 could be harmful to physicians/practices and block their full payment. Additionally,
17 testimony was unified in deletion of the new Recommendation 3 offered in the
18 Preliminary Report. Therefore, your Reference Committee recommends the removal of
19 the new Recommendation 3 and the reference to “flat payment” in Recommendation 2B.
20 Testimony related to the deletion of the third original recommendation was mixed. Some
21 testimony explained that the specificity of the calculation was important and would help
22 physicians and patients in accessing lower-cost medications when appropriate.
23 However, other testifiers voiced that the original third recommendation was too
24 prescriptive and supported its removal as is recommended in the Preliminary Report.
25 Your Reference Committee felt testimony supported the retention of the *original* third
26 recommendation and therefore recommends that the *original* third recommendation be
27 retained. Therefore, your Reference Committee recommends that the recommendations
28 in Council on Medical Service Report 4 be adopted as amended and the remainder of
29 the report be filed.

30
31 (16) RESOLUTION 805 – SHARED MEDICAL
32 APPOINTMENTS

33
34 RECOMMENDATION A:

35
36 Your Reference Committee recommends that the first
37 resolve of Resolution 805 be amended by addition and
38 deletion to read as follows:

39
40 RESOLVED, that our American Medical
41 Association recognizes Shared Medical Appointments,
42 ~~also known as~~ and/or Group Medical Visits, as an
43 effective model of care delivery (New HOD Policy);
44 and be it further

45
46 RECOMMENDATION B:

47
48 Your Reference Committee recommends that the
49 second resolve of Resolution 805 be amended by
50 addition and deletion to read as follows:

1
2 RESOLVED, that our AMA advocate to hospitals and
3 health systems that they support physicians and other
4 clinicians who desire to host Shared Medical
5 Appointments, ~~also known as~~ and/or Group Medical
6 Visits (Directive to Take Action); and be it further
7

8 RECOMMENDATION C:

9
10 Your Reference Committee recommends that the third
11 resolve of Resolution 805 be addition and deletion to
12 read as follows:

13
14 RESOLVED, that our AMA advocate ~~to Medicare,~~
15 ~~Medicaid, private insurers, and other appropriate~~
16 ~~indemnity organizations,~~ for payment of in-person or
17 telehealth Shared Medical Appointments, ~~also known~~
18 ~~as~~ and/or Group Medical Visits, utilizing CPT codes
19 and AMA-CPT coding guidance commensurate with
20 standard Evaluation and Management billing codes
21 (i.e., 99212-99215) based on Medical Decision
22 Making criteria or the time spent in the delivery of
23 individualized care, with individual assessments
24 occurring either within the group setting or in
25 private. (Directive to Take Action)
26

27 RECOMMENDATION D:

28
29 Your Reference Committee recommends that
30 Resolution 805 be adopted as amended.
31

32
33 **HOD ACTION: Resolution 805 is amended.**

34
35 **ADOPTED LANGUAGE:**

- 36
37 **1. RESOLVED, that our American Medical Association recognizes Shared Medical**
38 **Appointments and/or Group Medical Visits, as an effective model of care**
39 **delivery.**
40
41 **2. RESOLVED, that our AMA advocate to hospitals and health systems that**
42 **they support physicians and other clinicians who desire to host Shared**
43 **Medical Appointments-and/or Group Medical Visits.**
44
45 **3. RESOLVED, that our AMA advocate for payment of in-person or telehealth**
46 **Shared Medical Appointments and/or Group Medical Visits, utilizing CPT codes**
47 **and AMA-CPT coding guidance.**
48
-

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

4
5 RESOLVED, that our AMA advocate to hospitals and health systems that they support
6 physicians and other clinicians who desire to host Shared Medical Appointments, also
7 known as Group Medical Visits (Directive to Take Action); and be it further

8
9 RESOLVED, that our AMA advocate to Medicare, Medicaid, private insurers, and other
10 appropriate indemnity organizations, for payment of in-person or telehealth Shared
11 Medical Appointments, also known as Group Medical Visits, commensurate with
12 standard Evaluation and Management billing codes (i.e., 99212-99215) based on
13 Medical Decision Making criteria or the time spent in the delivery of individualized care,
14 with individual assessments occurring either within the group setting or in private.
15 (Directive to Take Action)

16
17 Testimony on Resolution 805 was supportive, with some testimony offering amendments
18 in line with the intent of the resolution. Testimony explained the importance and personal
19 success of shared medical appointments for physicians who utilize them. While still
20 supportive of the idea of the resolution, an amendment to the third resolve clause was
21 offered by a CPT expert outlining the importance of ensuring that the HOD and CPT
22 maintain an appropriate distance. Both the Council on Medical Service and the authors
23 of the resolution supported this amendment. Additionally, an amendment was proffered
24 to simplify the language and remove the use of the term “group medical appointments” in
25 order to limit confusion. The authors of this resolution suggested that maintaining group
26 medical appointments by adding “and/or” both reduces confusion and maintains the
27 original intent of the resolution. Your Reference Committee was convinced that the
28 combination of these amendments maintains the integrity of the original Resolution while
29 clarifying its language. Therefore, your Reference Committee recommends that
30 Resolution 805 be adopted as amended.

31
32 (17) RESOLUTION 806 – INSURANCE COVERAGE FOR
33 COLONOSCOPY PREPARATION COST

34
35 RECOMMENDATION A:

36
37 Your Reference Committee recommends that
38 Resolution 806 be amended by addition and deletion
39 to read as follows:

40
41 RESOLVED, that our American Medical Association
42 advocates ~~for a federal mandate to include full~~
43 coverage of that all health insurance plans
44 cover colonoscopy preparation costs without cost-
45 sharing as part of colorectal cancer screenings the
46 Affordable Care Act's preventative care
47 requirements, ensuring that all Americans have
48 access to necessary, cost-free preventative
49 measures for colorectal cancer.

1 RECOMMENDATION B:

2
3 Your Reference Committee recommends that
4 Resolution 806 be adopted as amended.

5
6
7 **HOD ACTION: Resolution 806 is amended.**

8
9 **ADOPTED LANGUAGE:**

10
11 **RESOLVED, that our American Medical Association advocates that all health**
12 **insurance plans cover colonoscopy preparation costs ~~without~~ cost-sharing as**
13 **part of colorectal cancer screenings, ensuring that all Americans have access to**
14 **necessary, cost-free preventative measures for colorectal cancer.**

15
16
17 **RESOLVED, that our American Medical Association advocates for a federal mandate to**
18 **include full coverage of colonoscopy preparation costs as part of the Affordable Care**
19 **Act's preventative care requirements, ensuring that all Americans have access to**
20 **necessary, cost-free preventative measures for colorectal cancer. (Directive to Take**
21 **Action)**

22
23 Testimony supported the intent of Resolution 806 to ensure that colonoscopy
24 preparation kits are accessible without cost-sharing. An amendment was proffered to
25 broaden the resolution's scope to advocate that all health plans, including public plans
26 such as Medicare that are not covered under ACA preventive screenings requirements,
27 cover these kits without cost-sharing. Because the sponsoring delegation testified in
28 support of this amendment, your Reference Committee recommends that Resolution
29 806 be adopted as amended.

30
31 (18) **RESOLUTION 807 – PROTECTING HOSPITALS AND**
32 **PATIENTS FROM INAPPROPRIATE DENIALS OF**
33 **INPATIENT ADMISSIONS**

34
35 **RECOMMENDATION A:**

36
37 Your Reference Committee recommends that
38 Resolution 807 be amended by addition and deletion
39 to read as follows:

40
41 **RESOLVED, that our American Medical Association**
42 **~~assert~~ advocate that if an insurance company denies**
43 **“full admission” status for a patient being hospitalized,**
44 **that the insurance company must provide the ability to**
45 **revert the status to observation ~~so~~ to protect the patient**
46 **and the hospital ~~and patient are protected~~ from total**
47 **denial of payment. (New HOD Policy)**

1 RECOMMENDATION B:
2

3 Your Reference Committee recommends that
4 Resolution 807 be adopted as amended.

7 HOD ACTION: Resolution 807 is amended.

9 ADOPTED LANGUAGE:

10
11 **RESOLVED, that our American Medical Association advocate that if an insurance**
12 **company denies “full admission” status for a patient being hospitalized, that the**
13 **insurance company must provide the ability to revert the status to observation to**
14 **protect the patient and the hospital from total denial of payment.**

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

21
22 Your Reference Committee heard mixed testimony on Resolution 807. While some
23 testimony supported reaffirmation of Policy H-320.943 in lieu of the resolution, the
24 sponsoring delegation explained that the resolution addresses what happens at the time
25 an insurer denies “full admission” status, whereas Policy H-320.943 advocates against
26 retrospective denials. Additional testimony supported the resolution, with one commenter
27 suggesting that “hospital” be deleted from the resolve so that the focus is on protecting
28 patients. However, testimony also argued against deleting “hospital” because protecting
29 hospitals from denials will also help patients. Testimony also suggested use of the term
30 “advocate” instead of “assert.” Your Reference Committee also suggests editorial
31 changes to at the end of the resolve and recommends that Resolution 807 be adopted
32 as amended.

33
34 (19) RESOLUTION 808 – NO PRIOR AUTHORIZATION FOR
35 INEXPENSIVE MEDICATIONS

37 RECOMMENDATION A:

38
39 Your Reference Committee recommends that the first
40 resolve of Resolution 808 be deleted.

41
42 ~~RESOLVED, that our American Medical Association~~
43 ~~identify through the Council on Medical Services or~~
44 ~~other professional content experts a cost threshold~~
45 ~~below which medical services and medications should~~
46 ~~not require prior authorization (Directive to Take~~
47 ~~Action); and be it further~~

1 RECOMMENDATION B:
2

3 Recommendation B: Your Reference Committee
4 recommends that Resolution 808 be adopted as
5 amended.

6
7
8 **HOD ACTION: Resolution 808 is amended.**

9
10 **ADOPTED LANGUAGE:**

11
12 **RESOLVED, that our American Medical Association advocate that low-cost**
13 **medications and procedures should not require prior authorization.**

14
15
16 RESOLVED, that our American Medical Association identify through the Council on
17 Medical Services or other professional content experts a cost threshold below which
18 medical services and medications should not require prior authorization (Directive to
19 Take Action); and be it further

20
21 RESOLVED, that our American Medical Association advocate that low-cost medications
22 and procedures should not require prior authorization. (Directive to Take Action)

23
24 Testimony on Resolution 808 was generally supportive of the resolution's intent but
25 differed recommended execution. Some testimony suggested that this resolution should
26 be adopted as written due to the excessive burdens and harms that come at the cost of
27 prior authorization. While agreeing with the harms of prior authorization, other testimony
28 voiced concerns about the feasibility and practicality of defining "low cost" in this context.
29 Additionally, testimony from the Council on Medical Service explained concern with the
30 appropriateness of developing a set threshold as it may indicate approval for prior
31 authorization if the cost is above the set threshold. A number of amendments were
32 suggested. One amendment suggested the development of a Coding and Procedural
33 Terminology® Code (CPT®) for prior authorization. Other testimony explained that this is
34 not appropriate as it violates the separation between CPT® and the AMA House of
35 Delegates and violates existing AMA policy. The Council proffered the deletion of the
36 first resolve and adoption of the second resolve, which was supported. In the hearing it
37 was suggested that existing AMA policy be amended in lieu of this resolution, however
38 this is not in order due to the policy not being addressed in the original resolution.
39 Additionally, other in-person testimony echoed concerns voiced online related to the cost
40 threshold in the first resolve and the support for the second resolve. Therefore, your
41 Reference Committee recommends that Resolution 808 be adopted as amended.

1 (20) RESOLUTION 810 – OPPOSING UNILATERAL
2 DOWNCODING OF PHYSICIAN SERVICES BY
3 INSURANCE COMPANIES
4

5 RECOMMENDATION A:

6 Your Reference Committee recommends that
7 resolve one and two be deleted:

8 ~~RESOLVED, that our American Medical~~
9 ~~Association vigorously oppose unilateral~~
10 ~~downcoding of evaluation and management~~
11 ~~(E/M) services by insurance companies,~~
12 ~~including but not limited to Cigna’s “Evaluation~~
13 ~~and Management Coding Accuracy (R49)”~~
14 ~~program and Aetna’s “Claim and Code Review~~
15 ~~Program (CCRP)” (New HOD Policy); and be it~~
16 ~~further~~

17
18 ~~RESOLVED, that our AMA advocate the insurers~~
19 ~~adhere to AMA CPT® and E/M guidelines as the~~
20 ~~nationally recognized standard for coding and~~
21 ~~reimbursement, without unilateral~~
22 ~~reinterpretation (Directive to Take Action); and~~
23 ~~be it further~~

24
25 RECOMMENDATION B:

26
27 Your Reference Committee recommends that
28 resolve three of Resolution 810 be amended by
29 addition and deletion to read as follows:

30
31 ~~RESOLVED, that our AMA work with state~~
32 ~~medical associations, specialty societies, and~~
33 ~~regulatory authorities to challenge these payer-~~
34 ~~initiated downcoding policies through regulatory,~~
35 ~~legislative, and when appropriate, legal channels~~
36 ~~(Directive to Take Action); and be it further~~

37
38 RECOMMENDATION C:

39
40 Your Reference Committee recommends the
41 addition of a new resolved clause to read as
42 follows:

43
44 ~~RESOLVED, That Policy D-320.972 be~~
45 ~~reaffirmed.~~

46
47 RECOMMENDATION D:

48
49 Your Reference Committee recommends Resolution
50 810 be adopted as amended.

1
2 **HOD ACTION: Resolution 810 is amended.**

3
4 **ADOPTED LANGUAGE:**

5
6 **RESOLVED, that our AMA work with state medical associations, specialty**
7 **societies, and regulatory authorities to challenge payer-initiated downcoding**
8 **policies through regulatory, legislative, and when appropriate, legal channels.**

9
10 **RESOLVED, that our AMA report back on payer downcoding practices, their**
11 **effects on physicians and patients, and strategies for collective advocacy at the**
12 **2026 Interim Meeting.**

13
14 **RESOLVED, that our AMA will develop and disseminate guidance and educational**
15 **materials for physicians regarding insurer downcoding and recoding practices,**
16 **including how to document, appeal, and report inappropriate payer conduct to**
17 **regulators and AMA advocacy channels.**

18
19 **RESOLVED, That Policy D-320.972 be reaffirmed.**

20
21
22 **RESOLVED, that our American Medical Association vigorously oppose unilateral**
23 **downcoding of evaluation and management (E/M) services by insurance companies,**
24 **including but not limited to Cigna’s “Evaluation and Management Coding Accuracy**
25 **(R49)” program and Aetna’s “Claim and Code Review Program (CCRP)” (New HOD**
26 **Policy); and be it further**

27
28 **RESOLVED, that our AMA advocate the insurers adhere to AMA CPT® and E/M**
29 **guidelines as the nationally recognized standard for coding and reimbursement, without**
30 **unilateral reinterpretation (Directive to Take Action); and be it further**

31
32 **RESOLVED, that our AMA work with state medical associations, specialty societies, and**
33 **regulatory authorities to challenge these payer policies through regulatory, legislative,**
34 **and when appropriate, legal channels (Directive to Take Action); and be it further**

35
36 **RESOLVED, that our AMA report back on payer downcoding practices, their effects on**
37 **physicians and patients, and strategies for collective advocacy at the 2026 Annual**
38 **Meeting. (Directive to Take Action)**

39
40 Testimony on Resolution 810 was fully supportive of the intent, but some testimony
41 indicated that the first three resolve clauses are already covered in existing AMA policy
42 D-320.972. However, other testimony disagreed and voiced that the language is unique
43 enough to be its own policy. Testimony explained the challenge of dealing with these
44 downcoding rulings from payers and how important it is for the AMA to advocate on this
45 issue. Your Reference Committee reviewed existing policy and agreed that the first two
46 resolves of this resolution are encompassed in current policy. However, your Reference
47 Committee agreed with Council on Medical Service testimony that the third resolve is
48 worded in a manner that is stronger and more specific. Your Reference Committee did
49 have concerns that the original third resolve does not stand on its own and therefore

1 offers an editorial amendment. Finally, testimony was in agreement regarding the
2 importance of the fourth resolve. Therefore, your Reference Committee recommends
3 that Policy D-320.972 be reaffirmed in lieu of the resolves 1 and 2, and resolves 3 and 4
4 of Resolution 810 be adopted as amended.

5
6 (21) RESOLUTION 815 – MANDATING HEALTH INSURERS
7 TO PROVIDE A REAL-TIME ONLINE TOOL FOR
8 COVERAGE AND PAYMENT POLICIES, INTEGRATED
9 INTO ELECTRONIC HEALTH RECORDS (EHRS)

10
11 RECOMMENDATION A:

12
13 Your Reference Committee recommends that the
14 second resolve of Resolution 815 be amended by
15 addition and deletion to read as follows:

16
17 RESOLVED, that our AMA advocates that the
18 online payment policy tool must include detailed,
19 accurate, and up-to-date information regarding
20 covered services, co-pays, deductibles, and
21 payment policies for specific procedures, and that
22 insurers honor the coverage and payment
23 determination provided at the time of approval
24 ~~this tool be binding on the insurers for the~~
25 ~~purposes of determining payment for~~
26 ~~claims. (Directive to Take Action)~~

27
28 RECOMMENDATION B:

29
30 Your Reference Committee recommends that
31 Resolution 815 be adopted as amended.

32
33
34 **HOD ACTION: Resolution 815 is amended.**

35
36 **ADOPTED LANGUAGE:**

37
38 **RESOLVED, that our American Medical Association shall advocate for legislation**
39 **or regulations requiring all health insurers in every State to provide a real-time**
40 **online tool for physicians and patients to determine coverage and payment**
41 **policies for medical procedures, treatments, and services at the time of suggested**
42 **procedures.**

43
44 **RESOLVED, that our AMA advocates that the online payment policy tool must**
45 **include detailed, accurate, and up-to-date information regarding covered services,**
46 **co-pays, deductibles, and payment policies for specific procedures, and that**
47 **insurers honor the coverage and payment determination provided at the time of**
48 **approval.**

1 **RESOLVED, that our AMA advocate that the online payment policy tool must be a**
2 **uniform interface that works across all insurers and physicians, ensuring**
3 **consistent and streamlined access to coverage information for physicians and**
4 **patients.**

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

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

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

24 Testimony was supportive of Resolution 815 and the need for health plans to make real-
25 time coverage and payment information available to physicians and patients as part of
26 the electronic health record. However, concerns were raised about the second resolve
27 and whether the information provided by such tools should be binding on insurers since
28 deductible and copay information is only accurate for a point in time. However, testimony
29 in the hearing was supportive of the second resolve as written. Your Reference
30 Committee suggests clarifying in the second resolve that our AMA will advocate that
31 insurers honor the coverage and payment determination provided at the time of the
32 approval. We recommend that Resolution 815 be adopted as amended.

34 (22) RESOLUTION 816 – PROHIBIT ARBITRARY TIME
35 LIMITS ON PREAUTHORIZATIONS

37 RECOMMENDATION A:

39 Your Reference Committee recommends that the
40 second resolve of Resolution 816 be amended by
41 addition to read as follows:

43 RESOLVED, that our AMA seek similar changes in
44 Federal legislation and policies to prohibit Medicare
45 Advantage, Medicaid, Veterans Affairs Community
46 Care, and Employee Retirement Income Securement
47 Act of 1974 (ERISA) plans from establishing time
48 limits on preauthorizations for care of less than one
49 year.

50

1 RECOMMENDATION B:
2

3 Your Reference Committee recommends that
4 Resolution 816 be adopted as amended.

5
6
7 **HOD ACTION: Resolution 816 is amended.**

8
9 **ADOPTED LANGUAGE:**

10
11 **RESOLVED, that our American Medical Association (AMA) advocate for changes**
12 **in State legislation and Division of Financial Services policy to prohibit health**
13 **insurers in any State, including Medicaid plans, from establishing time limits on**
14 **duration of preauthorization for care of less than one year**

15
16 **RESOLVED, that our AMA seek similar changes in Federal legislation and policies**
17 **to prohibit Medicare Advantage, Medicaid, Veterans Affairs Community Care, and**
18 **Employee Retirement Income Securement Act of 1974 (ERISA) plans from**
19 **establishing time limits on preauthorizations for care of less than one year.**

20
21
22 RESOLVED, that our American Medical Association advocate for changes in State
23 legislation and Division of Financial Services policy to prohibit health insurers in any
24 State, including Medicaid plans, from establishing time limits on duration of
25 preauthorization for care of less than one year (Directive to Take Action); and be it
26 further

27
28 RESOLVED, that our AMA seek similar changes in Federal legislation and policies to
29 prohibit Medicare Advantage, Medicaid, and Employee Retirement Income Securement
30 Act of 1974 (ERISA) plans from establishing time limits on preauthorizations for care of
31 less than one year. (Directive to Take Action)

32
33 Testimony was supportive of Resolution 816. Testimony indicated that frequent prior
34 authorization requirements impose unnecessary administrative burden on physicians
35 and delay patient care and suggested that Resolution 816 advances the shared goals of
36 reducing administrative waste, protecting continuity of care, and restoring physician
37 authority in clinical decision-making. One delegation proffered an amendment to expand
38 the second resolve to include Veterans Affairs (VA) Community Care, noting that VA
39 limits on pre-authorization for services are routinely set at 90 days. Several delegations
40 expressed strong support for the inclusion of Veterans Affairs Community Care;
41 therefore, your Reference Committee recommends Resolution 816 be adopted as
42 amended.

1 (23) RESOLUTION 817 – PROHIBITING INSURERS FROM
2 DENYING PAYMENT FOR PROCEDURES BASED ON
3 SITE OF SERVICE

4
5 RECOMMENDATION A:

6
7 Your Reference Committee recommends that
8 Resolution 817 be amended by addition and deletion to
9 read as follows:

10
11 RESOLVED, that our American Medical Association
12 advocates ~~for legislation or regulation that to~~ prohibit
13 insurers ~~in all States~~ from denying payment for a
14 procedure based solely on the site of service in which it
15 was performed, provided that the procedure is medically
16 necessary and can be safely performed in that location.
17 (Directive to Take Action)

18
19 RECOMMENDATION B:

20
21 Your Reference Committee recommends that
22 Resolution 817 be adopted as amended.

23
24
25 **HOD ACTION: Resolution 817 is amended.**

26
27 **ADOPTED LANGUAGE:**

28
29 **RESOLVED, that our American Medical Association advocate to prohibit insurers**
30 **from denying or reducing payment for a procedure based solely on the site of**
31 **service in which was performed, provided that the procedure is medically**
32 **necessary and can safely be performed in that location.**

33
34
35 RESOLVED, that our American Medical Association advocates for legislation or
36 regulation that prohibit insurers in all States from denying payment for a procedure
37 based on the site of service in which it was performed, provided that the procedure is
38 medically necessary. (Directive to Take Action)

39
40 Testimony was supportive of Resolution 817 and also included suggestions for
41 amendments and one call for referral. Several comments supported amending the
42 resolve to account for patient safety. Amendments also suggested deleting “legislation or
43 regulation” and “in all states” to broaden the resolution’s scope to include federal
44 advocacy and advocacy with insurers. An additional amendment requested the addition
45 of “solely” before site of service. Your Reference Committee believes that amendments
46 addressing payment for travel costs and selective contracting may be beyond the
47 resolution’s scope and focus on the site of service and does not recommend those
48 changes. One commenter asked that “or reducing” be added after “denying;” however,
49 your Reference Committee did not hear additional support for this change. Your
50 Reference Committee recommends that Resolution 817 be adopted as amended.

1 (24) RESOLUTION 819 – UPDATE THE STATUS OF
2 VIRTUAL CREDIT CARD POLICY, EFT FEES, AND LACK
3 OF ENFORCEMENT OF ADMINISTRATIVE
4 SIMPLIFICATION REQUIREMENTS BY CMS

5
6 RECOMMENDATION A:

7
8 Your Reference Committee recommends that
9 Resolution 819 be amended by addition and deletion to
10 read as follows:

11
12 RESOLVED, that our American Medical Association
13 report at the Annual ~~2027~~ 2026 Meeting on the
14 progress of, and action items for implementation of AMA
15 Policies D-190.970, H-190.955, and D-190.968.
16 (Directive to Take Action)

17
18 RECOMMENDATION B:

19
20 Your Reference Committee recommends that
21 Resolution 819 be adopted as amended.

22
23
24 **HOD ACTION: Resolution 819 is amended.**

25
26 **ADOPTED LANGUAGE:**

27
28 **RESOLVED, that our American Medical Association report at the**
29 **Annual 2026 Meeting on the progress of, and action items for implementation of**
30 **AMA Policies D-190.970, H-190.955, and D-190.968. (Directive to Take Action)**

31
32
33 RESOLVED, that our American Medical Association report at the Annual 2027 Meeting
34 on the progress of implementation of AMA Policies D-190.970, H-190.955, and D-
35 190.968. (Directive to Take Action)

36
37 Online testimony was limited and supportive of Resolution 819. Testimony indicated that
38 despite the efforts of the AMA, the financial burden of virtual credit cards and EFT fees
39 have not abated and require action by the AMA, national medical specialty societies, and
40 physicians. The author proffered an amendment asking the AMA to provide a progress
41 report one year earlier than originally requested. This amendment was supported during
42 in-person testimony, along with a request for “action items” to be added to the resolution.
43 Additional testimony supported the amendment, recognizing its time-sensitive nature,
44 and recommended adoption of the resolution as amended. Your Reference Committee
45 recommends that Resolution 819 be adopted as amended.

1 (25) RESOLUTION 822 – IMPROVING HOME OR
2 COMMUNITY-BASED SERVICES WAIVER WAITING
3 LIST MANAGEMENT

4
5 RECOMMENDATION A:

6
7 Your Reference Committee recommends that
8 Resolution 822 be amended by addition to read as
9 follows:

10
11 RESOLVED, that our American Medical Association
12 support automatic eligibility screening for home or
13 community-based services (HCBS) waivers for
14 individuals who may be eligible, including older adults
15 and people with disabilities. (New HOD Policy)

16
17 RECOMMENDATION B:

18
19 Your Reference Committee recommends that
20 Resolution 822 be adopted as amended.

21
22
23 **HOD ACTION: Resolution 822 is amended.**

24
25 **ADOPTED LANGUAGE:**

26
27 **RESOLVED, that our American Medical Association support automatic eligibility**
28 **screening for home or community-based services (HCBS) waivers for individuals**
29 **who may be eligible, including older adults and people with disabilities.**

30
31
32 RESOLVED, that our American Medical Association support automatic eligibility
33 screening for home or community-based services (HCBS) waivers. (New HOD Policy)

34
35 Your Reference Committee heard testimony that was supportive of Resolution 822 and
36 the use of automatic eligibility screening for Medicaid home and community-based
37 services to reduce extensive wait lists. A delegation requested that older adults and
38 people with disabilities be included in the resolve clause, therefore your Reference
39 Committee recommends that Resolution 822 be adopted as amended.

40
41 (26) RESOLUTION 823 – ACCOUNTABILITY IN THE USE OF
42 AUGMENTED INTELLIGENCE FOR PRIOR
43 AUTHORIZATION

44
45 RECOMMENDATION A:

46
47 Your Reference Committee recommends that the first
48 resolve, subclause 2 of Resolution 823 be amended by
49 addition and deletion to read as follows:

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

5
6 Our American Medical Association will work with
7 stakeholders ~~advocates to~~ advocate for legislative and/or
8 regulatory action for greater regulatory oversight ~~of related~~
9 to the use of augmented intelligence for review of patient
10 claims and prior authorization requests, including whether
11 insurers and/or contracted third parties are using a
12 thorough and fair process that:

13
14 1) is based on accurate and up-to-date clinical criteria
15 derived from national medical specialty
16 societies' evidence-based guidelines and peer-reviewed
17 clinical literature.

18
19 2) includes reviews by ~~doctors~~ physicians and other health
20 care professionals who are not incentivized to ~~deny~~ care
21 and with expertise for the service under review.

22
23 ~~3) requires such reviews include human examination of~~
24 ~~patient records prior to a care denial~~

25
26 3) provides for transparency and accountability over the
27 use of augmented intelligence for all medical service
28 denials, to include a direct review of patient records by a
29 qualified clinician.

30
31 4) requires direct review of the patient record by a qualified
32 clinician of all medications flagged for denial by augmented
33 intelligence platforms that were previously approved by
34 payers.

35
36 5) provides robust appeals processes and guardrails to
37 prevent algorithmic discrimination and ensure equitable
38 access to care.

39
40 RECOMMENDATION B:

41
42 Your Reference Committee recommends that Resolution
43 823 be adopted as amended.

1
2 **HOD ACTION: Resolution 823 is amended.**

3
4 **ADOPTED LANGUAGE:**

5
6 **1. Policy D-480.956 is amended to read as follows:**

7
8 **Our American Medical Association will work with stakeholders to advocate for**
9 **legislative and/or regulatory action for greater regulatory oversight related to the**
10 **use of augmented intelligence for review of patient claims and prior authorization**
11 **requests, including whether insurers and/or contracted third parties are using a**
12 **thorough and fair process that:**

13
14 **1) is based on accurate and up-to-date clinical criteria derived from**
15 **national medical specialty societies' evidence-based guidelines and peer-**
16 **reviewed clinical literature.**

17
18 **2) includes reviews by physicians and other health care professionals who**
19 **are not incentivized to deny care and with expertise for the service under**
20 **review.**

21
22 **3) provides for transparency and accountability over the use of augmented**
23 **intelligence for all medical service denials, to include a direct review of**
24 **patient records by a qualified clinician.**

25
26 **4) requires direct review of the patient record by a qualified clinician of all**
27 **medications flagged for denial by augmented intelligence platforms that**
28 **were previously approved by payers.**

29
30 **5) provides robust appeals processes and guardrails to prevent algorithmic**
31 **discrimination and ensure equitable access to care.**

32
33 **2. RESOLVED, that our AMA will report on actions taken by the 2026 Annual**
34 **Meeting of the AMA House of Delegates.**

35
36
37 **RESOLVED, that our American Medical Association will amend policy D-480.956, "Use**
38 **of Augmented Intelligence for Prior Authorization," by addition and deletion to read as**
39 **follows:**

40
41 **Our American Medical Association will work with stakeholders ~~advocates to~~**
42 **advocate for legislative and/or regulatory action for greater regulatory oversight**
43 **of related to the use of augmented intelligence for review of patient claims and**
44 **prior authorization requests, including whether insurers and/or contracted third**
45 **parties are using a thorough and fair process that:**

46 **1) is based on accurate and up-to-date clinical criteria derived from national**
47 **medical specialty societies' evidence-based guidelines and peer-reviewed clinical**
48 **literature.**

1 2) includes reviews by doctors and other health care professionals who are not
 2 incentivized to deny care and with expertise for the service under review.
 3 ~~3) requires such reviews include human examination of patient records prior to a~~
 4 ~~care denial~~
 5 3) provides for transparency and accountability over the use of augmented
 6 intelligence for all medical service denials, to include a direct review of patient
 7 records by a qualified clinician.
 8 4) requires direct review of the patient record by a qualified clinician of all
 9 medications flagged for denial by augmented intelligence platforms that were
 10 previously approved by payers.
 11 5) provides robust appeals processes and guardrails to prevent algorithmic
 12 discrimination and ensure equitable access to care. (Modify Current HOD Policy);
 13 and be it further
 14

15 RESOLVED, that our AMA will report on actions taken by the 2026 Annual Meeting of
 16 the AMA House of Delegates. (Directive to Take Action)
 17

18 Testimony was unanimously supportive of Resolution 823. Testimony indicated that the
 19 resolution enhances existing augmented intelligence (AI) policy by providing clear
 20 guidance for the use of oversight before the denial of care and will go far to protect
 21 patients and relieve the burden of prior authorization. One delegation proffered a minor
 22 amendment to subclause 2 of the first resolve, replacing the word “doctors” with
 23 “physicians,” to more accurately reflect a licensed medical doctor. This amendment was
 24 supported by several delegations. A second amendment proffered by an individual to
 25 include a detailed explanation of prior authorization denials did not receive any additional
 26 supportive testimony.
 27

28 During in-person testimony, several delegations supported the original language of the
 29 resolution, stating that it improved and enhanced AMA AI policy. Due to the supportive
 30 testimony, your Reference Committee recommends that the Resolution be adopted as
 31 amended.
 32

33 (27) RESOLUTION 824 – EQUITABLE PAYMENT AND
 34 INCREASED ACCESS FOR IN-OFFICE PEDIATRIC
 35 LEAD SCREENING AND TESTING
 36

37 RECOMMENDATION A:
 38

39 Your Reference Committee recommends that the
 40 third resolve of Resolution 824 be deleted.
 41

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

1 RECOMMENDATION B:
2

3 Your Reference Committee recommends that
4 Resolution 824 be adopted as amended.
5

6
7 **HOD ACTION: Resolution 824 is amended.**
8

9 **ADOPTED LANGUAGE:**
10

11 **RESOLVED, that our American Medical Association advocate for all public and**
12 **private payers for equitable payment rates for in-office pediatric lead screening**
13 **and testing to cover time, supplies, training, and administrative costs, including**
14 **both point-of-care and other methods.**
15

16 **RESOLVED, that our AMA support federal and state policies to reduce barriers to**
17 **improve access to lead screening and testing by incentivizing completion of such**
18 **services in physician offices.**
19

20
21 RESOLVED, that our American Medical Association advocate for all public and private
22 payers for equitable payment rates for in-office pediatric lead screening and testing to
23 cover time, supplies, training, and administrative costs, including both point-of-care and
24 other methods (Directive to Take Action); and be it further
25

26 RESOLVED, that our AMA support federal and state policies to reduce barriers to
27 improve access to lead screening and testing by incentivizing completion of such
28 services in physician offices (New HOD Policy); and be it further
29

30 RESOLVED, that our AMA advocate for increased accountability among insurers to
31 ensure that physicians do not face inappropriate disciplinary action, or decreased
32 financial incentives or other payment, due to lab orders for lead screening that go
33 unfulfilled for reasons outside the physician's control. (Directive to Take Action)
34

35 Your Reference Committee heard testimony in support of Resolution 824. One
36 delegation provided testimony in support of the resolution as written and one delegation
37 provided testimony in support of the first two resolve clauses and recommended the third
38 resolve clause be deleted. Testimony stated that the language used in the third resolve
39 clause, specifically the phrase "decreased financial incentives" is too broad and would
40 lead the AMA to opposing pay-for-performance programs that incentivize lead screening.
41 Furthermore, AMA Policy H-450.947 outlines the principles and guidelines for pay-for-
42 performance programs and opposes initiatives that do not adhere to this policy, so there
43 is no need to create standalone policy specifically regarding lead screening. Your
44 Reference Committee agrees and recommends that Resolution 824 be adopted as
45 amended.

1 (28) RESOLUTION 825 – ENSURING COVERAGE FOR IN-
2 OFFICE POINT-OF-CARE (POC) TESTING IN
3 OUTPATIENT MEDICAL PRACTICES
4

5 RECOMMENDATION A:
6

7 Recommendation: Your Reference Committee
8 recommends that the first resolve of Resolution 825 be
9 amended by addition and deletion to read as follows:
10

11 RESOLVED, that our American Medical Association
12 advocate for recognition, coverage, and adequate
13 payment by all public and private payers ~~to provide~~
14 ~~coverage and adequate payment for basic POC for~~
15 laboratory testing, when it is appropriately performed in
16 physician offices and urgent/emergency care settings,
17 to ensure timely and equitable access to
18 diagnostic services for their patients. (Directive to Take
19 Action). and be it further
20

21 RECOMMENDATION B:
22

23 Your Reference Committee recommends that the
24 second resolve of Resolution 825 be deleted.
25

26 ~~RESOLVED, that the AMA advocates for the~~
27 ~~recognition of physician offices as the appropriate~~
28 ~~setting for POC testing to ensure timely and equitable~~
29 ~~access to diagnostic services for their patients.~~
30 ~~(Directive to Take Action)~~
31

32 RECOMMENDATION C:
33

34 Your Reference Committee recommends that
35 Resolution 825 be adopted as amended.
36

37
38 **HOD ACTION: Resolution 825 is amended.**
39

40 **ADOPTED LANGUAGE:**
41

42 **RESOLVED, that our American Medical Association advocate for recognition,**
43 **coverage, and adequate payment by all public and private payers for laboratory**
44 **testing, when it is appropriately performed in physician offices and**
45 **urgent/emergency care settings, to ensure timely and equitable access to**
46 **diagnostic services for their patients.**
47

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

5
6 RESOLVED, that the AMA advocates for the recognition of physician offices as
7 the appropriate setting for POC testing to ensure timely and equitable access to
8 diagnostic services for their patients. (Directive to Take Action)

9
10
11 Testimony on Resolution 825 was entirely supportive of the intent but split regarding
12 proffered amendments. Testimony agreed that it is important to ensure that point-of-care
13 testing is both available to patients and covered by payers. Further testimony explained
14 how crucial this testing is to not only patient treatment, but also public health, prevention
15 of unnecessary emergency visits, and controlling chronic diseases. One delegation
16 proffered an amendment to remove ambiguous language, ensure terminology matches
17 best practices, and that the resolution does not conflict with current laboratory services
18 requirements. This amendment was supported by other delegations. Additionally,
19 another delegation suggested that the language could be modified to include point-of-
20 care testing in emergency departments. Your Reference Committee was persuaded by
21 testimony outlining the importance of matching language with industry standards and
22 ensuring that point-of-care testing is covered regardless of location and felt that the
23 second resolve clause was duplicative with the proffered amendments incorporated in
24 the first resolve clause. Therefore, your Reference Committee recommends that
25 Resolution 825 be adopted as amended.

26
27 (29) RESOLUTION 826 – INCREASE NATIONAL
28 IMMUNIZATION RATES BY ADVOCATING FOR
29 EQUITABLE VACCINE PAYMENTS

30
31 RECOMMENDATION A:

32
33 Your Reference Committee recommends that
34 Resolution 826 be amended by addition and deletion to
35 read as follows:

36
37 RESOLVED, that our American Medical Association
38 supports the establishment of national standards for
39 immunization payment rates that ensure physicians
40 are ~~reimbursed at no less than 125% of the CDC~~
41 private sector vaccine price paid at the full cost of
42 vaccine procurement and administration.

43
44 RECOMMENDATION B:

45
46 Your Reference Committee recommends that
47 Resolution 826 be adopted as amended.

1
2 **HOD ACTION: Resolution 826 is amended.**

3
4 **ADOPTED LANGUAGE:**

5
6 **RESOLVED, that our American Medical Association supports the establishment of**
7 **national standards for immunization payment rates that ensure physicians are paid**
8 **at the full cost of vaccine procurement and administration.**

10
11 RESOLVED, that our American Medical Association supports the establishment of
12 national standards for immunization payment rates that ensure physicians are
13 reimbursed at no less than 125% of the CDC private sector vaccine price. (New HOD
14 Policy)

15
16 Testimony on Resolution 826 was entirely supportive of the resolution's intent but
17 indicated concern with the original wording. All testimony supported the idea that
18 physicians should be paid fairly for vaccines, but there was concern that the referenced
19 price may not be the most accessible to all physicians. Additionally, there was concern
20 that specifying a certain percentage payment rate could backfire should the reference
21 price be too low to adequately cover costs. The Council on Medical Service and a
22 delegation offered similar amendments to both make the resolution more inclusive and
23 ensure that payment rates are not tied to a specific percentage. These amendments
24 were supported by other delegations and seem to address the concerns voiced in
25 testimony and your Reference Committee believes a hybrid of the two proffered
26 amendment captures the full breadth of online testimony. A delegation proffered an
27 alternative amendment in person, however other in-person testimony voiced significant
28 concerns with associating payment to a minimum rate. Additionally, there was concern
29 that the new amended language did not address costs like administration and
30 acquisition. Testimony supported the language offered in the Preliminary Report that
31 procurement, or the obtaining of goods, services, and works, and acquisition adequately
32 cover costs associated with physicians providing vaccine services. Therefore, your
33 Reference Committee recommends that Resolution 826 be adopted as amended.

34
35 (30) RESOLUTION 827 – OPPOSITION TO PRIOR
36 AUTHORIZATION IN MEDICARE FEE-FOR-SERVICE,
37 BURDENSOME ADMINISTRATIVE REQUIREMENTS

38
39 RECOMMENDATION A:

40
41 Your Reference Committee recommends that the first
42 resolve of Resolution 827 be referred for decision.

43
44 RECOMMENDATION B:

45
46 Your Reference Committee recommends that the
47 second resolve of Resolution 827 be deleted.

48

1 ~~RESOLVED, that our AMA will advocate against the~~
2 ~~implementation of the WISeR Model and any similar~~
3 ~~programs that impose new PA requirements in~~
4 ~~Medicare FFS, while continuing its efforts to educate~~
5 ~~Congress, the Centers for Medicare & Medicaid~~
6 ~~Services, and the public on the harms of PA to both~~
7 ~~patients and physicians, leveraging data from its own~~
8 ~~surveys and the experiences of its members (Directive~~
9 ~~to Take Action); and be it further~~

10
11 RECOMMENDATION C:

12
13 Your Reference Committee recommends the addition of
14 a new second resolve of Resolution 827 to read as
15 follows:

16
17 RESOLVED, that our AMA will work with the Centers
18 for Medicare & Medicaid Services to establish
19 provisions that are in accordance with AMA principles
20 and reform goals for prior authorization to protect
21 patients, physicians, and non-physician providers
22 including robust guardrails in any demonstration project
23 implementing prior authorization in Medicare fee for
24 service, such as the WISeR Model; and be it further

25
26 RECOMMENDATION D:

27
28 Your Reference Committee recommends that the third
29 resolve of Resolution 827 be amended by deletion to
30 read as follows:

31
32 ~~RESOLVED, that our AMA will continue to advocate~~
33 ~~for a legislative and regulatory framework that~~
34 ~~streamlines administrative processes, prioritizes~~
35 ~~patient access to timely care, and replaces~~
36 ~~burdensome prior authorization with clinically-sound~~
37 ~~alternatives, such as the adoption of "gold card"~~
38 ~~programs for high-performing providers and the~~
39 ~~greater use of evidence-based clinical guidelines.~~
40 ~~(Directive to Take Action)~~

41
42 RECOMMENDATION E:

43
44 Your Reference Committee recommends that
45 Resolution 827 be adopted as amended.

1
2 **HOD ACTION: Resolve 1 of Resolution 827 is Referred for Decision and Resolve 2**
3 **and 3 of Resolution 827 is amended.**

4
5 **LANGUAGE REFERRED FOR DECISION:**

6
7 **RESOLVED, that our American Medical Association opposes the use of prior**
8 **authorization (PA) and pre-payment review in Medicare Fee-for-Service (FFS),**
9 **including the proposed Wasteful and Inappropriate Service Reduction (WISeR)**
10 **Model which would implement a technology-enabled review system (including**
11 **augmented intelligence/artificial intelligence) (New HOD Policy); and be it further**

12
13 **ADOPTED LANGUAGE:**

14
15 **RESOLVED, that our AMA will work with the Centers for Medicare & Medicaid**
16 **Services to establish provisions that are in accordance with AMA principles and**
17 **reform goals for prior authorization to protect patients, physicians, and non-**
18 **physician providers including robust guardrails in any demonstration project**
19 **implementing prior authorization in Medicare fee for service, such as the WISeR**
20 **Model.**

21
22 **RESOLVED, that our AMA will continue to advocate for a legislative and**
23 **regulatory framework that streamlines administrative processes, prioritizes**
24 **patient access to timely care, and replaces burdensome prior authorization with**
25 **clinically-sound alternatives, such as the greater use of evidence-based clinical**
26 **guidelines.**

27
28
29
30 **RESOLVED, that our American Medical Association opposes the use of prior**
31 **authorization (PA) and pre-payment review in Medicare Fee-for-Service (FFS), including**
32 **the proposed Wasteful and Inappropriate Service Reduction (WISeR) Model which**
33 **would implement a technology-enabled review system (including augmented**
34 **intelligence/artificial intelligence) (New HOD Policy); and be it further**

35
36 **RESOLVED, that our AMA will advocate against the implementation of the WISeR**
37 **Model and any similar programs that impose new PA requirements in Medicare FFS,**
38 **while continuing its efforts to educate Congress, the Centers for Medicare & Medicaid**
39 **Services, and the public on the harms of PA to both patients and physicians, leveraging**
40 **data from its own surveys and the experiences of its members (Directive to Take Action);**
41 **and be it further**

42
43 **RESOLVED, that our AMA will continue to advocate for a legislative and regulatory**
44 **framework that streamlines administrative processes, prioritizes patient access to timely**
45 **care, and replaces burdensome PA with clinically-sound alternatives, such as the**
46 **adoption of "gold card" programs for high-performing providers and the greater use of**
47 **evidence-based clinical guidelines. (Directive to Take Action)**

1 Online testimony was largely supportive of Resolution 827. Two delegations testified in
2 opposition to the resolution, alternatively supporting collaborative engagement with
3 Centers for Medicare & Medicaid Innovation and advocacy for scalable, clinically guided
4 prior authorization (PA) reform across all Medicare programs. However, nine delegations
5 strongly supported the resolution as written, noting that technology-enabled review
6 systems will impose an additional administrative hurdle in an already opaque and
7 inconsistent PA process.

8
9 During the in-person hearing, the author proffered amendments to a new second resolve
10 and amendments to the third resolve with language supporting the establishment of
11 principles and guardrails to allow the AMA the opportunity to improve the model. The
12 Board of Trustees testified in support of these amendments but recommended the first
13 resolve be referred for decision. While the Board expressed support of the intent of the
14 resolution, there was concern that outright opposition to the WISeR model would make it
15 difficult to continue AMA advocacy efforts. The Council on Medical Service, Council on
16 Legislation, and several delegations agreed with the Board, recommending that the first
17 resolve be referred for decision, the new second resolve be adopted, and the third
18 resolve be adopted as amended. Due to the preponderance of testimony, your
19 Reference Committee recommends that the first resolve be referred for decision and the
20 second and third resolves be adopted as amended.

DRAFT

RECOMMENDED FOR REFERRAL FOR DECISION

1 (31) RESOLUTION 820 – ESTABLISHING AN AMA “FIRST
2 RESPONDER TEAM” FOR REAL-TIME PHYSICIAN
3 ADVOCACY AGAINST ADVERSE INSURANCE
4 COMPANY ACTIONS

5
6 RECOMMENDATION:

7 Your Reference Committee recommends that
8 Resolution 820 be referred for decision.
9

10
11 **HOD ACTION: Resolution 820 is referred for decision.**
12

13
14 RESOLVED, that our American Medical Association establish a “first responder team for
15 physician advocacy against adverse insurance company actions” to provide urgent
16 liaison services and advocacy representation for individual physicians and their practices
17 when they are confronted with what appears to be predatory harassment, systematic
18 obstruction, or punitive changes including, but not limited to:

- 19 • sudden increased in claim denials,
- 20 • arbitrarily onerous documentation requirements,
- 21 • mid-treatment coverage interruptions

22 (Directive to Take Action); and be it further
23

24 RESOLVED, that an AMA “first responder team for physician advocacy against adverse
25 insurance company actions” be a pilot program for the first two years of operation that
26 will develop ongoing protocols to prioritize future cases brought to them, catalog them,
27 and then report back to the House of Delegates annually (Directive to Take Action); and
28 be it further
29

30 RESOLVED, that an AMA “first responder team for physician advocacy against adverse
31 insurance company actions” will coordinate relevant information and strategy with other
32 existing AMA programs already engaged in implementing existing AMA policy protecting
33 the rights of physicians and their practices from insurance company behaviors. (Directive
34 to Take Action)
35

36 Testimony on Resolution 820 was mixed. Several delegations supported the original
37 language, suggesting that the AMA currently lacks a mechanism for providing physician
38 advocacy against adverse insurance company actions. The Board of Trustees
39 recommended that the resolution be referred for decision, as coordination and careful
40 consideration is a critical component in the development of a “First Responder Team.”
41 Testimony included that some states have similar ongoing programs which could be
42 used as models for future AMA efforts. Testimony supported the Board’s
43 recommendations. Therefore, your Reference Committee recommends that Resolution
44 820 be referred for decision.

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

1 (32) RESOLUTION 813 – INCREASED REGULATION OF
2 FOR-PROFIT HEALTHCARE INSURANCE

3
4 RECOMMENDATION:

5
6 Your Reference Committee recommends that Policies
7 D-160.907, H-180.947, D-160.906, D-160.908, and H-
8 160.884 be reaffirmed in lieu of Resolution 813.

9
10
11 **HOD ACTION: Policies D-160.907, H-180.947, D-160.906, D-160.908, and H-160.884**
12 **be reaffirmed in lieu of Resolution 813.**

13
14
15 RESOLVED, that our American Medical Association promote public awareness of the
16 harms of for-profit vertical integration of health insurance systems (Directive to Take
17 Action); and be it further

18
19 RESOLVED, that our AMA advocate for a comprehensive review by the legislature of
20 current regulations and increased regulatory oversight and increased resources for the
21 monitoring of State Medicaid and Managed Medicare for-profit health plans, including
22 vertical integration. (Directive to Take Action)

23
24 Your Reference Committee recommends that the policies listed above be reaffirmed in
25 lieu of Resolution 813. The authors testified that the novelty of this resolution was the
26 “public awareness” aspect and urged the AMA to act. One additional delegation provided
27 testimony against reaffirmation and in support of the resolution as written, although the
28 Reference Committee notes many of the points raised in these comments seem to
29 expand beyond the scope of the resolve clauses of this resolution. The Council on
30 Medical Service provided testimony in support of reaffirmation, highlighting several
31 recent Council reports and additional policies that address consolidation and the
32 corporate practice of medicine broadly. Furthermore, the Council stated concerns with
33 the original language, questioning the feasibility of the second resolve clause as well as
34 why only for-profit insurers were called out in the first resolve clause. To address the
35 authors concern about public awareness, your Reference Committee would like to
36 highlight the AMA Policy Research Perspective titled: Competition in Health Insurance: A
37 comprehensive study of U.S. markets. Your Reference Committee agrees that there is
38 sufficient AMA policy that addresses the request of this resolution and thus recommends
39 that Policies D-160.907, H-180.947, D-160.906, D-160.908, and H-160.884 be
40 reaffirmed in lieu of Resolution 813.

41
42 HEALTH SYSTEM CONSOLIDATION, D-160.907

43 1. Our American Medical Association will assess and report
44 annually on nationwide health system and hospital
45 consolidation, as well as payer consolidation, to assist
46 policymakers and the federal government.

1 2. Our AMA annual report on nationwide hospital
2 consolidation will be modeled after the “Competition in health
3 insurance: A comprehensive study of U.S. Markets” in its
4 comprehensiveness to include for example data an analyses
5 as:
6 a. A review of the current level of hospital and/or health
7 system consolidation at the level of all metropolitan statistical
8 areas, state, and national markets.
9 b. A list of all mergers and acquisition transactions valued
10 above a set threshold amount resulting in hospital and/or
11 health system consolidation.
12 c. Analyses of how each transaction has changed or is
13 expected to change the level of competition in the affected
14 service and geographic markets.
15 d. Analyses of healthcare costs and prices have changes in
16 affected markets after a large consolidation transaction has
17 taken place.
18 3. Our AMA will report the initial findings of this study to the
19 House of Delegates by Annual 2024.
20 4. Our AMA will report the findings of this study to its
21 members and stakeholders, including policymakers and
22 legislators, to inform future healthcare policy.
23 (Res. 727, A-23)
24

25 MAINTAINING FREEDOM OF CHOICE WITH INSURANCE 26 PRODUCTS, H-180.947

27 Our AMA opposes consolidation in the health insurance
28 industry that may result in anticompetitive markets.
29 (Sub Res. 202, I-15; Reaffirmed: BOT Rep. 09, A-25)
30

31 STRENGTHENING EFFORTS AGAINST HORIZONTAL & 32 VERTICAL CONSOLIDATION, D-160.906

33 Our American Medical Association advocates to adequately
34 resource competition policy authorities such as the Federal
35 Trade Commission (FTC) and Department of Justice Antitrust
36 Division to perform oversight of health care markets.
37 (Res. 813, I-23)
38

39 VERTICAL CONSOLIDATION IN HEALTH CARE – 40 MARKETS OR MONOPOLIES, D-160.908

41 Our American Medical Association advocates against
42 anticompetitive business practices that have the potential to
43 adversely affect the physician patient relationship, to result in
44 higher costs or decreased quality of care, or are not in the
45 best interest of patients, the public and/or physicians.
46

47 Our AMA supports efforts to increase transparency, review,
48 and enforcement of laws with respect to vertical mergers that
49 have the potential to negatively impact the health care
50 industry.

1
2 Our AMA will work with all appropriate stakeholders to create
3 model legislation to prohibit anticompetitive business
4 practices within the health care sector.

5 (Res. 723, A-23)

6 STRENGTHENING EFFORTS AGAINST HORIZONTAL &
7 VERTICAL CONSOLIDATION, H-160.884

8 1. Our American Medical Association opposes not-for-profit
9 firm immunity from FTC competition policy enforcement in the
10 health care sector.

11 2. Our AMA supports appropriate transaction value
12 thresholds, including cumulative transaction values, for
13 merger reporting in health care sectors to ensure that vertical
14 acquisitions in health care do not evade antitrust scrutiny.

15 3. Our AMA supports health care-specific advocacy efforts
16 that will strengthen antitrust enforcement in the health care
17 sector through multiple mechanisms.

18 (Res. 813, I-23)

19
20 (33) RESOLUTION 818 – UNIVERSAL OUT-OF-NETWORK
21 BENEFITS

22
23 RECOMMENDATION:

24
25 Your Reference Committee recommends that AMA
26 Policies H-285.904, H-285.907, D-285.958, D-
27 285.963, H-165.838, H-180.952, and H-285.908 be
28 reaffirmed in lieu of Resolution 818.

29
30
31 **HOD ACTION: Policies H-285.904, H-285.907, D-285.958, D-285.963, H-165.838, H-
32 180.952, and H-285.908 reaffirmed in lieu of Resolution 818.**

33
34
35 **RESOLVED**, that our American Medical Association will advocate for federal and state
36 laws that requires all private insurers to offer health insurance plans with out-of-network
37 benefits. (Directive to Take Action)

38
39 Testimony on Resolution 818 was mixed. Your Reference Committee heard some
40 support for reaffirmation of the AMA's network adequacy and out-of-network care
41 policies in lieu of the resolution. Other commenters supported the resolution as written,
42 with one supporter simultaneously citing the AMA's policy on out-of-network care. A
43 concern was raised regarding the inconsistency of Resolution 818 with AMA policy on
44 patient choice of insurance, which generally includes Health Maintenance Organization
45 (HMO) options that by definition have closed networks, and the perception that adoption
46 would suggest that the AMA believes HMOs should no longer exist. Your Reference
47 Committee points to existing AMA policy that opposes the denial of coverage and/or
48 payment for services that is based solely on the network participation of the ordering
49 physician (Policies H-285.907, D-285.958, and D-285.963); states that insurance options
50 offered in an exchange must not restrict enrollees' access to out-of-network physicians

1 (H-165.838[5]); opposes any penalties implemented by insurance companies against
2 physicians when patients independently choose to obtain out-of-network services (Policy
3 H-180.952); supports requiring insurers to indemnify patients for any covered medical
4 expenses provided by out-of-network providers incurred over the copay and deductibles
5 that would apply to in-network providers (Policy H-285.908); and supports other
6 principles for out-of-network care, including that patients must not be financially
7 penalized for receiving unanticipated care from an out-of-network provider, insurers must
8 meet appropriate network adequacy standards that include adequate patient access to
9 care, and minimum coverage standards should pay out-of-network providers at the usual
10 and customary out-of-network charges for services. (Policy H-285.904). Your Reference
11 Committee believes that these policies address the concerns raised about out-of-
12 network care and recommends that they be reaffirmed in lieu of Resolution 818.

13 14 OUT-OF-NETWORK CARE H-285.904

- 15 1. Our American Medical Association adopts the following
16 principles related to unanticipated out-of-network care:
17 a. Patients must not be financially penalized for receiving
18 unanticipated care from an out-of-network provider.
19 b. Insurers must meet appropriate network adequacy
20 standards that include adequate patient access to care,
21 including access to hospital-based physician specialties.
22 State regulators should enforce such standards through
23 active regulation of health insurance company plans.
24 c. Insurers must be transparent and proactive in informing
25 enrollees about all deductibles, copayments and other out-
26 of-pocket costs that enrollees may incur.
27 d. Prior to scheduled procedures, insurers must provide
28 enrollees with reasonable and timely access to in-network
29 physicians.
30 e. Patients who are seeking emergency care should be
31 protected under the "prudent layperson" legal standard as
32 established in state and federal law, without regard to prior
33 authorization or retrospective denial for services after
34 emergency care is rendered.
35 f. Out-of-network payments must not be based on a
36 contrived percentage of the Medicare rate or rates
37 determined by the insurance company.
38 g. Minimum coverage standards for unanticipated out-of-
39 network services should be identified. Minimum coverage
40 standards should pay out-of-network providers at the usual
41 and customary out-of-network charges for services, with the
42 definition of usual and customary based upon a percentile of
43 all out-of-network charges for the particular health care service
44 performed by a provider in the same or similar specialty and
45 provided in the same geographical area as reported by a
46 benchmarking database. Such a benchmarking database must
47 be independently recognized and verifiable, completely

1 transparent, independent of the control of either payers or
2 providers and maintained by a non-profit organization. The
3 non-profit organization shall not be affiliated with an insurer, a
4 municipal cooperative health benefit plan or health
5 management organization.

6 h. Independent Dispute Resolution (IDR) should be allowed in
7 all circumstances as an option or alternative to come to
8 payment resolution between insurers and physicians.

9 2. Our AMA will advocate for the principles delineated in Policy
10 H-285.904 for all health plans, including ERISA plans.

11 3. Our AMA will advocate that any legislation addressing
12 surprise out of network medical bills use an independent, non-
13 conflicted database of commercial charges.

14 15 OUT OF NETWORK RESTRICTIONS OF PHYSICIANS H- 16 285.907

17 Our American Medical Association opposes the denial of
18 payment for a medically necessary prescription of a drug or
19 service covered by the policy based solely on the network
20 participation of the duly licensed physician ordering it.

21 22 PATIENT ACCESS TO COVERED BENEFITS ORDERED BY 23 OUT-OF-NETWORK PHYSICIANS D-285.958

24 1. Our American Medical Association will develop model
25 legislation to protect patients managed by out-of-network
26 physicians by prohibiting insurance plans from denying
27 payment for covered services, including imaging, laboratory
28 testing, referrals, medications, and other medically-necessary
29 services for patients under their commercial insurance, based
30 solely on the network participation of the ordering physician
31 while preserving evidence based high quality care and
32 healthcare affordability.

33 2. Our AMA will collaborate with other physician organizations
34 to develop resources, toolkits, and education to support out-of-
35 network care models.

36 37 OUT OF NETWORK COVERAGE DENIALS FOR PHYSICIAN 38 PRESCRIPTIONS AND ORDERED SERVICES D-285.963

39 Our American Medical Association will pursue regulation or
40 legislation to prohibit any insurer from writing individual or
41 group policies which deny or unreasonably delay coverage of
42 medically necessary prescription drugs or services based on
43 network distinctions of the licensed health care provider
44 ordering the drug or service.

45 46 HEALTH SYSTEM REFORM LEGISLATION H-165.838

47 ...5. AMA policy is that insurance coverage options offered in
48 a health insurance exchange be self-supporting, have uniform
49 solvency requirements; not receive special advantages from

1 government subsidies; include payment rates established
2 through meaningful negotiations and contracts; not require
3 provider participation; and not restrict enrollees' access to out-
4 of-network physicians.
5

6 PHYSICIAN PENALTIES FOR OUT-OF-NETWORK
7 SERVICES H-180.952

8 Our AMA vehemently opposes any penalties implemented by
9 insurance companies against physicians when patients
10 independently choose to obtain out-of-network services.
11

12 NETWORK ADEQUACY H-285.908

- 13 1. Our AMA supports state regulators as the primary enforcer
14 of network adequacy requirements.
- 15 2. Our AMA supports requiring that provider terminations
16 without cause be done prior to the enrollment period, thereby
17 allowing enrollees to have continued access throughout the
18 coverage year to the network they reasonably relied upon
19 when purchasing the product. Physicians may be added to the
20 network at any time.
- 21 3. Our AMA supports requiring health insurers to submit and
22 make publicly available, at least quarterly, reports to state
23 regulators that provide data on several measures of network
24 adequacy, including the number and type of providers that
25 have joined or left the network; the number and type of
26 specialists and subspecialists that have left or joined the
27 network; the number and types of providers who have filed an
28 in network claim within the calendar year; total number of
29 claims by provider type made on an out-of-network basis; data
30 that indicate the provision of Essential Health Benefits; and
31 consumer complaints received.
- 32 4. Our AMA supports requiring health insurers to indemnify
33 patients for any covered medical expenses provided by out-of-
34 network providers incurred over the co-payments and
35 deductibles that would apply to in-network providers, in the
36 case that a provider network is deemed inadequate by the
37 health plan or appropriate regulatory authorities.
- 38 5. Our AMA advocates for regulation and legislation to require
39 that out-of-network expenses count toward a participant's
40 annual deductibles and out-of-pocket maximums when a
41 patient is enrolled in a plan with out-of-network benefits, or
42 forced to go out-of-network due to network inadequacies.
- 43 6. Our AMA supports fair and equitable compensation to out-
44 of-network providers in the event that a provider network is
45 deemed inadequate by the health plan or appropriate
46 regulatory authorities.
- 47 7. Our AMA supports health insurers paying out-of-network
48 physicians fairly and equitably for emergency and out-of-
49 network bills in a hospital. AMA policy is that any legislation
50 which addresses this issue should assure that insurer payment

1 for such care be based upon a number of factors, including the
2 physicians' usual charge, the usual and customary charge for
3 such service, the circumstances of the care and the expertise
4 of the particular physician.

5 8. Our AMA provides assistance upon request to state medical
6 associations in support of state legislative and regulatory
7 efforts, and disseminate relevant model state legislation, to
8 ensure physicians and patients have access to adequate and
9 fair appeals processes in the event that they are harmed by
10 inadequate networks.

11 9. Our AMA supports the development of a mechanism by
12 which health insurance enrollees are able to file formal
13 complaints about network adequacy with appropriate
14 regulatory authorities.

15 10. Our AMA advocates for legislation that prohibits health
16 insurers from falsely advertising that enrollees in their plans
17 have access to physicians of their choosing if the health
18 insurer's network is limited.

19 11. Our AMA advocates that health plans should be required
20 to document to regulators that they have met requisite
21 standards of network adequacy including hospital-based
22 physician specialties (i.e. radiology, pathology, emergency
23 medicine, anesthesiologists and hospitalists) at in-network
24 facilities, and ensure in-network adequacy is both timely and
25 geographically accessible.

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

- 1 Madam Speaker, this concludes the report of Reference Committee J. I would like to
- 2 thank Teresa Girolami, MD, Patricia Kolowich, MD, Mary LaPlante, MD, Michele Nedelka,
- 3 MD, Daniel Pfeifle, MD, and Laurel Ries, MD.

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American College of Chest Physicians

Patricia Kolowich, MD
Michigan State Medical Society

Laurel Ries, MD (Alternate)
Minnesota Medical Association

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American College of Obstetricians and
Gynecologists

Mary Campagnolo, MD, MBA
Medical Society of New Jersey

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Medical Society of Virginia

DRAFT

DISCLAIMER

The following is a preliminary report of actions taken by the House of Delegates at its 2025 Interim Meeting and should not be considered final. Only the Official Proceedings of the House of Delegates reflect official policy of the Association.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (I-25)

Final Report of Reference Committee K

Samuel Huang, MD, Chair

RECOMMENDED FOR ADOPTION

1. BOT 24 - Amending Vaccine-Related Policies
2. Resolution 901 - Distinction Between Healthful and Unhealthful “Ultraprocessed” Foods
3. Resolution 920 - Alcohol and Aging: Educating Physicians and Advocating for Safer Warnings
4. Resolution 922 - Addressing Health Impacts of Indian Boarding Schools
5. Resolution 923 - Enhancing Disaster Preparedness Mechanisms for People with Disabilities
6. Resolution 924 - Preserving Access to Gamete Donation and Gestational Carriers and Protecting Parental Rights
7. Resolution 926 - Establishment of Federal and State Offices of Men's Health
8. Resolution 929 - Protecting Access to Evidence-base Psychotropic Medications for the Treatment of Pediatric Mental Illness
9. Resolution 932 - Shared Decision-Making and Low Dose CT Lung Cancer Screening in Clinical Practice

RECOMMENDED FOR ADOPTION AS AMENDED

10. CSAPH 02 - Regulation of Ionizing Radiation Exposure for Health Care Professionals
11. CSAPH 03 - Plastic Pollution Reduction
12. Resolution 902 - Advocating For Improvements in Systems of Care for Autism
13. Resolution 905 - Standardizing Brain Death Policies
14. Resolution 907- In-Office Dispensing of Generic Medications
15. Resolution 909 - Clinical Significance of Sleepiness
16. Resolution 911- Safeguarding NIH-Funded and Other Women's Health Research in Peer-Reviewed Publishing
17. Resolution 912 - Increasing Access through Federated Healthcare Data Architecture
18. Resolution 933 - Addressing Gaps in National Healthcare Safety Network (NHSN) Data Quality
19. Resolution 935 - Enhancing Healthcare System Preparedness to Address Veteran-Specific Health Disparities

1 RECOMMENDED FOR ADOPTION IN LIEU OF

- 2
3 20. Resolution 931 - Preserving Evidence-Based, Equitable Grooming Standards in
4 Military Service

5 RECOMMENDED FOR REFERRAL

- 6
7 21. Resolution 906 - Rethinking the Medicare Annual Wellness Visit
8 22. Resolution 917 - Urging Comprehensive Research and Safety Testing of
9 Industry-Engineered Food Additives (IEFAs), Including High Fructose Corn Syrup
10 23. Resolution 918 - Remove Outdated Barriers to Genetic Testing
11 24. Resolution 921 - Prioritizing Deprescribing Seniors
12 25. Resolution 927 - Battlefield Acupuncture - An Educational Call to Arms
13 26. Resolution 930 - Establishing Fire Risk Standards for Civilian and Non-Industrial
14 Clothing

**15
16 RECOMMENDED FOR REFERRAL FOR DECISION**

- 17
18 27. Resolution 919 - Strengthening Trust through AMA-Based Leadership for
19 Evidence-Based Vaccines (STABLE Vaccines)
20 Resolution 925 - Evidence-Based Vaccine and Preventive Services
21 Recommendation
22

23 RECOMMENDED FOR NOT ADOPTION

- 24
25 28. Resolution 904 - Supporting Certification of the Public Health Workforce
26 29. Resolution 908 - Support of Access to Insulin-Detemir
27

28 RECOMMENDED FOR REAFFIRMATION IN LIEU OF

- 29
30 30. Resolution 903 - Nitrous Oxide Inhalant Abuse

RECOMMENDED FOR ADOPTION

1
2 (1) BOT 24 - AMENDING VACCINE-RELATED POLICIES

3
4 **RECOMMENDATION:**

5
6 **Your Reference Committee recommends that the Board**
7 **of Trustees Report 24 be adopted.**

8
9 **HOD ACTION: BOT 24 adopted and the remainder of the Report filed.**

10
11
12 The Board of Trustees recommends that the House of Delegates policies listed in the
13 appendix to this report be acted upon in the manner indicated and the remainder of this
14 report be filed. (Directive to Take Action)

15
16 Your Reference Committee heard unanimously supportive testimony for this item. Multiple
17 delegations testified in favor of the report. A delegation emphasized that medical specialty
18 recommendations are important, especially given the multiple concurrent initiatives at the
19 state level. Another delegation highlighted the importance of maintaining scientific
20 evidence as the highest priority. Your Reference Committee agrees with these points and;
21 therefore, your Reference Committee recommends that the report's recommendations be
22 adopted.

23
24 (2) RESOLUTION 901 - DISTINCTION BETWEEN
25 HEALTHFUL AND UNHEALTHFUL "ULTRAPROCESSED"
26 FOODS

27
28 **RECOMMENDATION:**

29
30 **Your Reference Committee recommends that**
31 **Resolution 901 be adopted.**

32
33 **HOD ACTION: Resolution 901 adopted.**

34
35
36 RESOLVED, that our American Medical Association encourage public education on the
37 difference between healthful "ultraprocessed" foods and unhealthy "ultraprocessed"
38 foods (New HOD Policy); and be it further

39
40 RESOLVED, that our AMA amend AMA policy H-150.914, Addressing the Health Impacts
41 of Ultraprocessed Foods, by deletion to remove the first appearance of the word "food,"
42 so as to read "Our AMA supports and promotes public awareness and education about
43 the differences between healthful foods and unhealthy ultraprocessed foods (UPF) and
44 the benefits of minimally processed and unprocessed foods." (Modify Current HOD Policy)

1 Your Reference Committee heard testimony that was largely supportive of this resolution.
2 Current AMA policy assumes that all ultra-processed foods are unhealthy, but as noted
3 in testimony there are some foods classified as ultra-processed food that have health
4 benefits. This proposed amendment better aligns AMA policy with current evidence. There
5 was some concern that there is no standard definition of ultra-processed foods, but that
6 work is being undertaken and is beyond the scope of this resolution. Therefore, your
7 Reference Committee recommends that Resolution 901 be adopted.

8
9 (3) RESOLUTION 920 - ALCOHOL AND AGING:
10 EDUCATING PHYSICIANS AND ADVOCATING FOR
11 SAFER WARNINGS

12
13 **RECOMMENDATION:**

14
15 **Your Reference Committee recommends that**
16 **Resolution 920 be adopted.**

17
18 **HOD ACTION: Resolution 920 adopted.**

19
20
21 **RESOLVED**, that our American Medical Association advocate for the inclusion of clear,
22 evidence-based warnings concerning the health risks of alcohol use in seniors on all
23 alcoholic beverage containers, and work with regulatory bodies to develop standards for
24 such warning labels in alignment with AMA policy. (Directive to Take Action)

25
26 Your Reference Committee heard unanimously supportive testimony on this resolution,
27 with many dementia specialists and geriatric practitioners noting a need for greater
28 awareness around the harmful effects of alcohol on aged populations. Therefore, your
29 Reference Committee recommends that Resolution 920 be adopted.

30
31 (4) RESOLUTION 922 - ADDRESSING HEALTH IMPACTS OF
32 INDIAN BOARDING SCHOOLS

33
34 **RECOMMENDATION:**

35
36 **Your Reference Committee recommends that**
37 **Resolution 922 be adopted.**

38
39 **HOD ACTION: Resolution 922 adopted.**

40
41
42 **RESOLVED**, that our American Medical Association support efforts to address the
43 historical injustices and ongoing health impacts of Indian boarding schools. (New HOD
44 Policy)

1 Your Reference Committee heard mostly supportive testimony for Resolution 922. Multiple
2 delegations/sections in support noted the importance of addressing the ongoing health
3 harms of Indian boarding schools and their resultant health disparities. Testimony in
4 support also noted that physicians must acknowledge the historical harms that continue
5 to manifest in the bodies, minds, and communities of Indigenous patients and
6 communities. Two individuals in opposition noted that this resolution is out of scope of the
7 AMA's advocacy efforts. Given that the majority of the testimony was in support of this
8 resolution, your Reference Committee recommends that Resolution 922 be adopted.

9
10 (5) RESOLUTION 923 - ENHANCING DISASTER
11 PREPARADNESS MECHANISMS FOR PEOPLE WITH
12 DISABILITIES

13
14 **RECOMMENDATION:**

15
16 **Your Reference Committee recommends that**
17 **Resolution 923 be adopted.**

18
19 **HOD ACTION: Resolution 923 adopted.**

20
21
22 RESOLVED, that our American Medical Association, in coordination with relevant
23 stakeholders, advocate for greater integration of inclusive emergency alert systems (e.g.,
24 visual, auditory, and haptic notifications) in emergency preparedness planning to ensure
25 disaster response accessibility for people with disabilities (Directive to take Action); and
26 be it further

27
28 RESOLVED, that our AMA support increased federal and state funding for disability-
29 specific disaster preparedness measures such as assistive technologies, durable medical
30 equipment, mobility devices, and education programs in collaboration with relevant
31 stakeholders. (New HOD Policy

32
33 Your Reference Committee heard unanimous testimony in support of adopting resolution
34 923 and in opposition to reaffirmation. Multiple delegations/sections in support of adoption
35 noted that this resolution builds upon existing AMA policy by providing specific and
36 critically needed inclusive language that advocates for disaster preparedness that is
37 tailored to our disabled population. A delegation proffered an amendment to delete
38 " increased federal and state funding for" in the second Resolved clause noting that early
39 responders such as the Red Cross and other local agencies are funded by donations and
40 fundraising so the request for federal and state dollars is not beneficial. Given that the
41 majority of the testimony by multiple delegations/sections was in support of including
42 language about increasing federal and state funding, your Reference Committee
43 recommends that Resolution 923 be adopted.

1 (6) RESOLUTION 924 - PRESERVING ACCESS TO GAMETE
2 DONATION AND GESTATIONAL CARRIERS AND
3 PROTECTING PARENTAL RIGHTS
4

5 **RECOMMENDATION:**
6

7 **Your Reference Committee recommends that**
8 **Resolution 924 be adopted.**
9

10 **HOD ACTION: Resolution 924 adopted.**
11

12
13 RESOLVED, that our American Medical Association support policies and initiatives that
14 protect, standardize, and improve access to gamete donation and gestational carrying as
15 recognized options for assisted reproduction (New HOD Policy); and be it further
16

17 RESOLVED, that our AMA support efforts by appropriate parties to provide resources for
18 intended parents, gestational carriers, gamete donors, and children born with the aid of
19 gamete donation and/or gestational carrying (New HOD Policy); and be it further
20

21 RESOLVED, that our AMA advocates for accessibility, timeliness, and dignity in the
22 process of establishing parentage for children born from gamete donation and/or
23 gestational carrying. (Directive to Take Action)
24

25 Your Reference Committee heard strong support from multiple delegations. Two
26 delegations highlighted that Resolution 924 is in strong alignment with existing policy
27 including Policy 4.2.1 (Assisted Reproductive Technology), 4.2.2 (Gamete Donation), and
28 4.2.4 (Third-Party Reproduction). Moreover, it builds upon AMA's long-standing
29 commitment to ethical, inclusive, and evidence-based reproductive care. A handful of
30 individuals opposed the resolution as unethical, racist, ableist, and sexist. Given the
31 alignment with existing policy and strong section and delegation support, your Reference
32 Committee recommends Resolution 924 be adopted.
33

34 (7) RESOLUTION 926 - ESTABLISHMENT OF FEDERAL
35 AND STATE OFFICES OF MEN'S HEALTH
36

37 **RECOMMENDATION:**
38

39 **Your Reference Committee recommends that**
40 **Resolution 926 be adopted.**
41

42 **HOD ACTION: Resolution 926 adopted.**
43

44 **ADOPTED LANGUAGE:**

45 **Policy D-160.985 "Establishment of Federal and State Offices of Men's Health"**
46

47 **1. Our AMA encourages the establishment of an Office of Men's Health within the**
48 **federal Department of Health and Human Services to coordinate awareness,**
49 **outreach, and outcomes on men's health.**

1 **2. Our AMA encourages the establishment of an Office of Men's Health within**
2 **each state's Department of Health and Human Services to coordinate awareness,**
3 **outreach, and outcomes on men's health.**
4

5
6 RESOLVED, that our American Medical Association amend Policy D-160.985,
7 Establishment of an Office of Men's Health, to read as follows:
8

9 **Establishment of an Federal and State Offices of Men's Health**

10
11 1. Our AMA encourages the establishment of an Office of Men's Health at the U.S. within
12 the federal Department of Health and Human Services to coordinate awareness, outreach,
13 and outcomes on men's health.

14
15 2. Our AMA encourages the establishment of an Office of Men's Health within each state's
16 Department of Health and Human Services to coordinate awareness, outreach, and
17 outcomes on men's health. (Modify Current HOD Policy)
18

19 Your Reference Committee heard unanimously supportive testimony in favor of this
20 resolution, with many delegations and sections noting the timeliness of this policy as
21 suicide rates among men have continued to climb. Therefore, your Reference Committee
22 recommends resolution 926 be adopted.
23

24 (8) RESOLUTION 929 - PROTECTING ACCESS TO
25 EVIDENCE-BASE PSYCHOTROPIC MEDICATIONS FOR
26 THE TREATMENT OF PEDIATRIC MENTAL ILLNESS
27

28 **RECOMMENDATION:**

29
30 **Your Reference Committee recommends that**
31 **Resolution 929 be adopted.**
32

33 **HOD ACTION: Resolution 929 adopted.**
34

35
36 RESOLVED, that our American Medical Association opposes limitations on access to
37 psychotropic medication as part of a comprehensive mental health treatment plan (New
38 HOD Policy); and be it further
39

40 RESOLVED, that our AMA advocates that the U.S. Department of Health and Human
41 Services and Congress use peer reviewed pediatric mental health research, and evidence
42 based clinical guidelines developed by non-profit medical professional societies to inform
43 pediatric mental health policy. (Directive to Take Action)

1 Your Reference Committee heard testimony that was unanimously supportive of this
2 resolution. In particular, there was concern for politicalization and misinformation limiting
3 the access for critical mental health treatment in pediatric patients, noting that this specific
4 resolution advocates with the detailed policy needed to support evidence-based
5 treatment. Therefore, your Reference Committee recommends Resolution 929 be
6 adopted.

7
8 (9) RESOLUTION 932 - SHARED DECISION-MAKING AND
9 LOW DOSE CT LUNG CANCER SCREENING IN
10 CLINICAL PRACTICE

11
12 **RECOMMENDATION:**

13
14 **Your Reference Committee recommends that**
15 **Resolution 932 be adopted.**

16
17 **HOD ACTION: Resolution 932 adopted.**

18
19
20 **RESOLVED**, that our American Medical Association, in conjunction with other interested
21 national specialty societies of expertise (e.g., ACP, AAFP, ACR, etc.), create and share
22 educational resources and training to help physicians efficiently discuss and document
23 low-dose computed tomography (LDCT) lung cancer screening during shared decision-
24 making visits for high-risk populations. (Directive to Take Action)

25
26 Your Reference Committee heard testimony from three delegations and one individual in
27 support of adopting Resolution 932, therefore your Reference Committee recommends
28 adoption of Resolution 932

RECOMMENDED FOR ADOPTION AS AMENDED**(10) CSAPH 02 REGULATION OF IONIZING RADIATION
EXPOSURE FOR HEALTH CARE PROFESSIONALS****RECOMMENDATION A:**

Your Reference Committee recommends that the Recommendation in the Council on Science and Public Health (CSAPH) Report 2 be amended by addition and deletion to read as follows:

Policy H-455.975, "Regulation of Ionizing Radiation Exposure for Health Care Workers" be amended by addition and deletion to read as follows:

1. Our American Medical Association encourages: (1) public and private health care institutions to ensure the availability of personal protective equipment (PPE) that provides comprehensive coverage of different body types by providing readily available PPE that reduces to reduce ionizing radiation exposure to as low as reasonably achievable for employees—health care personnel and trainees of all genders and pregnancy statuses; (2) the use of dosimetry badges for all employees health care personnel and trainees who work in exposure-prone settings, with clear follow-up actions for those with elevated cumulative exposure; (3) continued research on the health effects of low level and very-low level exposure to ionizing radiation, the effectiveness of PPE and administrative and engineering controls designed to reduce exposure (e.g., shielding, interlock systems, labeling,), barriers to PPE use (e.g., fit, availability, cost), and ways to improve PPE use fidelity (e.g., training, education, and access to appropriately sized and ergonomic PPE);—and (4) education for all health care personnel, including trainees, and trainees specific to their expected exposure exposed to ionizing radiation that includes awareness of and methods to limit radiation exposure to both patients and clinicians; and (5) collaboration between medical specialty societies to establish education and training standards for the use of PPE and engineering controls to reduce exposure to ionizing radiation for health care personnel and trainees. Training programs should provide education specific to their specialties so trainees know which protective equipment and controls their facilities should have in place and know how to use them correctly.

1 ~~2. Our AMA will work with the appropriate and interested~~
2 ~~parties to study how best to accomplish comprehensive~~
3 ~~protection from ionizing radiation for employees, taking~~
4 ~~into account variation in body types, pregnancy status,~~
5 ~~specifics of procedures being performed, as well as how~~
6 ~~exposure can be limited beyond PPE (personal~~
7 ~~protected equipment), with report back at I-25.~~

8
9 **RECOMMENDATION B:**

10
11 Your Reference Committee recommends that the
12 Recommendation in the Council on Science and Public
13 Health (CSAPH) Report 2 adopted as amended and the
14 remainder of the report be filed.

15
16 **HOD ACTION:** CSAPH Report 2 adopted as amended and remainder of Report
17 filed.

18
19 **ADOPTED LANGUAGE:**

20 Policy H-455.975, "Regulation of Ionizing Radiation Exposure for Health Care
21 Workers"

22
23 **1. Our American Medical Association encourages:** (1) public and private health
24 care institutions to ensure the availability of personal protective equipment (PPE)
25 that provides comprehensive coverage of different body types to reduce ionizing
26 radiation exposure to as low as reasonably achievable for health care personnel
27 and trainees of all genders and pregnancy statuses; (2) the use of dosimetry
28 badges for all health care personnel and trainees who work in exposure-prone
29 settings, with clear follow-up actions for those with elevated cumulative exposure;
30 (3) continued research on the health effects of low level and very-low level
31 exposure to ionizing radiation, the effectiveness of PPE and administrative and
32 engineering controls designed to reduce exposure (e.g., shielding, interlock
33 systems, labeling,), barriers to PPE use (e.g., fit, availability, cost), and ways to
34 improve PPE use fidelity (e.g., training, education, and access to appropriately
35 sized and ergonomic PPE); (4) education for all health care personnel and trainees
36 specific to their expected exposure to ionizing radiation that includes awareness
37 of and methods to limit radiation exposure to both patients and clinicians; and (5)
38 collaboration between medical specialty societies to establish education and
39 training standards for the use of PPE and engineering controls to reduce
40 exposure to ionizing radiation for health care personnel and trainees.

41
42
43 Your Council on Science and Public Health recommends that the following be adopted
44 and the remainder of this report be filed.

45
46 That Policy H-455.975, "Regulation of Ionizing Radiation Exposure for Health Care
47 Workers" be amended by addition and deletion to read as follows:
48

- 1 1. Our American Medical Association encourages: (1) public and private health care
2 institutions to ensure the availability of personal protective equipment (PPE) that
3 provides comprehensive coverage of different body types by providing readily
4 available PPE that reduces to reduce ionizing radiation exposure to as low as
5 reasonably achievable for employees and trainees of all genders and pregnancy
6 statuses; (2) continued research on the health effects of low level and very-low
7 level ionizing radiation, the effectiveness of PPE and administrative and
8 engineering controls designed to reduce exposure (e.g., shielding, interlock
9 systems, labeling,), barriers to PPE use (e.g., fit, availability, cost), and ways to
10 improve PPE use fidelity (e.g., training, education, and access to appropriately
11 sized and ergonomic PPE), and (3) education for all health care personnel,
12 including trainees, exposed to ionizing radiation that includes awareness of and
13 methods to limit radiation exposure to both patients and clinicians. Training
14 programs should provide education specific to their specialties so trainees know
15 which protective equipment and controls their facilities should have in place and
16 know how to use them correctly.
- 17
- 18 2. ~~Our AMA will work with the appropriate and interested parties to study how best to~~
19 ~~accomplish comprehensive protection from ionizing radiation for employees,~~
20 ~~taking into account variation in body types, pregnancy status, specifics of~~
21 ~~procedures being performed, as well as how exposure can be limited beyond PPE~~
22 ~~(personal protected equipment), with report back at I-25.~~

23

24 Your Reference Committee heard testimony in strong support of the report's
25 recommendations from multiple delegations and sections. Three amendments were
26 proposed. The first amendment suggested adding "sexes" to the first recommendation, so
27 it would read "...and trainees of all sexes, genders, and pregnancy statuses." However,
28 this addition was not supported by other testimony. The two remaining amendments
29 received unanimous support. One delegation proposed adding language to advocate for
30 routine radiation monitoring using dosimetry badges for all employees and trainees who
31 work in exposure-prone settings. Another section recommended changing the language
32 from "employees and trainees" to "health care personnel and trainees" to better include
33 non-clinician employees. They also proposed revising the last clause to state:
34 "collaboration between medical specialty societies to establish education and training
35 standards for the use of PPE and engineering controls to reduce exposure to ionizing
36 radiation for health care personnel and trainees." Testimony submitted through the online
37 Reference Committee was also supportive of the report's recommendations. Given the
38 strong support for the latter two amendments and supportive online testimony, your
39 Reference Committee recommends that the report's recommendation be adopted as
40 amended.

1 (11) CSAPH 03 - PLASTIC POLLUTION REDUCTION

2
3 **RECOMMENDATION A:**

4
5 Your Reference Committee recommends that the
6 second Recommendation in CSAPH 3 be amended by
7 addition and deletion to read as follows:
8

9 2. That Policy D-135.976, “Modernization of the Federal
10 Toxic Substances Control Act (TSCA) of 1976” be
11 amended by addition and deletion to read as follows:
12

13 Our AMA will: (1) collaborate with relevant stakeholders
14 to advocate for modernizing the Toxic Substances
15 Control Act (TSCA) to require chemical manufacturers
16 to provide adequate safety information on all chemicals
17 and give federal regulatory agencies reasonable
18 authority to regulate hazardous chemicals in order to
19 protect the health of all individuals, especially
20 vulnerable populations; (2) support the public
21 disclosure of chemical use, exposure and hazard data
22 in forms that are appropriate for use by medical
23 practitioners, workers, and the public; (3) encourage
24 advocate for the U.S. Environmental Protection Agency
25 to consider the cumulative impacts of chemicals within
26 their risk assessment process and quantify exposures
27 across pathways and populations; and (34) work with
28 members of the Federation to promote a reformed
29 TSCA that is consistent with goals of Registration,
30 Evaluation, Authorisation, and Restriction of Chemicals
31 (REACH), and (5) support the proactive restriction or
32 phasing-out of chemicals suspected of posing
33 significant health risks.
34

35 **RECOMMENDATION B:**

36
37 Your Reference Committee recommends that the
38 Recommendations in CSAPH 3 be adopted as amended
39 and the remainder of the report be filed.
40

41 **HOD ACTION:** CSAPH Report 3 adopted as amended and remainder of Report
42 filed.

43
44 **ADOPTED LANGUAGE:**

45 1. Policy H-135.901, “Addressing the Health Consequences of Microplastics in
46 Humans”

47 1. Our American Medical Association recognize the potential health risks
48 associated with plastics and microplastics and encourage increased research to

1 **better understand the human health effects and environmental impacts of plastics**
2 **across their lifespan, including the chemicals used in plastic production.**

3
4 **2. Our AMA supports the development of evidence-based guidelines for monitoring**
5 **and mitigating microplastic exposure in water, food, air, and other consumer**
6 **products.**

7
8 **3. Our AMA will collaborate with relevant stakeholders to promote public education**
9 **about microplastics, their sources, potential health risks, and possible strategies**
10 **for reducing exposure.**

11
12 **4. Our AMA supports policies to reduce plastic pollution, such as limits on single-**
13 **use plastics (for example plastic bags), incentivizing non-plastic alternatives such**
14 **as reusable bags, food containers, and packaging, incentivizing alternative**
15 **reformulations of synthetic plastics (such as bioplastics), and improving recycling**
16 **infrastructure and systems to better manage plastic waste.**

17
18 **2. Policy D-135.976, “Modernization of the Federal Toxic Substances Control Act**
19 **(TSCA) of 1976”**

20
21 **Our AMA will: (1) collaborate with relevant stakeholders to advocate for**
22 **modernizing the Toxic Substances Control Act (TSCA) to require chemical**
23 **manufacturers to provide adequate safety information on all chemicals and give**
24 **federal regulatory agencies reasonable authority to regulate hazardous**
25 **chemicals in order to protect the health of all individuals, especially vulnerable**
26 **populations; (2) support the public disclosure of chemical use, exposure and**
27 **hazard data in forms that are appropriate for use by medical practitioners,**
28 **workers, and the public; (3) advocate for the U.S. Environmental Protection**
29 **Agency to consider the cumulative impacts of chemicals within their risk**
30 **assessment process and quantify exposures across pathways and populations;**
31 **and (4) work with members of the Federation to promote a reformed TSCA that is**
32 **consistent with goals of Registration, Evaluation, Authorisation, and Restriction**
33 **of Chemicals (REACH), and (5) support the proactive restriction or phasing-out of**
34 **chemicals suspected of posing significant health risks.**

35
36
37 **The Council on Science and Public Health recommends that the following be adopted,**
38 **and the remainder of the report be filed.**

39
40 **1. That Policy H-135.901, “Addressing the Health Consequences of Microplastics in**
41 **Humans” be amended by addition and deletion to read as follows:**

42
43 **Addressing the Health Consequences of Plastics and Microplastics in Humans**

44
45 **1. Our American Medical Association recognize the potential health risks associated**
46 **with plastics and microplastics exposure and encourage increased research to better**
47 **understand the human health effects and environmental impacts of plastics across their**
48 **lifespan microplastics, including the chemicals used in plastic production.**
49

1 ~~2. Our AMA supports the development of respective specialty medical societies with~~
2 ~~subject matter expertise and federal and state public health agencies, including the~~
3 ~~Centers for Disease Control and Prevention (CDC) and the Environmental Protection~~
4 ~~Agency (EPA), to develop evidence-based guidelines for monitoring and mitigating~~
5 ~~microplastic exposure in water, food, air, and other consumer products.~~
6

7 3. Our AMA will collaborate with relevant stakeholders to promote public education about
8 microplastics, their sources, potential health risks, and possible strategies for reducing
9 exposure.

10
11 ~~4. Our AMA will study and report back with policy recommendations on ways to reduce~~
12 ~~plastic pollution and its impact on climate change and health, including but not limited to~~
13 ~~federal, state, and local taxes and limitations on the use of single-use plastic consumer~~
14 ~~products and other types of plastic, interventions to reduce microplastics, and alternatives~~
15 ~~to plastic.~~
16

17 4. Our AMA supports policies to reduce plastic pollution, such as limits on single-use
18 plastics (for example plastic bags), incentivizing non-plastic alternatives such as reusable
19 bags, food containers, and packaging, incentivizing alternative reformulations of synthetic
20 plastics (such as bioplastics), and improving recycling infrastructure and systems to better
21 manage plastic waste.
22

23 2. That Policy D-135.976, "Modernization of the Federal Toxic Substances Control Act
24 (TSCA) of 1976" be amended by addition and deletion to read as follows:

25 Our AMA will: (1) collaborate with relevant stakeholders to advocate for modernizing the
26 Toxic Substances Control Act (TSCA) to require chemical manufacturers to provide
27 adequate safety information on all chemicals and give federal regulatory agencies
28 reasonable authority to regulate hazardous chemicals in order to protect the health of all
29 individuals, especially vulnerable populations; (2) support the public disclosure of chemical
30 use, exposure and hazard data in forms that are appropriate for use by medical
31 practitioners, workers, and the public; (3) encourage the U.S. Environmental Protection
32 Agency to consider the cumulative impacts of chemicals within their risk assessment
33 process and quantify exposures across pathways and populations; and (34) work with
34 members of the Federation to promote a reformed TSCA that is consistent with goals of
35 Registration, Evaluation, Authorisation, and Restriction of Chemicals (REACH), and (5)
36 support the proactive restriction or phasing-out of chemicals suspected of posing
37 significant health risks.
38

39 Your Reference Committee heard unanimously supportive testimony for this report noting
40 that the report discusses environmental and health impacts of plastic across the product
41 lifespan, as well as tangible strategies for reducing those impacts. A delegation proffered
42 an amendment to change the word "support" to "advocate for" in Policy D-135.976 noting
43 that the AMA needs to lead the way in advocating for better regulations on production, use
44 and disposal of plastic chemicals. Your Reference Committee agrees with this
45 amendment. Therefore, your Reference Committee recommends adoption of the
46 recommendations in CSAPH Report 3 as amended.

1 (12) RESOLUTION 902 - ADVOCATING FOR
2 IMPROVEMENTS IN SYSTEMS OF CARE FOR AUTISM
3

4 **RECOMMENDATION A:**

5
6 **Your Reference Committee recommends Resolution**
7 **902 be amended by addition and deletion to read as**
8 **follows:**
9

10 **RESOLVED, that our American Medical Association**
11 **advocate for peer reviewed, evidence-based guidance**
12 **for states on innovative health systems solutions to**
13 **reduce specific barriers to the diagnosis and treatment**
14 **of autism, including ~~and~~ complex care coordination in**
15 **the medical home by primary care team members**
16 **trained in the diagnosis and treatment of autism.**
17 **(Directive to Take Action)**
18

19 **RECOMMENDATION B:**

20
21 **Your Reference Committee recommends that**
22 **Resolution 902 be adopted as amended.**
23

24 **HOD ACTION: Resolution 902 be adopted as amended.**

25
26 **ADOPTED LANGUAGE:**

27 **RESOLVED, that our American Medical Association advocate for peer reviewed,**
28 **evidence-based guidance for states on innovative health systems solutions to**
29 **reduce specific barriers to the diagnosis and treatment of autism, including**
30 **complex care coordination in the medical home by primary care team members**
31 **trained in the diagnosis and treatment of autism.**
32

33
34 **RESOLVED, that our American Medical Association advocate for peer reviewed,**
35 **evidence-based guidance for states on innovative health systems solutions to reduce**
36 **specific barriers to the diagnosis of autism and complex care coordination in the medical**
37 **home by primary care team members trained in the diagnosis of autism. (Directive to Take**
38 **Action)**
39

40 The Reference Committee only heard supportive testimony regarding Resolution 902.
41 Speakers emphasized the importance of this policy. Members shared compelling personal
42 stories illustrating the challenges families face when navigating the diagnostic process
43 and coordinating care for children with autism. Members noted that these barriers to care
44 not only strain families financially and emotionally but also delay timely interventions that
45 are critical for positive outcomes. Resolution 902 was described as a meaningful step
46 toward reducing these burdens and ensuring equitable, comprehensive care for
47 individuals with autism and their families. An amendment was proffered to expand the
48 language of the resolution, which your Reference Committee agreed with and provided
49 additional editorial changes to include treatment, as testimony noted the importance of

1 treatment as well as diagnosis. Therefore, your Reference Committee recommends
2 Resolution 902 be adopted as amended.

3
4 (13) RESOLUTION 905 - STANDARDIZING BRAIN DEATH
5 POLICIES

6
7 **RECOMMENDATION A:**

8
9 Your Reference Committee recommends the second
10 Resolve clause of Resolution 905 be amended by
11 addition and deletion to read as follows:

12
13 **RESOLVED, that our AMA work with interested parties**
14 **to develop and disseminate model hospital policy for a**
15 **single, unified method of declaration or determination**
16 **of encourage and support legislative and regulatory**
17 **efforts to have one uniform set of standards for brain**
18 **death/death by neurologic criteria used throughout the**
19 **United States. (New HOD Policy)**

20
21 **RECOMMENDATION B:**

22
23 Your Reference Committee recommends that
24 Resolution 905 be adopted as amended.

25
26 **HOD ACTION: Resolution 905 be adopted as amended.**

27
28 **ADOPTED LANGUAGE:**

29 **RESOLVED, that our American Medical Association collaborate with appropriate**
30 **stakeholders to identify “accepted medical standards” for determination of brain**
31 **death/death by neurologic criteria (BD/DNC) as required by the Uniform**
32 **Determination of Death Act.**

33
34 **RESOLVED, that our AMA work with interested parties to develop and disseminate**
35 **model hospital policy for a single, unified method of declaration or determination**
36 **of brain death/death by neurologic criteria.**

37
38
39 **RESOLVED, that our American Medical Association collaborate with appropriate**
40 **stakeholders to identify “accepted medical standards” for determination of brain**
41 **death/death by neurologic criteria (BD/DNC) as required by the Uniform Determination of**
42 **Death Act (Directive to Take Action); and be it further**

43
44 **RESOLVED, that our AMA encourage and support legislative and regulatory efforts to**
45 **have one uniform set of standards for brain death/death by neurologic criteria used**
46 **throughout the United States. (New HOD Policy)**

47
48 Your Reference Committee heard mixed testimony for Resolution 905 online and in
49 person. There was strong support for the first Resolve, with multiple delegations and

1 individuals in support. Multiple delegations and an individual opposed the first Resolve.
2 The second Resolve was unanimously opposed as written, with parties expressing
3 concerns over inviting legislatures into decisions about the practice of medicine, slow
4 legislative process, and the need to retain flexibility around medical standards. One
5 delegation proposed an amendment that shifted the focus from legislative and regulatory
6 efforts to the development and dissemination of model hospital policy for a single, unified
7 method of declaration or determination of brain death/death by neurologic criteria. Multiple
8 delegations and an individual were in support of the amendment to the second Resolve.
9 One delegation also proposed adding a third resolve to expressly oppose legislative and
10 regulatory efforts to set BD/DNC standards – this received mixed testimony. One
11 delegation proposed referral, noting both the importance and complexity of the issue.
12 Finally, multiple individuals opposed the resolution in its entirety, whereas one individual
13 supported the first and second Resolves and proposed a third Resolve. Despite the mixed
14 testimony, there was a slight preference for the first Resolve and amended second
15 Resolve; therefore, your Reference Committee recommends adopting Resolution 905 as
16 amended.

17

18 (14) RESOLUTION 907 - IN-OFFICE DISPENSING OF
19 GENERIC MEDICATIONS

20

21 **RECOMMENDATION A:**

22

23 **Your Reference Committee recommends that the first**
24 **Resolve clause of Resolution 907 be amended by**
25 **addition and deletion to read as follows:**

26

27 **RESOLVED, that our AMA ~~consider developing support~~**
28 **development of educational material for physicians**
29 **interested in dispensing generic medications to reduce**
30 **patient costs, improve access, and decrease**
31 **unnecessary prior authorization requirements**
32 **(Directive to Take Action); and be it further**

33

34 **RECOMMENDATION B:**

35

36 **Your Reference Committee recommends that**
37 **Resolution 907 be adopted as amended.**

38

39 **HOD ACTION: Resolution 907 be adopted as amended.**

40

41 **ADOPTED LANGUAGE:**

42 **RESOLVED, that our AMA support development of educational material for**
43 **physicians interested in dispensing generic medications to reduce patient costs,**
44 **improve access, and decrease unnecessary prior authorization requirements.**

45

46 **RESOLVED, that our AMA encourage medical associations in states with**
47 **restrictive dispensing laws to advocate for legislation allowing physicians to**
48 **dispense generic medications to patients.**

1 RESOLVED, that our American Medical Association consider developing educational
2 material for physicians interested in dispensing generic medications to reduce patient
3 costs, improve access, and decrease unnecessary prior authorization requirements
4 (Directive to Take Action); and be it further

5
6 RESOLVED, that our AMA encourage medical associations in states with restrictive
7 dispensing laws to advocate for legislation allowing physicians to dispense generic
8 medications to patients.

9
10 Your Reference Committee heard varied testimony on this resolution. Largely there was
11 support for this resolution noting the goal of improving access for patients to affordable
12 medications. Further benefits were noted regarding how this work supports physician
13 practice and patients, particularly in areas of pharmacy deserts. Opposition and calls for
14 referral were rendered detailing the potential complexities and burden for physicians to
15 implement a generic medication dispensing process as well as the many regulatory
16 components from federal and state entities. Those opposed to referral highlighted the
17 individualized, voluntary nature of the resolution, where this resolution is not requiring
18 physicians to dispense if the practice is onerous and is more an olive branch of support
19 with educational materials. An amendment was proffered to strengthen the first Resolve,
20 and a second amendment was proffered to broaden the second Resolve. While your
21 Reference Committee accepted the amendment to the first Resolve, we felt the
22 amendment to the second Resolve broadened the policy beyond the intent and was
23 redundant with current policy H-120.99, "Physician Dispensing." Therefore, your
24 Reference Committee recommends adoption as amended.

25
26 (15) RESOLUTION 909 - CLINICAL SIGNIFICANCE OF
27 SLEEPINESS

28
29 **RECOMMENDATION A:**

30
31 **Your Reference Committee recommends that the first**
32 **Resolve of Resolution 909 be amended by addition and**
33 **deletion to read as follows:**

34
35 **RESOLVED, that our AMA support the evaluation and**
36 **management of sleepiness using validated clinical**
37 **tools as a vital component of routine clinical services**
38 **that are essential for patient safety and patient-centered**
39 **care (New HOD Policy); and be it further**

40
41 **RECOMMENDATION B:**

42
43 **Your Reference Committee recommends that the**
44 **second Resolve of Resolution 909 be amended by**
45 **addition and deletion to read as follows:**

46
47 **RESOLVED, that our AMA support initiatives that**
48 **strengthen the clinical assessment ~~assess the impact~~**
49 **of sleepiness and improve pathways to ~~and its~~**

1 ~~treatment on daytime functioning and quality of life in~~
2 ~~diverse populations.~~ (New HOD Policy)

3
4 **RECOMMENDATION C:**

5
6 Your Reference Committee recommends that
7 Resolution 909 be adopted as amended.

8
9 **HOD ACTION: Resolution 909 be adopted as amended.**

10
11 **ADOPTED LANGUAGE:**

12 **RESOLVED, that our AMA support the evaluation and management of sleepiness**
13 **using validated clinical tools as a vital component of routine clinical services.**

14
15 **RESOLVED, that our AMA support initiatives that strengthen the clinical**
16 **assessment of sleepiness and improve pathways to treatment.**

17
18
19 **RESOLVED, that our AMA support the evaluation and management of sleepiness as vital**
20 **clinical services that are essential for patient safety and patient-centered care (New HOD**
21 **Policy); and be it further**

22
23 **RESOLVED, that our AMA support initiatives that assess the impact of sleepiness and its**
24 **treatment on daytime functioning and quality of life in diverse populations. (New HOD**
25 **Policy)**

26
27 Your Reference Committee heard strong support for Resolution 909. One delegation
28 proposed amendments to both resolves to improve clarity of the author's original intent.
29 Specifically, in the first Resolve, language was added to highlight the importance of using
30 validated clinical tools for evaluation and management of sleepiness. In the second
31 Resolve, language was revised to highlight the need for initiatives that strengthen the
32 clinical assessment and improve treatment pathways. Testimony also noted that it was
33 important to expand beyond daytime sleepiness, and your Reference Committee agrees.
34 These amendments were unanimously supported. Therefore, your Reference Committee
35 recommends adoption of Resolution 909 as amended.

36
37 (16) RESOLUTION 911- SAFEGAUARDING NIH-FUNDED AND
38 OTHER WOMEN'S HEALTH RESEARCH IN PEER-
39 REVIEWED PUBLISHING

40
41 **RECOMMENDATION A:**

42
43 Your Reference Committee recommends that the first
44 Resolve clause of Resolution 911 be amended by
45 deletion to read as follows:

46
47 **RESOLVED, that our American Medical Association**
48 **supports the independence of scientific research**
49 **concerning women and underrepresented populations**

1 and the integrity of peer-reviewed medical journals
2 (New HOD Policy); and be it further
3

4 **RECOMMENDATION B:**

5
6 Your Reference Committee recommends that the
7 second Resolve clause of Resolution 911 be amended
8 by addition and deletion to read as follows:
9

10 **RESOLVED**, that our AMA advocates for continued
11 dissemination of rigorous women's health research in
12 respected, independent journals and oppose measures
13 that could impede access to this research ~~silence or~~
14 ~~sideline these efforts~~ (Directive to Take Action); and be
15 it further
16

17 **RECOMMENDATION C:**

18
19 Your Reference Committee recommends that
20 Resolution 911 be adopted as amended.
21

22 **HOD ACTION:** Resolution 911 be adopted as amended.
23

24 **ADOPTED LANGUAGE:**

25 **RESOLVED**, that our American Medical Association supports the independence of
26 scientific research and the integrity of peer-reviewed medical journals; and be it
27 further
28

29 **RESOLVED**, that our AMA advocates for continued dissemination of rigorous
30 women's health research in respected, independent journals and oppose measures
31 that could impede access to this research; and be it further
32

33 **RESOLVED**, that our AMA publicly supports the freedom of the National Institutes
34 of Health and other federally funded scientists and researchers to publish in
35 independent, peer-reviewed journals of their choosing.
36

37
38 **RESOLVED**, that our American Medical Association supports the independence of
39 scientific research concerning women and underrepresented populations and the integrity
40 of peer-reviewed medical journals (New HOD Policy); and be it further
41

42 **RESOLVED**, that our AMA advocates for continued dissemination of rigorous women's
43 health research in respected, independent journals and oppose measures that could
44 silence or sideline these efforts (Directive to Take Action); and be it further
45

46 **RESOLVED**, that our AMA publicly supports the freedom of the National Institutes of
47 Health and other federally funded scientists and researchers to publish in independent,
48 peer-reviewed journals of their choosing. (Directive to Take Action)

1 Your Reference Committee heard testimony in support of this resolution, noting the critical
2 time for reinforcing the freedom and integrity of researchers to pursue and disseminate
3 evidence. Further, testimony highlighted the importance of research to support evidence-
4 based, high-quality practice. While the testimony was supportive of the intent,
5 amendments were proffered to expand resolve 1 to all scientific research and temper
6 inflammatory language in resolve 2. Your Reference Committee agreed with these
7 amendments and recommends adoption as amended.
8

9 (17) RESOLUTION 912 - INCREASING ACCESS THROUGH
10 FEDERATED HEALTHCARE DATA ARCHITECTURE

11
12 **RECOMMENDATION A:**

13
14 Your Reference Committee recommends that
15 Resolution 912 be amended by addition to read as
16 follows:
17

18 **RESOLVED**, that our American Medical Association
19 study federated and other data architecture to evaluate
20 its utility in expanding access to large de-identified
21 healthcare datasets across institutions with the aims of
22 enhancing interoperability through multi-center
23 collaboration, preserving confidentiality by avoiding
24 centralization of PHI, and accelerating ethical research
25 and precision care. (Directive to Take Action)
26

27 **RECOMMENDATION B:**

28
29 Your Reference Committee recommends that
30 Resolution 912 be adopted as amended.
31

32 **HOD ACTION:** Resolution 912 be adopted as amended.

33
34 **ADOPTED LANGUAGE:**

35
36 **RESOLVED**, that our American Medical Association study federated and other
37 data architecture to evaluate its utility in expanding access to large de-identified
38 healthcare datasets across institutions with the aims of enhancing interoperability
39 through multi-center collaboration, preserving confidentiality by avoiding
40 centralization of PHI, and accelerating ethical research and precision care.
41

42 **RESOLVED**, that our American Medical Association study federated data architecture to
43 evaluate its utility in expanding access to large de-identified healthcare datasets across
44 institutions with the aims of enhancing interoperability through multi-center collaboration,
45 preserving confidentiality by avoiding centralization of PHI, and accelerating ethical
46 research and precision care. (Directive to Take Action)

1 Your Reference Committee heard testimony that was supportive of this resolution.
2 Testimony noted the need for broader multi-center health care research collaborations
3 and federated data systems, while improving patient data safety by avoiding the
4 centralization of protected health information to accelerate ethical research and precision
5 care. It was noted that it is critical to understand why other large-scale data coordination
6 strategies have failed to advance despite decades of interest. An amendment was
7 suggested to broaden this study beyond federated data architecture to also include other
8 data architecture. Your Reference Committee agrees and recommends adoption of this
9 resolution as amended.

10
11 (18) RESOLUTION 933 - ADDRESSING GAPS IN NATIONAL
12 HEALTHCARE SAFETY NETWORK (NHSN) DATA
13 QUALITY

14
15 **RECOMMENDATION A:**

16
17 Your Reference Committee recommends the second
18 Resolve clause of Resolution 933 be amended by
19 addition and deletion to read as follows:

20
21 **RESOLVED**, that our AMA advocate for the CDC to
22 **establish and enforce consistent NHSN data collection**
23 **methods for surgical site infection (SSI) surveillance**
24 **across hospitals and audit hospital NHSN data quality**
25 **for SSI regardless of hospital performance status.**
26 **(Directive to Take Action)**

27
28 **RECOMMENDATION B:**

29
30 Your Reference Committee recommends that
31 Resolution 933 be adopted as amended.

32
33 **HOD ACTION:** Resolution 933 be adopted as amended.

34
35 **ADOPTED LANGUAGE:**

36 **RESOLVED**, that our American Medical Association advocate for the CDC to use
37 its January 2024 definition of Surgical Site Infection (SSI) in the National
38 Healthcare Safety Network (NHSN), and require documented clinical impression of
39 an SSI; and be it further

40
41 **RESOLVED**, that our AMA advocate for the CDC to establish consistent NHSN
42 data collection methods for surgical site infection (SSI) surveillance across
43 hospitals and audit hospital NHSN data quality for SSI regardless of hospital
44 performance status.

45
46
47 **RESOLVED**, that our American Medical Association advocate for the CDC to use its
48 January 2024 definition of Surgical Site Infection (SSI) in the National Healthcare Safety

1 Network (NHSN), and require documented clinical impression of an SSI (Directive to Take
2 Action); and be it further

3
4 RESOLVED, that our AMA advocate for the CDC to establish and enforce consistent
5 NHSN data collection methods across hospitals and audit hospital NHSN data quality
6 regardless of hospital performance status. (Directive to Take Action)

7
8 Your Reference Committee heard limited but mostly supportive testimony on Resolution
9 933. One delegation in support noted the importance of having an acceptable definition of
10 surgical site infection. Another delegation noted that while they support the first resolved
11 clause, the second clause could be misinterpreted as endorsing sweeping new data
12 mandates that lack clear evidence of benefit and could introduce infrastructure burdens
13 without improving patient care. Your Reference Committee agrees with this issue and has
14 proffered an amendment to address this concern by narrowing the scope of the second
15 Resolved clause to surgical site infections. Therefore, your Reference Committee
16 recommends Resolution 933 be adopted as amended.

17
18 (19) RESOLUTION 935 - ENHANCING HEALTHCARE
19 SYSTEM PREPAREDNESS TO ADDRESS VETERAN-
20 SPECIFIC HEALTH DISPARITIES

21
22 **RECOMMENDATION A:**

23
24 Your Reference Committee recommends that the
25 second Resolve in Resolution 935 be amended by
26 addition and deletion to read as follows:

27
28 **RESOLVED, that our AMA actively advocate with**
29 **medical education accrediting bodies to require**
30 **encourage medical schools, residency programs, and**
31 **providers of continuing medical education providers to**
32 **incorporate training on military service-related health**
33 **conditions, occupational exposure assessment, and**
34 **Veteran-specific screening protocols into curricula in**
35 **order and licensure requirements to improve**
36 **preparedness of the healthcare workforce (Directive to**
37 **Take Action); and be it further**

38
39 **RECOMMENDATION B:**

40
41 Your Reference Committee recommends that the
42 remainder of Resolution 935 be adopted as amended.

43
44 **HOD ACTION: Resolution 935 be adopted as amended.**

45
46 **ADOPTED LANGUAGE:**

47 **RESOLVED, that our American Medical Association actively advocate for federal,**
48 **state, and local legislation and regulatory action requiring healthcare systems to**
49 **develop and implement standardized protocols for identifying Veterans in patient**

1 populations, including documenting military service history (deployment locations
2 and occupational exposures), and stratifying quality and safety data by Veteran
3 status, in accordance with Joint Commission accreditation standards.
4

5 **RESOLVED**, that our AMA actively advocate with medical education accrediting
6 bodies to encourage medical schools, residency programs, and providers of
7 continuing medical education to incorporate training on military service-related
8 health conditions, occupational exposure assessment, and Veteran-specific
9 screening protocols into curricula in order to improve preparedness of the
10 healthcare workforce.

11
12 **RESOLVED**, that our AMA advocate for, and facilitate, robust collaboration with
13 Veterans Service Organizations, medical specialty societies, and state public health
14 authorities to develop, disseminate, and promote adoption of evidence-based
15 clinical guidelines for Veteran-specific health conditions.
16

17 **RESOLVED**, that our AMA advocate for inclusion of Veteran health considerations
18 in all relevant health equity initiatives, community health needs assessments, and
19 population health frameworks, at all levels of government, recognizing that
20 systematic identification, documentation, and management of service-connected
21 conditions are critical to addressing health disparities for those who have served.
22

23
24 **RESOLVED**, that our American Medical Association actively advocate for federal, state,
25 and local legislation and regulatory action requiring healthcare systems to develop and
26 implement standardized protocols for identifying Veterans in patient populations, including
27 documenting military service history (deployment locations and occupational exposures),
28 and stratifying quality and safety data by Veteran status, in accordance with Joint
29 Commission accreditation standards (Directive to Take Action); and be it further

30
31 **RESOLVED**, that our AMA actively advocate with medical education accrediting bodies to
32 require medical schools, residency programs, and continuing medical education providers
33 to incorporate training on military service-related health conditions, occupational exposure
34 assessment, and Veteran-specific screening protocols into curricula and licensure
35 requirements to improve preparedness of the healthcare workforce (Directive to Take
36 Action); and be it further

37
38 **RESOLVED**, that our AMA advocate for, and facilitate, robust collaboration with Veterans
39 Service Organizations, medical specialty societies, and state public health authorities to
40 develop, disseminate, and promote adoption of evidence-based clinical guidelines for
41 Veteran-specific health conditions (Directive to Take Action); and be it further

42
43 **RESOLVED**, that our AMA advocate for inclusion of Veteran health considerations in all
44 relevant health equity initiatives, community health needs assessments, and population
45 health frameworks, at all levels of government, recognizing that systematic identification,
46 documentation, and management of service-connected conditions are critical to
47 addressing health disparities for those who have served. (Directive to Take Action)

1 Your Reference Committee heard near-unanimous support for this resolution. Many
2 delegations and individuals testified to the importance of veterans' health as an issue that
3 should be addressed similarly to social determinants of health (SDOH). One delegation
4 noted that many veterans seek care outside the Veterans Health Administration (VA),
5 either due to access issues or a preference for community-based care. They emphasized
6 that physicians practicing outside the VA need additional education and awareness to
7 screen for veterans' status, which is associated with multiple health conditions. Your
8 Council on Medical Education testified in opposition to the second Resolve, which
9 originally called for the AMA to advocate for mandatory medical school and licensure
10 requirements. This recommendation conflicts with existing policy H-300.953, which states
11 that the AMA and other medical organizations do not have the authority or responsibility
12 to set standards and curricula for continuing medical education (CME), and that state
13 medical societies should amend their own CME mandates. Further, testimony supported
14 the view that mandates could have unintended consequences, and that the AMA should
15 prioritize further education and advocacy rather than requiring new competencies. In
16 response, your Reference Committee proposed an amendment to remove the mandate in
17 the second Resolve. Therefore, your Reference Committee recommends that Resolution
18 935 be adopted as amended.

DRAFT

RECOMMENDED FOR ADOPTION IN LIEU OF

1
2
3 (20) RESOLUTION 931 - PRESERVING EVIDENCE-BASED,
4 EQUITABLE GROOMING STANDARDS IN MILITARY
5 SERVICE
6

RECOMMENDATION:

7
8
9 Your Reference Committee recommends Alternate
10 Resolution 931 be adopted in lieu of Resolution 931.
11

12 **PRESERVING EVIDENCE-BASED, EQUITABLE**
13 **GROOMING STANDARDS IN THE UNIFORMED**
14 **SERVICES.**
15

16 **RESOLVED, that our American Medical Association**
17 **advocate against Uniformed Services policy changes**
18 **that restrict or eliminate evidence-based, medically**
19 **necessary shaving waivers for service members, and**
20 **oppose administrative or physical evaluation board**
21 **separation on this basis when service members**
22 **otherwise meet qualifications for continued service**
23 **(Directive to Take Action); and be it further**
24

25 **RESOLVED, that our AMA urge the Uniformed Services**
26 **to implement any changes to shaving waiver policy**
27 **through an evidence-based and transparent process**
28 **that incorporates input from Uniformed Services**
29 **dermatologists, occupational health experts, affected**
30 **service members, and other interested parties with**
31 **relevant expertise (Directive to Take Action); and be it**
32 **further**
33

34 **RESOLVED, that our AMA advocate for consistent and**
35 **equitable shaving waiver policies across all Uniformed**
36 **Services branches, including standardized criteria,**
37 **clear re-evaluation intervals and portability of waivers**
38 **across duty stations (Directive to Take Action); and be**
39 **it further**
40

41 **RESOLVED, that our AMA urge the Uniformed Services**
42 **to authorize permanent shaving waivers for service**
43 **members with severe or refractory pseudofolliculitis**
44 **barbae, especially those who have already received**
45 **Uniformed Services dermatologist recommendations**
46 **for permanent waivers and are unresponsive to**
47 **optimized medical therapy, and to extend this option**
48 **consistently across all service branches (Directive to**
49 **Take Action); and be it further**

1 **RESOLVED**, that our AMA support ongoing research on
2 pseudofolliculitis barbae and related dermatologic
3 conditions, including medical management, equity
4 impacts of grooming practices, and evidence-based
5 approaches to accommodations within the Uniformed
6 Services. (New HOD Policy)
7

8 **HOD ACTION: Alternate Resolution 931 be adopted in lieu of Resolution 931.**
9

10 **ADOPTED LANGUAGE:**

11 **PRESERVING EVIDENCE-BASED, EQUITABLE GROOMING STANDARDS IN THE**
12 **UNIFORMED SERVICES.**

13
14 **RESOLVED**, that our American Medical Association advocate against Uniformed
15 Services policy changes that restrict or eliminate evidence-based, medically
16 necessary shaving waivers for service members, and oppose administrative or
17 physical evaluation board separation on this basis when service members
18 otherwise meet qualifications for continued service;
19

20 **RESOLVED**, that our AMA urge the Uniformed Services to implement any changes
21 to shaving waiver policy through an evidence-based and transparent process that
22 incorporates input from Uniformed Services dermatologists, occupational health
23 experts, affected service members, and other interested parties with relevant
24 expertise;
25

26 **RESOLVED**, that our AMA advocate for consistent and equitable shaving waiver
27 policies across all Uniformed Services branches, including standardized criteria,
28 clear re-evaluation intervals and portability of waivers across duty stations;
29

30 **RESOLVED**, that our AMA urge the Uniformed Services to authorize permanent
31 shaving waivers for service members with severe or refractory pseudofolliculitis
32 barbae, especially those who have already received Uniformed Services
33 dermatologist recommendations for permanent waivers and are unresponsive to
34 optimized medical therapy, and to extend this option consistently across all
35 service branches;
36

37 **RESOLVED**, that our AMA support ongoing research on pseudofolliculitis barbae
38 and related dermatologic conditions, including medical management, equity
39 impacts of grooming practices, and evidence-based approaches to
40 accommodations within the Uniformed Services.
41

42
43 **RESOLVED**, that our American Medical Association advocate against Department of War
44 policy changes that restrict or eliminate evidence-based, medically necessary shaving
45 waivers for service members, and oppose administrative or physical evaluation board
46 separation on this basis when service members otherwise meet qualifications for
47 continued service (Directive to Take Action); and be it further
48

1 RESOLVED, that our AMA urge the Department of War to implement any changes to
2 shaving waiver policy through an evidence-based and transparent process that
3 incorporates input from military dermatologists, occupational health experts, affected
4 service members, and other interested parties with relevant expertise (Directive to Take
5 Action); and be it further

6
7 RESOLVED, that our AMA advocate for consistent and equitable shaving waiver policies
8 across all military service branches, including standardized criteria, clear re-evaluation
9 intervals and portability of waivers across duty stations (Directive to Take Action); and be
10 it further

11
12 RESOLVED, that our AMA urge the Department of War to authorize permanent shaving
13 waivers for service members with severe or refractory pseudofolliculitis barbae, especially
14 those who have already received military dermatologist recommendations for permanent
15 waivers and are unresponsive to optimized medical therapy, and to extend this option
16 consistently across all service branches (Directive to Take Action); and be it further

17
18 RESOLVED, that our AMA support ongoing research on pseudofolliculitis barbae and
19 related dermatologic conditions, including medical management, equity impacts of
20 grooming practices, and evidence-based approaches to accommodations within the
21 Armed Forces. (New HOD Policy)

22
23 Your Reference Committee heard testimony in strong support for Resolution 931 from
24 multiple delegations and sections. One delegation proposed an amendment to expand
25 language in all resolves to include the Public Health Service Commissioned Corps and
26 the National Oceanic and Atmospheric Administration Commissioned Officer Corps. The
27 majority of sections and delegations supported the amendment and in accordance the
28 author proposed a title change to ensure alignment, so your Reference Committee
29 recommends adopting Alternate Resolution 931 in lieu of Resolution 931.

RECOMMENDED FOR REFERRAL

- 1
2
3 (21) RESOLUTION 906 - RETHINKING THE MEDICARE
4 ANNUAL WELLNESS VISIT

RECOMMENDATION:

5
6
7
8 **Your Reference Committee recommends that**
9 **Resolution 906 be referred.**

10
11 **HOD ACTION: Resolution 909 be referred.**

12
13
14 RESOLVED, that our American Medical Association advocate for a thoughtful
15 reevaluation of the Medicare annual wellness visit and consider replacing it with an annual
16 comprehensive examination that would integrate preventive care services, a thorough
17 physical exam, and the management of acute or chronic health conditions. (Directive to
18 Take Action)

19
20 Your Reference Committee heard mixed testimony on this item. One delegation noted that
21 current evidence supports periodic provision of many services, but it doesn't include a
22 comprehensive examination. One delegation in support of adoption noted that the
23 Medicare Wellness Visit (AWV) has proven to be cumbersome, with little benefits from its
24 implementation and that a comprehensive physical would be better utilization of physician
25 time. A delegation and multiple individuals noted that while the AWV might warrant
26 scrutiny, available evidence does not indicate that there is a health benefit to performing
27 routine, complete exams and therefore proposed referral of this item for study. Given the
28 mixed testimony and the complexity of this issue, your Reference Committee recommends
29 that Resolution 906 be referred.

- 30
31 (22) RESOLUTION 917 - URGING COMPREHENSIVE
32 RESEARCH AND SAFETY TESTING OF INDUSTRY-
33 ENGINEERED FOOD ADDITIVES (IEFAS), INCLUDING
34 HIGH FRUCTOSE CORN SYRUP

RECOMMENDATION:

35
36
37
38 **Your Reference Committee recommends that**
39 **Resolution 917 be referred.**

40
41 **HOD ACTION: Resolution 917 be referred.**

42
43
44 RESOLVED, that our American Medical Association supports stronger safety protocols
45 and regulatory oversight of food additives, to protect the health and well-being of the
46 American public (New HOD Policy); and be it further
47

1 RESOLVED, that our AMA advocate federal policies requiring comprehensive scientific
2 research and safety testing of industry-engineered food additives, including HFCS and
3 other similar substances, prior to their approval by federal regulators for use in the food
4 supply. (Directive to Take Action)
5

6 The Reference Committee heard mixed testimony on Resolution 917 calling for
7 comprehensive research and safety testing of industry-engineered food additives (IEFAs),
8 including high fructose corn syrup. Testimony reflected broad concern about the potential
9 health impacts of these additives and emphasized the need for stronger regulatory
10 oversight. However, the issue was acknowledged as complex, involving multiple
11 stakeholders and intersecting with broader food policy considerations. Several speakers
12 noted that while the intent of the resolution is important, more information is needed to
13 fully understand the implications and scope of such research and regulation. It was also
14 highlighted that a CSAPH report on food subsidies will be presented at the upcoming
15 Annual Meeting, which will highlight food additives including high fructose corn syrup
16 related policy discussions. However, there was concern that this would not sufficiently
17 address issues in this resolution. Therefore, your Reference Committee recommends that
18 Resolution 917 be referred.
19

20 (23) RESOLUTION 918 - REMOVE OUTDATED BARRIERS TO
21 GENETIC TESTING
22

23 **RECOMMENDATION:**

24
25 **Your Reference Committee recommends that**
26 **Resolution 918 be referred.**
27

28 **HOD ACTION: Resolution 918 be referred.**
29

30
31 RESOLVED, that our American Medical Association advocate for federal and state
32 legislation to remove requirements for separate written consent for genetic or genomic
33 testing, and to eliminate unnecessary restrictions on sharing test result records with the
34 treating team of providers, while preserving essential patient protections, including
35 safeguards against discrimination by insurance companies (Directive to Take Action); and
36 be it further
37

38 RESOLVED, that our AMA advocate for changes to laws nationwide in the states that
39 continue to impose barriers to genetic or genomic testing in the form of written consent
40 requirements in Massachusetts, Michigan, Nebraska, New York, South Dakota, and that
41 our AMA report on the status of this resolution at the 2026 Annual Meeting. (Directive to
42 Take Action)

1 Your Reference Committee heard generally mixed testimony on this resolution. Some
2 members in support of the resolution noted that genetic testing is often ordered by Family
3 Physicians and can create barriers to practice. Others in opposition noted that the request
4 to remove unnecessary restrictions on sharing test results is redundant due to all testing
5 results being housed in the electronic medical record. Two delegations requested referral
6 for study due to the complexity of genetic testing, informed consent, and variable policy
7 state by state. Your Reference Committee agrees with the complexity noted, and
8 therefore, recommends that Resolution 918 be referred.

9
10 (24) RESOLUTION 921 - PRIORITIZING DESPRESCRIBING
11 IN SENIORS

12
13 **RECOMMENDATION:**

14
15 **Your Reference Committee recommends that**
16 **Resolution 921 be referred.**

17
18 **HOD ACTION: Resolution 921 be referred.**

19
20
21 RESOLVED, that our American Medical Association declare that deprescribing, the
22 proactive and systematic identification and discontinuation of medications with potential
23 risk greater than potential benefits, is a medical priority in the management of senior
24 patients and advocate for the integration of deprescribing as a standard component of
25 high-quality prescribing practices (Directive to Take Action); and be it further

26
27 RESOLVED, that our AMA advocate for the development of educational initiatives and
28 clinical decision support tools to facilitate safe and effective deprescribing in electronic
29 health records (Directive to Take Action); and be it further

30
31 RESOLVED, that our AMA call for research and policy efforts to address barriers for
32 implementation of deprescribing in routine medical care (Directive to Take Action); and be
33 it further

34
35 RESOLVED, that our AMA advocate for all insurers to reimburse deprescribing activities
36 (Directive to Take Action); and be it further

37
38 RESOLVED, that our AMA shall report back on the status of deprescribing to the House
39 of Delegates at A-26 and yearly thereafter, with appropriate metrics to address potential
40 barriers and to guide further advocacy, until it has become implemented as a mainstream
41 component of health care. (Directive to Take Action)

42
43 The Reference Committee heard mixed testimony from Resolution 921 on the topic of
44 deprescribing. Several speakers emphasized that deprescribing should be viewed not
45 merely as an extension of medication reconciliation but as a broader strategy for
46 medication optimization. They highlighted its potential to improve patient safety and
47 reduce costs. However, testimony also reflected significant concern about unintended
48 consequences, particularly around proposals to support reimbursement for deprescribing
49 activities. Some members cautioned that introducing reimbursement mechanisms could

1 inadvertently incentivize inappropriate deprescribing or create administrative burdens
2 without clear evidence of improved outcomes. Others noted the need for safeguards to
3 ensure that deprescribing decisions remain clinically driven and patient centered. Overall,
4 with these concerns in mind, multiple delegations called for referral of this item to further
5 understand the implications. Therefore, your Reference Committee recommends
6 Resolution 921 be referred.

7
8 (25) RESOLUTION 927 - BATTLEFIELD ACUPUNCTURE - AN
9 EDUCATIONAL CALL TO ARMS

10
11 **RECOMMENDATION:**

12
13 **Your Reference Committee recommends that**
14 **Resolution 927 be referred.**

15
16 **HOD ACTION: Resolution 927 be referred.**

17
18
19 RESOLVED, that our American Medical Association encourage greater awareness of
20 and/or instruction in the use of Battlefield Acupuncture as a quick, safe, and effective
21 means to treat acute and chronic pain in patients, given its exceptional safety record, high
22 level of reproducibility, and ability to be administered in an extremely cost-effective
23 manner, without concerns for drug-drug interactions or dependence on narcotic
24 analgesics. (New HOD Policy)

25
26 Your Reference Committee heard mixed testimony on this resolution. Supporters
27 emphasized the effectiveness of battlefield acupuncture (BFA), highlighting both its
28 treatment efficacy and cost benefits. They also cited extensive evidence of BFA's utility
29 within the Veterans Health Administration (VA), referencing over 95 studies that
30 demonstrate treatment effectiveness. In contrast, many of the sections and individual
31 members, including your Council on Science and Public Health, were against adoption.
32 Concerns centered on a lack of evidence for BFA's effectiveness outside the VA and the
33 overall absence of rigorous studies that adequately controlled for bias and placebo effect.
34 Additionally, a delegation noted that AMA policy typically does not endorse specific clinical
35 procedures. Your Reference Committee recognizes the positive intentions of the
36 resolution's authors and appreciates that all physicians seek effective treatments for
37 chronic pain; however, the lack of broader evidence remains a concern. Therefore, your
38 Reference Committee recommends that Resolution 927 be referred.

1 (26) RESOLUTION 930 - ESTABLISHING FIRE RISK
2 STANDARDS FOR CIVILIAN AND NON-INDUSTRIAL
3 CLOTHING

4
5 **RECOMMENDATION:**

6
7 **Your Reference Committee recommends that**
8 **Resolution 930 be referred.**
9

10 **HOD ACTION: Resolution 930 be referred.**

11
12
13 RESOLVED, that our American Medical Association study the flammability of and fire-
14 resistant treatments for consumer clothing materials and their potential public health
15 benefits (Directive to Take Action); and be it further

16
17 RESOLVED, that our AMA study the value of updated flammability risk standards that
18 incorporate modern textile compositions and their associated fire risks (Directive to Take
19 Action); and be it further

20
21 RESOLVED, that our AMA encourage the Consumer Product Safety Commission (CPSC)
22 and relevant regulatory bodies to update and enforce stricter fire safety labeling and
23 testing requirements for civilian clothing and support educating the public on flammability
24 risk on apparel labels. (New HOD Policy)

25 Your Reference Committee heard mixed testimony. One delegation was supportive of
26 resolves one and two but proposed removing the third resolve noting concerns about the
27 safety of classes of chemicals used as fire retardant and the need for more study. In
28 contrast, a different delegation only supported resolve three. One section supported all
29 the original resolves and proposed the addition of a fourth resolve that called for the
30 Consumer Product Safety Commission, the National Institute of Standards and
31 Technology, and the National Institute for Occupational Safety and Health, to evaluate the
32 potential dermatologic impacts of flame-resistant and chemically treated textiles and to
33 consider labeling standards that disclose chemical treatments and known skin sensitizers
34 used in textile manufacturing. Finally, one individual and one delegation called for referral
35 for study. Given the lack of consensus and multiple calls for study, your Reference
36 Committee recommends that Resolution 930 be referred.

RECOMMENDED FOR REFERRAL FOR DECISION

(27) RESOLUTION 919 - STRENGTHENING TRUST THROUGH AMA-BASED LEADERSHIP FOR EVIDENCE-BASED VACCINES (STABLE VACCINES)
RESOLUTION 925 - EVIDENCE-BASED VACCINE AND PREVENTIVE SERVICES RECOMMENDATION

RECOMMENDATION:

Your Reference Committee recommends that Alternate Resolution 919 be referred for decision.

HOD ACTION: Resolution 919 be referred for decision.

RESOLVED, that our American Medical Association will serve as a convener of key stakeholders to advance science-based vaccine recommendations (Directive to Take Action); and be it further

RESOLVED, that our AMA will establish itself as a trusted, centralized source and public-facing megaphone for science-based vaccine guidance (Directive to Take Action); and be it further

RESOLVED, that our AMA will contribute expertise and funding, as appropriate, to advance the mission of coordinating and promoting scientifically grounded and reliable vaccine guidance. (Directive to Take Action)

RESOLVED, that our American Medical Association will replace all references in our policies to the Advisory Committee on Immunization Practices (ACIP) and the U.S. Preventive Services Task Force (USPSTF) with “current evidence-based recommendations developed by authoritative medical entities” (Directive to Take Action); and be it further

RESOLVED, that our AMA will study options for replacing, to the extent possible, the ACIP and USPSTF at the earliest possible time with a national entity which will develop and publish credible evidence-based recommendations for vaccines and preventive services. (Directive to Take Action)

Your Reference Committee heard mixed testimony on alternate Resolution 919. There was broad recognition that it is imperative for physicians and the public to have evidence-based guidance on preventive services, including vaccines, that they can rely on. It is also clear based on testimony that this is of urgent concern given the changes made to the ACIP as well as the possible changes to the USPSTF. While some who testified supported alternate Resolution 919 citing the need for a transparent process that can best serve patients, others noted that efforts are already underway in response to the emergency resolution adopted by the House of Delegates at A-25, and there is no need to unnecessarily impede the AMA’s ability to act. There was also concern regarding the framing of the fourth Resolve clause calling for a study of options to replace the ACIP and

1 USPSTF. It was noted by several who testified that the goal should be restoration of these
2 evidence-based bodies and not replacement. Others who testified noted that we should
3 not be looking back but rather looking for an optimal way forward. A number of delegations
4 actively working in this space called for referral of this resolution for study with a report
5 back at A-26. Given work already underway by the AMA and the need for timely action
6 around options for convening and the development of evidence-based recommendations
7 going forward, your Reference Committee believes that alternate Resolution 919 should
8 be referred for decision.

DRAFT

RECOMMENDED FOR NOT ADOPTION

- 1
2
3 (28) RESOLUTION 904 - SUPPORTING CERTIFICATION OF
4 THE PUBLIC HEALTH WORKFORCE

RECOMMENDATION:

5
6
7
8 **Your Reference Committee recommends that**
9 **Resolution 904 be not adopted.**

10
11 **HOD ACTION: Resolution 904 not adopted.**

12
13
14 RESOLVED, that our American Medical Association support and endorse the Certified in
15 Public Health (CPH) credential as a valuable certification for public health professionals
16 (New HOD Policy); and be it further

17
18 RESOLVED, that our AMA encourage physicians engaged in public health practice to
19 pursue and advocate for the CPH certification. (New HOD Policy)

20
21 Your Reference Committee heard unanimous testimony in opposition to this resolution.
22 Multiple individuals and delegations/sections noted that while they support the education
23 and training of both physicians and non-physicians in public health, adoption of this
24 resolution by the AMA will confuse physicians and sets up an endorsement of training that
25 includes non-physicians which is not within the primary scope of the AMA. Therefore, your
26 Reference Committee recommends that Resolution 904 be not adopted.

- 27
28 (29) RESOLUTION 908 - SUPPORT OF ACCESS TO INSULIN-
29 DETEMIR

RECOMMENDATION:

30
31
32
33 **Your Reference Committee recommends that**
34 **Resolution 908 be not adopted.**

35
36 **HOD ACTION: Resolution 908 not adopted.**

37
38
39 RESOLVED, that our American Medical Association support the designation of insulin-
40 detemir as a drug in shortage to expedite FDA review and approval of biosimilar versions
41 while the reference product remains available globally (New HOD Policy); and be it further

42
43 RESOLVED, that our AMA support allowing some of the funding allocated to the Special
44 Diabetes Program to be used to incentivize domestic manufacturing of insulin, including
45 insulin-detemir (New HOD Policy); and be it further

46
47 RESOLVED, that our AMA encourages the FDA to consider classifying insulin-detemir as
48 an over-the-counter medication to expand access and affordability for individuals with
49 diabetes (New HOD Policy); and be it further

1
2 RESOLVED, that our American Medical Association lobby Congress to pass legislation,
3 or a similarly effective action, to accomplish the goals outlined in this resolution. (Directive
4 to Take Action)
5

6 Your Reference Committee heard testimony that access to insulin and diabetes
7 treatments is critical to their patients. However, there was opposition to each of the
8 resolves for different reasons. First, there was significant opposition to advocating for
9 insulin detemir to be deemed an over-the-counter product due to the potential for adverse
10 events as a high-risk medication. Testimony was additionally heard in opposition to
11 adjustments to the Special Diabetes Program funding which may hinder research and
12 work in Type 1 Diabetes and underserved tribal populations. Finally, there was concern
13 on amendments proffered to advocating for a drug to be deemed a drug shortage outside
14 of the FDA regulated pathway. It was noted that new long-acting biosimilar insulin is soon
15 to be on the market at a lower cost to minimize the challenge of insulin detemir being
16 pulled from the market. Therefore, your Reference Committee recommends that this
17 resolution be not adopted.

DRAFT

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

(30) RESOLUTION 903 - NITROUS OXIDE INHALANT ABUSE

RECOMMENDATION:

Your Reference Committee recommends that policy D-95.951 be reaffirmed in lieu of Resolution 903.

HOD ACTION: Resolution 903 adopted as amended with a title change.

ADOPTED LANGUAGE:**NITROUS OXIDE INHALANT MISUSE**

RESOLVED, that our American Medical Association encourage and support the regulation of the branding of nitrous oxide canisters by U.S. Food and Drug Administration.

RESOLVED, that our American Medical Association encourage and support the regulation of the branding of nitrous oxide canisters by U.S. Food and Drug Administration. (New HOD Policy)

Your Reference Committee heard limited and mixed testimony on this resolution. One delegation agreed with reaffirmation due to the similarity of existing policy D-95.951. Another delegation supported the original resolution and disagreed with reaffirmation due to the coercive branding employed by nitrous oxide manufacturers that policy D-95.951 does not cover. The authors proffered an amendment to replace the term “branding” with “labeling”. However, despite this effort, there continues to be limited clarity around what the regulation would actually entail on the label related to nitrous oxide inhalant misuse and a lack of clarity of what the Resolve would actually accomplish. Therefore, your Reference Committee recommends that policy D-95.951 be reaffirmed in lieu of Resolution 903.

- 1 This concludes the report of Reference Committee K. I would like to thank Jade Anderson,
- 2 MD, Shanna Combs, MD, Oluwasegun Paul Emenogu, MD, Beulette Hooks, MD, Charles
- 3 Lopresto, DO, Arlene Seid, MD, MPH, and all those who testified before the Committee,
- 4 as well as our AMA staff Jennie Jarrett, Katlyn Dillane, Jane Sachs, and Mary Soliman.

Jade A. Anderson, MD
Radiological Society of North America

Beulette Hooks, MD
American Academy of Family
Physicians

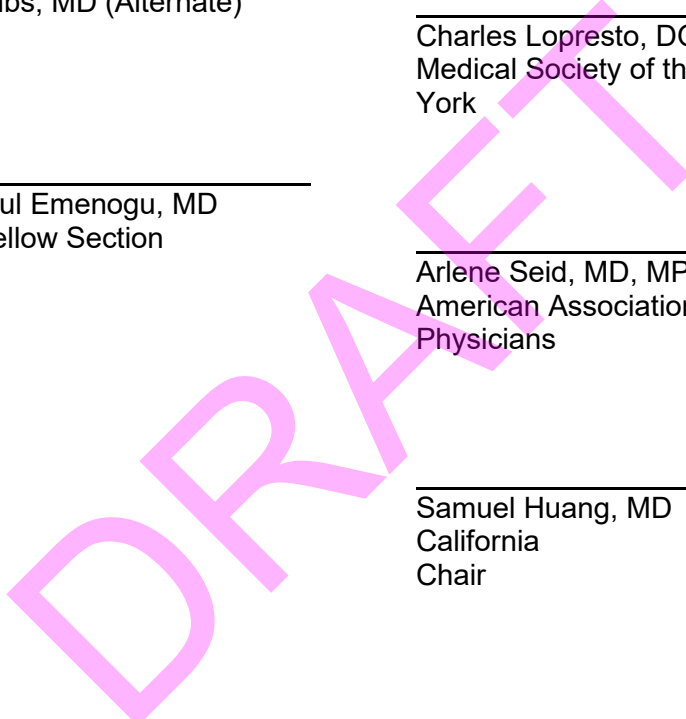
Shanna M. Combs, MD (Alternate)
Texas

Charles Lopresto, DO
Medical Society of the State of New
York

Oluwasegun Paul Emenogu, MD
Resident and Fellow Section

Arlene Seid, MD, MPH
American Association of Public Health
Physicians

Samuel Huang, MD
California
Chair



Amendments

If you wish to propose an amendment to an item of business, scan the QR code below:



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DRAFT