AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

REFERRAL CHANGES AND OTHER REVISIONS
2026 INTERIM MEETING

REVISED REPORTS

- CME 03 - Professional Regulation of Physicians (*page 2, lines 10-15*)

WITHDRAWN RESOLUTIONS

- Res. 913 - Advancing Evidence-Based Physician Education, Research, and AMA Policy Regarding Medical Cannabis and Cannabinoid Therapeutics (Maryland)

RESOLUTIONS WITH ADDITIONAL SPONSORS
(Additional sponsors underlined)

- Res. 215 - Establishing Product Liability for Clinical Augmented Intelligence Failures (Washington, Mississippi)
- Res. 217 - Strengthening the Patients First Act and Medicare Physician Payment Reform (American Society of Plastic Surgeons; Michigan State Medical Society, American Society for Maxillofacial Surgeons, American Society of Aesthetic Plastic Surgery)
- Res. 226 - Physician-Led Governance of the Use of Augmented Intelligence in Hospital Credentialing, Privileging, and Peer Review
(Organized Medical Staff Section, Oklahoma)
- Res. 233 - Medicaid Protections & Continuous Coverage for Active Cancer Care (Association for Clinical Oncology, American Society of Hematology, American Academy of Hospice and Palliative Medicine, American Society for Radiation Oncology, American Academy of Family Physicians, American College of Rheumatology)
- Res. 601 - Strengthening Board Oversight and Engagement in Major AMA Federal Advocacy (American Society of Plastic Surgeons; American Society for Maxillofacial Surgeons; Michigan State Medical Society; American Association for Hand Surgery; American Society of Aesthetic Plastic Surgeons; Missouri State Medical Association; American Society for Reconstructive Microsurgery, Medical Student Section)
- Res. 804 - Medicare Coverage of Continuous Glucose Monitoring for Non-Insulin-Treated Type 2 Diabetes (Kentucky, American College of Lifestyle Medicine)
- Res. 815 - Improving Technology to Combat Automated and Artificial Intelligence-Directed Downcoding of Evaluation and Management Services by Health Insurance Companies (Florida, Oklahoma, Georgia)
- Res. 816 - Enhancing Advocacy to Combat Automated Insurance Downcoding of EM Services (Florida, Oklahoma, Georgia)
- Res. 919 - Protecting the Use of Evidence-Based Psychotropic Medications for the Treatment of Psychiatric Conditions (American Academy of Child and Adolescent Psychiatry, American Psychiatric Association, American Association for Geriatric Psychiatry, Academy of Consultation-Liaison Psychiatry)

- Res. 924 - Ensuring Evidence-Based Nutrition Guidance in Public Health and Clinical Practice (Resident and Fellow Section, American College of Lifestyle Medicine)
- Res. 925 - Opposition to Mandatory Testosterone Testing for Active Duty Servicemembers (Organized Medical Staff Section, American Association of Clinical Endocrinology, Oklahoma)
- Res. 928 - Electric Bike and Scooter Safety, Regulation, and Enforcement (California, American Association of Neurological Surgeons, Congress of Neurological Surgeons, American Academy of Emergency Medicine, Arizona, Guam, Washington, American College of Surgeons)

ORDER OF BUSINESS
SECOND SESSION

Saturday, November 7, 2026; 12:00 PM

1. **Call to Order by the Speaker – Lisa Bohman Egbert, MD**
2. **Report of the Rules and Credentials Committee – Shelley Glover, MD, Chair**
3. **Presentation Correction and Adoption of Minutes from the June 2026 Annual Meeting**
4. **Referral Changes and Other Revisions**
5. **Acceptance of Business**

--REPORTS--

Report(s) of the Board of Trustees - Toluwalasé Ajayi, MD, Chair

01	Study of Grading Systems in AMA Board Reports	F
02	American Medical Association Optimal Health Outcomes Annual Report	Info. Report
03	Reduce Environmental Impact of Medical Journals	K
04	Informed Consent for Genetic Testing	K
05	Increasing Access through Federated Healthcare Data Architecture	K
06	Restoring Balance Billing and Allowing Copay Forgiveness to Preserve Independent Practice and Improve Access to Care	B
07	Support for Legislative Changes Allowing Partial Medicare Opt-Out for Physicians	B
08	Access to, and Retention of, Electronic Medical Records	B
09	Medicare Should Not Unfairly Penalize Physicians	B
10	AMA Reimbursement of Necessary HOD Business Meeting Expenses for Delegates and Alternates	F
11	Opposing Unilateral Downcoding of Physician Services by Insurance Companies	J
12	Rethink the Medicare Annual Wellness Visit	K
13	Enhancing the Work of the Center for Digital Health and AI	Info. Report
14	Patient Options to Restrict Secondary Use of Their Healthcare Data	E&B
15	Gender-Based Pay Equity in Medicine	E&B
16	Ensuring Medical Liability Insurance Transparency and Continuity	B
17	Addressing and Reducing Patients Boarding in the Emergency/Reducing Emergency Department Boarding through Payment Reform	B
18	Improving Usability of Electronic Health Records (EHRs) for Transgender and Gender Diverse Patients	E&B
19	2026 AMA Advocacy Efforts	Info. Report
20	AMA Efforts on Medicare Payment Reform	Info. Report
21	Extending and Expanding the AMA Task Force to Preserve the Patient Physician Relationship to Ensure Access and Regulatory Clarity in Gender Affirming Care	B
22	Clarifying Conscientious Objection	E&B
23*	Specialty Society Representation in the House of Delegates - Five-Year Review	E&B

Report(s) of the Council on Constitution and Bylaws - Mary Ann Contogiannis, MD, Chair

01	Clarifications Regarding Establishment and Nominations to AMA Committees	E&B
02	Amendments to Bylaws Governing the AMA Sections	E&B
03	Autonomy of House of Delegate Member Entities: Bylaw Clarification	E&B

Report(s) of the Council on Ethical and Judicial Affairs - Larry E. Reaves, MD, Chair

01	Preserving Autonomy in the Patient-Physician Relationship	E&B
02	Clarifying Conscientious Objection	E&B
03	Guidelines on Chaperones for Sensitive Exams	E&B
04	Supporting Efforts to Strengthen Medical Staffs Through Collective Actions and/or Unionization	E&B
05	Care of Patients in Legal Custody	E&B
06	Recording Clinical Encounters	E&B
07	Physicians Are Not Providers	E&B

Report(s) of the Council on Long Range Planning and Development – G. Sealy Massingill, MD, Chair

01	Evaluation of the Size and Structure of the AMA House of Delegates	F
02	Underrepresented in Medicine Advocacy Section Five-Year Review	F
03	Integrated Physician Practice Section Five-Year Review	F

Report(s) of the Council on Medical Education - Shannon M. Kilgore, MD, Chair

01	Medical Education Program and Content	C
02	Medical Education Systems	C
03	Professional Regulation of Physicians	C
04	Physician as Medical Professional	C
05	Entry into and transition through the medical education continuum	C
06	Obligations to Students and Trainees	C
07	Mission of Medical Education	C
08	Hardship for International Medical Graduates in Humanitarian Crisis or Conflict	C

Report(s) of the Council on Medical Service - A. Patrice Burgess, MD, Chair

01	Transparency with the Term “Emergency Department”	J
02	The Impact of the Inflation Reduction Act on Physician Practices	J
03	Non-Medical Switching of Prescription Drugs	J
04	Determining Fair Market Value when Contracting with Physician Practices	J
05	Improving Marketplace Affordability through Premium Tax Credits	J
06	Study of Physicians Utilizing Ambulatory Surgical Centers and Office-Based Laboratories or Performing Office-Based Surgeries	J

Report(s) of the Council on Science and Public Health - Tamaan Osbourne-Roberts, MD, MBA, Chair

01	Drug Shortages: 2026 Update	K
02	Urging Comprehensive Research and Safety Testing of Industry-Engineered Food Additives (IEFAs), Including High Fructose Corn Syrup	K
03	Establishing Fire Risk Standards for Civilian and Non-Industrial Clothing	K
04	Deprescribing in Clinical Practice	K
05	Battlefield Acupuncture	K

Report(s) of the HOD Committee on Compensation of the Officers - Hilary Fairbrother, MD, MPH, FACEP, Chair

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

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

01	Election Rule Updates	F
02	Recommended Policy Reconciliations	Info. Report

--EXTRACTION OF INFORMATIONAL REPORTS--

Report(s) of the Board of Trustees

02	American Medical Association Optimal Health Outcomes Annual Report
13	Enhancing the Work of the Center for Digital Health and AI
19	2026 AMA Advocacy Efforts
20	AMA Efforts on Medicare Payment Reform

Report(s) of the Speakers

02	Recommended Policy Reconciliations	Info. Report

--INTRODUCTION OF RESOLUTIONS--

001	Recognition of Intersex Individuals and their Human Rights	EB
002	Surgical Consent	EB
005	Opposing Trading on the Outcomes of Biomedical Research and Clinical Trials	EB
006	Ethics of Medical Usury	EB
007	Opposing the Required Creation of "Detransition Clinics"	EB
008	Recognition of Moral Injury in the Physician Workforce	EB
009	Ensuring the Appropriate Placement of Children After Parental Deportation	EB
010	Preserving Human Dignity and Safety by Limiting Unnecessary Restraints and Monitoring	EB
201	Artificial Intelligence Having Prescriptive Authority	B
202	Rapid Response Framework for Unsupported Medical Claims by Public Officials	B
203	Set-Aside Federal Funding for Tribal Health Programs	B
204	Federal Framework for Social Media Access by Minors Under Age 16	B
205	Ensuring Accuracy and Physician Protections for Patient Attribution in Health Plan Quality Measurement and Value-Based Programs	B
206	Third-Party Litigation Funding in Medical Liability Claims	B
207	Protecting Physician-Led Interventional Pain Medicine, Ending Unsupervised Nonphysician Practice, and Ensuring Patient Transparency and Safety	B
208	Facilitating Short-Term Supervised Clinical Training for International Physicians	B
209	Protecting GME Subject to Funding Uncertainty	B
210	Requiring Physician Oversight for Artificial Intelligence Tools	B
211	Fair and Clinically Appropriate EMTALA Investigations	B

212	Medical Staff Approval of Quality-of-Care Issues Prior to Exclusive Contract	B
213	Clear Identification and Differentiation of Physicians and Nonphysicians in Clinical Rosters, Signage, and Listings	B
214	Prohibiting Health Care Sale-Leaseback Transactions	B
215	Establishing Product Liability for Clinical Augmented Intelligence Failures	B
216	Comprehensive Reform of the No Surprises Act Independent Dispute Resolution Process	B
217	Strengthening the Patients First Act and Medicare Physician Payment Reform	B
218	Firearm Manufacturer Accountability for the Cost of Gun Violence	B
219	Opposing the Use of Artificial Intelligence to Produce Child and Adolescent Sexual Exploitative Material	B
220	Advocating for the Older Americans Act and Community-Based Services for Older Adults	B
221	Preserving Duration of Status for J-1 Physicians in Graduate Medical Education	B
222	Increasing Legislative Advocacy and Dedicated National Educational Programming for International Medical Graduates (IMGs)	B
223	Advancing Physician Payment and Medicare and Medicaid Access for Street Medicine	B
224	Modernize the Medicare Primary Care Exception to Ensure Appropriate Reimbursement for Services Provided by Residents	B
225	Supporting a Common Legal Framework for Medical Capacity Holds	B
226	Physician-Led Governance of the Use of Augmented Intelligence in Hospital Credentialing, Privileging, and Peer Review	B
227	Increasing Access to Long-Acting Injectable Medications for SUD	B
228	Hospital-Based Substance Use Disorder Care	B
229	Protecting Individual Rights in the Era of Developing Neurotechnologies, Including for Mental Augmentation	B
230	Due Process, Transparency, and Accountability for Delegated Third-Party Prior Authorization and Utilization Management Entities	B
231	Medicare and Medicaid Payment Equity for Puerto Rico	B
232	Timely Processing of DEA Practitioner Registrations to Protect Patient Access to Care	B
233	Medicaid Protections & Continuous Coverage for Active Cancer Care	B
234	Research Infrastructure & Overcoming Non-Medical Clinical Trial Barriers	B
235	Assisting Physicians in Navigating Changes to Medicaid Medical Frailty Exemptions	B
236*	Standardization of Quality Performance Reporting in Value-Based Payment Arrangements	B
237*	Action Regarding CMS Authority to Exclude Entities from Medicare, Medicaid, and Federal Health Care Programs	B
238*	Timely Processing of DACA Renewal Applications	B
239*	Protecting the Integrity of Public Participation in Federal Health Policymaking	B
240*	Minimizing Patient Harm from Autonomous Artificial Intelligence	B
302	Augmented Intelligence Use in Assessment Development During Medical Education	C
304	Transparency in AI-Assisted Admissions	C
305	Certification for Hospice Medical Directors	C
306	Fee Parity for International Medical Graduates Taking USMLE Examinations Outside the United States	C

311*	Ensuring Flexible Testing Dates by the USMLE and Appropriate Stakeholder Engagement	C
601	Strengthening Board Oversight and Engagement in Major AMA Federal Advocacy	F
602	Enhancing Equity in House of Delegates Resolution Processes by Removal of the Resolutions Committee and Broadening of the Interim Meeting's Focus	F
603	Ensuring Relevance and Mission Alignment in House of Delegates Business	F
604	Increasing Time Between Handbook Release and Opening of Online Reference Committees	F
801	Improving the External Appeals Process for Denied Claims	J
802	Payer Coverage and Tax-Advantaged Access for Physical Activity Professionals, Services, and Programs	J
803	Coverage of Embryonic Monogenic Disorder Screening as a Medically Necessary Benefit	J
804	Medicare Coverage of Continuous Glucose Monitoring for Non-Insulin-Treated Type 2 Diabetes	J
805	Meaningful Enforcement of Prohibitions on the Corporate Practice of Medicine	J
806	Proration of Liability Insurance Premiums for Senior Physicians Based on Hours Worked	J
807	Continuing Care Retirement Communities (CCRC's)	J
808	Increasing Payment for Patient Portal Messages	J
809	Joint Commission Standards for Medical Staff Self-Governance	J
810	Strengthening Medicare and Accreditation Standards for Organized Medical Staff Independence	J
811	Government Support of Adaptive Sports Programming	J
812	Protect Patient Choice and Physician Privileges in Hospitals Merger and Acquisitions	J
813	Small Medical Practice Website and other Digital Service Compliance with ADA Regulation	J
814	Coverage of SMART Therapy for Asthma	J
815	Improving Technology to Combat Automated and Artificial Intelligence-Directed Downcoding of Evaluation and Management Services by Health Insurance Companies	J
816	Enhancing Advocacy to Combat Automated Insurance Downcoding of EM Services	J
817	Proposed revised H-450.982, Patient Satisfaction, Patient Experience, and Quality of Care	J
818	Proposed Revised D-385.958 - Patient Satisfaction Surveys and Quality Parameters as Criteria for Physician Payment	J
819	Modifiers Indicating Independent Non-Physician Practitioner Use of Physician Consults and Transfers	J
820	Strengthening Emergency Interfacility Transfer Infrastructure	J
901	The Establishment of Mandatory National Reporting of Naegleria Fowleri and Other Amebic Encephalitides	K
902	Illegal Electronic Health Record Sharing and Patient Trust	K
903	Improving Health Outcomes in Native Hawaiian Populations	K
904	Regulation of Organ Transplant Open Offers	K
905	Integrating Drowning Prevention Counseling and Resource Referral into Pediatric Preventive Care	K
906	Establishing Menstrual Products as a Standard of Inpatient Care	K
907	Affirming Support for the National Institutes of Health Advisory Councils	K

908	Improving Access to Phenotype-Matched Blood for Transfusion-Dependent Patients	K
909	Public Emergency Alert Reporting Requirements on Private Platforms	K
910	Consolidating and Modernizing AMA Policy on Alcohol Excise Taxation	K
912	Reducing Medical Waste Through Electronic Instructions for Use (e-IFU) for Surgical and Medical Device Products	K
913	Advancing Evidence-Based Physician Education, Research, and AMA Policy Regarding Medical Cannabis and Cannabinoid Therapeutics	K
914	National Strategy to Close the Women's Health Gap	K
915	Ensuring Expert and Lived Experience Input in Federal National Health Plans	K
916	Opposition to Recreational Nicotine Products in Federal Correctional Facilities	K
917	Modernizing Sunscreen Regulation to Advance Skin Cancer Prevention and Public Health	K
918	Strengthening the Radiation Protection Standard	K
919	Protecting the Use of Evidence-Based Psychotropic Medications for the Treatment of Psychiatric Conditions	K
920	Improving Protection for Patient Medical Records and Health Care	K
921	Transgender and Gender Diverse Cancer Research	K
922	Eliminating Tax Barriers to Equitable Clinical Trial Participation	K
923	Research the Community Health Impacts of Data Centers	K
924	Ensuring Evidence-Based Nutrition Guidance in Public Health and Clinical Practice	K
925	Opposition to Mandatory Testosterone Testing for Active Duty Servicemembers	K
926	Support for One Health Approaches to Protect Human, Animal, and Environmental Health	K
927	Patient Safety and Clinical Authority in Deceased Organ Donation and Procurement	K
928	Electric Bike and Scooter Safety, Regulation, and Enforcement	K
929	Strengthening Physician Education and Standardized Protocols for Human Rabies Post-Exposure Prophylaxis	K
930	Supporting the Use of Firearm Suppressors to Prevent Hearing Loss	K
931	Allocation, Liability Protections, & Generic Drug Shortages	K
932	Recognizing the Challenge of Tobacco use in the Era of Commercial E-Cigarettes and Nicotine Products	K
933	Preventing Silicosis Associated with Engineered Stone Countertops	K
934*	Protecting Evidence-Based Family Planning Services in Title X-Funded Programs	K
935*	Opposition to EPA Rules Delaying and Rescinding Federal PFAS Drinking Water Standards	K

--RESOLUTIONS NOT FOR CONSIDERATION--

003	Support for Completion of Medical Directives Before Elective Surgeries	EB
004	Use of Live Animals in Medical Training	EB
301	Missing Indigenous People Crisis in Medical Education	C
303	Transparent Visiting Rotation Fee Disclosure	C
307	Promoting Transparency on Fertility Healthcare Policies for Trainees	C
308	Update on Financial Transparency of the Revenue Generated by Trainees at Health Systems	C
309	Stronger Recognition and Promotion of Accommodations for Neurodivergent Learners	C

310	Disparities in Preliminary and Transitional Year GME Funding	C
911	Annual Alcohol Report and Comprehensive Review of AMA Alcohol Policy	K
011*	Standards for Physician Communication of Executive Health Evaluations	EB

**Contained in Meeting Tote*

Report of the AMPAC Board of Directors

Presented by: John W. Poole, MD
AMPAC Chair

On behalf of the AMPAC Board of Directors, I am pleased to present this report to the House of Delegates on AMPAC's activities during the 2025–2026 election cycle and our ongoing work to advance medicine's priorities. As AMPAC marks its 65th anniversary this year, our profession continues to face health care policy challenges that directly affect our practices and our patients. Our mission remains unchanged: to provide physicians with opportunities to support physician-friendly candidates who will help advance an advocacy agenda that protects our profession and our patients. That commitment extends beyond any single election. Through our political education programs, we also help physician advocates build the skills and tools needed to work on campaigns or run for office themselves.

AMPAC Membership Fundraising

Thank you to the members of the House of Delegates for your support of AMPAC during our 65th anniversary year. AMPAC has experienced positive growth during the 2025–2026 election cycle, with receipts exceeding $2.1 million, representing a 30% increase over the previous cycle. Hard-dollar contributions increased by 33%. These strong fundraising results are due in part to new initiatives which have helped expand AMPAC's visibility and engagement throughout the election cycle. We would also like to thank the AMA Board of Trustees, the State Delegation Chairs and all our AMPAC contributors for recognizing the pivotal role AMPAC plays in advancing our advocacy efforts and for their support in making AMPAC a priority.

AMPAC also launched its inaugural AMPAC Leadership Cup this year to recognize state delegations and AMA Councils achieving 100% participation among their members. The program helped bring additional attention to AMPAC participation across the House of Delegates and Councils providing an opportunity to recognize their strong support. Congratulations to the following 2026 inaugural AMPAC Leadership Cup winners: Florida Delegation (Big Five); New Jersey Delegation (Large); Tennessee Delegation (Medium); Delaware Delegation (Small) and the AMA's Council on Legislation.

During this meeting, AMPAC will be introducing the Advocate Program, a new initiative designed to provide physicians with additional opportunities to engage their colleagues and strengthen AMPAC's outreach efforts. The program is planned to launch in early 2027. Don't miss AMPAC's Advocate educational session on Sunday, November 8 at 9:45 am in Northern Hemisphere Salon A1/A2 to learn more. If you or any of your colleagues think you might be interested serving as an AMPAC Advocate at the local level, make sure to attend and learn more. Sunday's activities continue with our annual Capitol Club Luncheon at noon, featuring guest speaker David Wasserman, Senior Editor and Election Analyst for *The Cook Political Report*. Capitol Club Diamond members are also invited to an exclusive VIP meet-and-greet from 11:30 a.m. to noon. The day concludes with the AMPAC Diamond Club Reception from 5:30 to 7:00 p.m.

Overall HOD AMPAC participation is 59%, with state delegations at 74% and specialty delegates at 40%. Your participation plays an important role in AMPAC's success and helps strengthen the AMA's ability to advance the interests of physicians and patients through opportunities in the AMA's federal advocacy efforts. We encourage members to visit the AMPAC booth during the Interim Meeting to learn more about our activities, renew their membership, or contribute for the coming year. As leaders of the House of Medicine, sent to the HOD as representatives from our states or specialty delegations, I would hope we would all set an example by bringing HOD AMPAC member participation closer to 100%.

2026 Election Overview

The 2026 election cycle was one of the most expensive and intensely contested midterm elections in modern history. Mid-decade redistricting efforts across several states complicated the landscape, creating competitive races beyond traditional battleground districts. Changes to campaign finance rules for coordinated campaign and party expenditures, combined with historic levels of outside spending, also helped expand the battleground map into states not traditionally considered competitive such as Iowa, Kansas, and Texas. As in previous midterm elections, voter dissatisfaction with the incumbent president drove the national political environment leading to an historic wave election cycle for Democrats to regain the majority in both the House and Senate.

Despite a highly polarized national political environment, AMPAC remained committed to identifying and supporting federal candidates who best support organized medicine. Working with state medical society partners, AMPAC provided opportunities to build relationships with key decision makers in Congress on both sides of the aisle and help advance medicine's legislative agenda. These efforts strengthened existing relationships and built new bonds with allies of medicine. Staff and physicians informed members of Congress, both on Capitol Hill and in their home districts and states, about issues of importance to organized medicine including Medicare physician payment reform, Medicaid access, scope of practice, and prior authorization reform.

Political Contributions and Independent Expenditures

AMPAC spent more than $2.3 million during the 2026 election cycle. This included more than $1.3 million in contributions to candidate campaigns, leadership, and national party committees, supporting 220 medicine-friendly House and Senate candidates from both political parties. These investments in friends of medicine will continue to ensure that the AMA has a place at the table when important healthcare policy debates take place. While not all were successful, AMPAC supported 26 physician candidates running for Congress in 2026. New physician members elected this year include: Amish Shah, MD (D-AZ-01), Richard Pan, MD (D-CA-06), John Cowan, MD (R-GA-11), Adam Hamawy, MD (D-NJ-12), Abdul El-Sayed, MD (D-MI-SEN), Annie Andrews, MD (D-SC-SEN). Once all race results are finalized, the total number of physicians in the 120th Congress will be between 19 and 22.

AMPAC also dedicated over $1 million towards independent expenditures in support of four physician candidates running for Congress this cycle. Two independent expenditure campaigns were conducted in competitive primary elections in June supporting Richard Pan, MD (D-CA-06) and Tina Shah, MD (D-NJ-07). In the general election, AMPAC conducted independent expenditures for physician candidates running in two of the most competitive open seats in the country this cycle: Amish Shah, MD (D-AZ-01) and Ralph Alvarado, MD (R-KY-06). In all these efforts, AMPAC utilized a multi-media strategy to reach key demographics in each district to persuade likely voters to support these medicine-friendly candidates. Of these four races, two of the AMPAC-supported candidates were successful in their races and will be serving in the next Congress.

AMPAC Election Hub

This cycle, AMPAC launched a new mobile-friendly, interactive Election Hub on AMPAConline.org to help physicians and supporters explore AMPAC's political activity, supported candidates, and voter engagement opportunities. The hub provides searchable race and candidate information, AMPAC's independent expenditures,

and a national overview highlighting the geographic reach and bipartisan nature of AMPAC's support. It also offers voter information resources and resources for physicians and other candidates considering elected office. The site is designed to provide a comprehensive view of how AMPAC's political engagement advances our AMA's advocacy efforts.

2026 Election Results

As of November 5, 31 race outcomes are still unknown as states continue to tabulate votes and report election results. Of those races that have been decided, 82% of AMPAC-supported candidates won election/re-election.

This election cycle produced one of the highest turnover rates in Congress in modern history. Heading into the election, there were 86 member departures resulting in open seat contests. Combined with incumbent election losses, there will be a significant number of new members of Congress. This presents a vital opportunity for AMPAC and physicians to help educate the next Congress on issues important to medicine.

Political Education Programs

The 2026 Campaign School took place September 10-13, at the AMA offices in Washington, DC. Interest in the program remains strong with 22 registrants and 18 participants. This included: twelve member physicians, one non-member physician, one specialty society staff and four member residents and students.

The Campaign School is renowned for its use of a simulated campaign for the U.S. House of Representatives, complete with demographics, voting statistics and detailed candidate biographies. During the three-day program participants were placed into campaign teams and with a hands-on approach, our team of bipartisan political experts walked them through a simulated campaign and applied what they learned in real-time exercises on strategy, vote targeting, social media, paid advertising, and public speaking.

This year's program also included a pre-recorded video from Congresswoman Kelly Morrison, MD of Minnesota, who shared her stories and insights from the campaign trail as a physician candidate for office and encouraged participants to stay engaged in the political process – whether running for office or being a valuable advocate on the issues facing medicine. Once again, the program received high marks from participants, with 100% responding in feedback surveys that they "very much agreed" the AMPAC Campaign School helped them increase their level of experience in building a winning campaign.

Planning is currently underway for the 2027 Candidate Workshop. AMPAC is working to identify dates in the spring, and the program will be held in-person again at the new AMA offices in Washington, DC. As always, the political education programs remain a member benefit with registration fees heavily discounted for AMA members. Program dates will be announced soon on AMPAConline.org.

Conclusion

On behalf of the AMPAC Board of Directors, I thank the members of the House of Delegates for your continued support of AMPAC and our mission. As our 65th anniversary year draws to a close, your commitment strengthens our ability to support physician-friendly candidates, build relationships on both sides of the aisle, and prepare physicians to participate in the political process. Looking ahead to the next Congress and the launch of the Advocate Program in 2027, we encourage you to remain engaged, invite your colleagues to participate, and make use of AMPAC's political education opportunities. Together, through political and grassroots advocacy, we can help shape sound health care policy and keep the interests of physicians and patients front and center on Capitol Hill and in Washington, DC.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

MEMORIAL RESOLUTION (I-26)

Robert S. Block, MD

Introduced by: Vermont Medical Society

Whereas, Robert Stuart Block, MD, born February 23, 1947, of Bennington, VT, passed away peacefully on February 19, 2026, at the age of 78; and

Whereas, Dr. Block was a devoted husband, father, brother, and grandfather whose life was defined by service, compassion, and dedication; and

Whereas, he was a board-certified specialist in orthopedics and enjoyed over 30 years in clinical practice with Orthopedic and Hand Surgery, PC, where he was widely respected for his clinical skill, empathetic nature, and connection with his patients who appreciated his undivided attention and personalized course of treatment; and

Whereas, he served as President of the Vermont Medical Society from 1997 to 1998; continued his service to Vermont physicians as the Vermont delegate to the American Medical Association for many years; was a vocal advocate for healthcare reform, participating in efforts to establish a single-payor system; and Dr. Block strongly believed in patient autonomy and joined the group Compassion and Choices to advance medical aid in dying legislation in Vermont; and

Whereas, Dr. Block was an avid bicyclist and helped found the Bennington Cycle Club and co-organized the Bennington Tour de Cure to benefit the American Diabetes Association; therefore be it

RESOLVED, that our American Medical Association honors the life, legacy, and extraordinary contributions of Robert Stuart Block, MD, including his dedication to patient care, personalized treatment, and patient autonomy in end-of-life care; and be it further

RESOLVED, that our AMA extends its heartfelt condolences to Dr. Block’s family, friends, and professional colleagues, acknowledging his profound impact on physicians and patients alike; and be it further

RESOLVED, that our AMA record this resolution in the minutes and a copy of this resolution be sent to his family as a testament to his enduring legacy.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

MEMORIAL RESOLUTION (I-26)

E. Scott Ferguson, MD, FACR

Introduced by: Arkansas Medical Society, American College of Radiology

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Whereas, E. Scott Ferguson, MD, FACR, a distinguished radiologist, former member of the American Medical Association (AMA) Board of Trustees, state legislator, and dedicated advocate for patients and physicians, passed away on October 11, 2026; and

Whereas, Dr. Ferguson devoted more than four decades to the practice of diagnostic radiology in West Memphis, Arkansas, where he established Outpatient Radiology Clinic and provided compassionate, high-quality care to generations of patients in his community; and

Whereas, Dr. Ferguson was a respected leader within the AMA, serving as a member of the Arkansas Delegation to the AMA House of Delegates beginning in 2009, including service as delegation chair, as chair of the AMA Council on Legislation, and as vice chair of the AMA Radiology Section Council; and

Whereas, Dr. Ferguson was elected to the AMA Board of Trustees in 2018 and reelected in 2022, completing eight years of distinguished service during which he served as Secretary of the Board, chair of its Finance Committee, and liaison to numerous AMA councils, sections, and other organizations, bringing extensive legislative experience and a steadfast commitment to physician advocacy to the AMA's national leadership; and

Whereas, Dr. Ferguson's dedication to organized medicine extended to leadership at the state and local levels, including serving as president of the Arkansas Medical Society from 2004 to 2005, president of the Crittenden County Medical Society, and chair of the Arkansas Medical Society's Legislative and Political Action Committees; and

Whereas, during two terms in the Arkansas House of Representatives, Dr. Ferguson championed landmark legislation to protect patients' rights to choose their physicians, and following his legislative service, Dr. Ferguson continued to advocate for medical liability reform, network adequacy, expanded health insurance coverage, telehealth, and policies protecting physician autonomy and the patient-physician relationship; and

Whereas, as a Fellow of the American College of Radiology, Dr. Ferguson demonstrated a longstanding commitment to the quality and safety of medical imaging, serving on the Arkansas Mammography Quality Assurance Board and as chair of the Food and Drug Administration's National Mammography Quality Assurance Advisory Committee, and receiving the Distinguished Service Award from the Arkansas Radiological Society; and

Whereas, Dr. Ferguson was equally committed to the future of medicine, supporting physician education through service on the University of Arkansas for Medical Sciences College of Medicine Admissions Committee and advocating for expanded residency training opportunities in Arkansas; and

Whereas, Dr. Ferguson's devotion to organized medicine remained unwavering, as reflected in his plans to seek the AMA presidency in the June 2027 election, demonstrating his continuing commitment to serving physicians and patients nationwide; and

Whereas, Dr. Ferguson will be remembered for his principled leadership, friendship, generosity, and tireless advocacy, and his legacy of service will endure through the physicians and patients whose lives he touched, as well as through his wife, Deborah Ferguson, DDS, their children, Catherine, Scott, and Caroline, and his family, friends, and colleagues; therefore be it

RESOLVED, that our American Medical Association honors the life and legacy of E. Scott Ferguson, MD, FACR, and expresses its profound gratitude for his extraordinary contributions to organized medicine, patient advocacy, physician leadership, and the advancement of public health; and be it further

RESOLVED, that our AMA House of Delegates observe a moment of silence in memory of Dr. Ferguson and extend its deepest sympathies to his family, friends, and colleagues; and be it further

RESOLVED, that this memorial resolution be entered into the permanent proceedings of the AMA House of Delegates and that a copy be presented to the family of Dr. Ferguson.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

MEMORIAL RESOLUTION (I-26)

Debra Judelson, MD

Introduced by: Sean Figy, MD, FACS

Whereas, Debra Judelson, MD, of Westborogh, MA, departed this life on September 28, 2026, leaving behind a legacy of great dedication, service and leadership; and

Whereas, Dr. Judelson earned her medical degree from Harvard University in 1976, completed her residency in Internal Medicine at the Kaiser Permanente in San Francisco in 1979; and fellowship in Cardiology at Kaiser Permanente Los Angeles in 1982; and

Whereas, Dr. Judelson enjoyed a 35-year career as a board-certified Cardiologist for Cardiovascular Medical Group seeing patients at Cedars Sinai where was known for her ability to relate to patients and reach the most marginalized populations. She was known for treating everyone as though they were her only patient; and

Whereas, Dr. Judelson was a recognized physician leader and held prominent positions, and received many awards for her advocacy, outreach and leadersihp; including servicing as President of AMWA, the recipient of the Elizabeth Blackwell Award, an NIH Local Legends Designation; and

Whereas, Dr. Judelson was a fervent advocate for Women's Health, working tirelessly to increase awareness and knowledge surrounding women's health; and

Whereas, Dr. Judelson's legacy will endure through her renowned generous philanthropy to charities for healthcare, education, and women's rights, as well as her esteemed leadership; therefore be it

RESOLVED, that our American Medical Association recognize Dr. Debra Judelson passing with a moment of silence; and be it further

RESOLVED, that our AMA record this resolution in the minutes and a copy of this resolution be sent to the family of Dr. Debra Judelson.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

MEMORIAL RESOLUTION (I-26)

Elizabeth “Liz” Pascher Kanof Levine, MD

Introduced by: North Carolina Medical Society

Whereas, Elizabeth "Liz" Pascher Kanof Levine, MD, of Raleigh, North Carolina (by way of Brooklyn, NY), departed this life on February 9, 2026, leaving behind a legacy of pioneering leadership, selfless advocacy, and profound dedication to organized medicine; and

Whereas, Dr. Kanof earned her undergraduate degree from Mount Holyoke College in 1956, her medical degree from New York University School of Medicine, and broke barriers as a female physician in the early 1960s by completing her dermatology residency at Duke University Medical Center; and

Whereas, Dr. Kanof built one of the largest and most respected dermatology practices in North Carolina, combining clinical excellence with a passionate commitment to mentoring women in the medical profession and providing generations of patients with energetic, gentle care; and

Whereas, Dr. Kanof was a towering leader in organized medicine, serving as President of the Wake County Medical Society in 1983, President of the North Carolina Medical Board (NCMB) in 2001, and as President of the North Carolina Medical Society (NCMS) in 1994, where she became only the second female president in the Society's history, and was an AMA delegate for the NCMS starting in 1989 and served for many years; and

Whereas, Dr. Kanof co-founded a transformative physician leadership program in 2002 that now bears her name—the Kanof Institute for Physician Leadership (KIPL)—which has honed the leadership skills of over a thousand clinicians and medical leaders to advance collaborative, patient-centered care, which eventually inspired and became a model for other states’ medical leadership programs; and

Whereas, Dr. Kanof fiercely championed physician and clinician health, partnering with the NC Physician's Health Program to build a national model for treating chemical dependency, and working tirelessly for years to pass a 2009 milestone recovery program providing essential rehabilitation resources for impaired emergency medical services (EMS) workers; and

Whereas, Dr. Kanof partnered with Dr Robert Bilbro to challenge physician participation in executions in 2007 essentially ending executions in the state of North Carolina; and.

Whereas, Dr. Kanof's family generosity lives on at the North Carolina Museum of Art’s Judaic Art Gallery containing an impressive and important collection of ceremonial art donated by her family; and

Whereas, Dr. Kanof’s immense legacy will endure through her visionary professional leadership, her advocacy for health workforce rehabilitation, and her generous philanthropy to cultural arts, environmental conservation, and the community; therefore be it

RESOLVED, that our American Medical Association recognize Dr. Elizabeth Pascher Kanof Levine's passing with a moment of silence; and be it further

RESOLVED, that our AMA record this resolution in the minutes and a copy of this resolution be sent to the family of Dr. Elizabeth Pascher Kanof Levine.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

MEMORIAL RESOLUTION (I-26)

Grace Elizabeth Nolan

Introduced by: Michigan Delegation

Whereas, Grace Elizabeth Nolan, a second-year medical student, was born July 11, 2001, and passed away on October 18, 2026; and

Whereas, Grace was a native of Clarkston, Michigan, and earned her undergraduate and graduate degrees from Oakland University; and

Whereas, Grace chose to pursue her dream of becoming a physician at Oakland University William Beaumont School of Medicine; and

Whereas, Grace excelled academically and in track and cross-country throughout high school and college and had recently signed with the professional running team Gazelle Elite; and

Whereas, Grace was truly a role model and utilized her knowledge, compassion, and dedication to improving the lives of others; and

Whereas, so many people's lives were impacted for the better through their relationships and interactions with Grace; and

Whereas, Grace was an active member of the Michigan State Medical Society and the American Medical Association; therefore be it

RESOLVED, that our American Medical Association House of Delegates recognize and honor Grace Elizabeth Nolan for her personal integrity, relentless work ethic, and dedication to a life of service to others; and be it further

RESOLVED, that our American Medical Association House of Delegates extend its deepest sympathy to the family members of Grace Elizabeth Nolan; and be it further

RESOLVED, that our AMA record this resolution in the minutes and a copy of this resolution be sent to the family of Grace Elizabeth Nolan.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

MEMORIAL RESOLUTION (I-26)

Stephen L Schwartz, MD

Introduced by: Pennsylvania Delegation, American Psychiatric Association

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Whereas, Stephen L. Schwartz, MD, a distinguished physician leader, long-time American Medical Association (AMA) delegate from Pennsylvania, former Member of Pennsylvania Board of Medicine, and a psychiatric faculty member of both Hahnemann University and Thomas Jefferson University, passed away on October 15, 2026; and

Whereas, Dr. Schwartz was noted for sustained and principled commitment to organized medicine, a stalwart in the Pennsylvania Medical Society House of Delegates and on the council and past president of the Pennsylvania district branch of the American Psychiatric Association; and

Whereas, Dr. Schwatz was a skilled administrator, leading institutions through the tumultuous changes brought about by the rise of managed care, inspiring and enabling his fellow physicians to continue to provide exemplary care; and

Whereas, Dr. Schwartz mentored countless medical students, residents, and junior faculty throughout his career, modeling thoughtful, compassionate and effective care; and

Whereas, Dr. Schwartz served his country retiring from service as a Lieutenant Commander of the Navy; and

Whereas, Dr. Schwartz is remembered now by his colleagues for his dry sense of humor, his ability to seamlessly come up with a humorous anecdote for any occasion, and a keen ability to discern the crux of a problem and rephrase issues to reveal their most critical aspects; and

Whereas, Dr. Schwartz is survived by his wife of almost 65 years, Miriam (nee Abeloff) their three sons Stuart (Abby), Daniel (Robin) and Joel Schwartz and 6 grandchildren; therefore be it

RESOLVED, that our American Medical Association recognize Dr. Stephen L. Schwartz's passing with a moment of silence; and be it further

RESOLVED, that our AMA record this resolution in the minutes and a copy of this resolution be sent to the family of Dr. Stephen L. Schwartz.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Supplementary Report of Committee on Rules and Credentials

Presented by: Shelley Glover, MD, Chair

Saturday, November 7, 2026

Madam Speaker, Members of the House of Delegates:

The Committee on Rules and Credentials met Friday, November 6, to discuss Late Resolutions. The sponsors of the late resolutions met with the committee and were given the opportunity to present for the committee's consideration the reason the resolution could not be submitted in a timely fashion and the urgency of consideration by the House of Delegates at this meeting.

Recommended for acceptance:

- Late 1001 – Signed Consent for Antidepressant Use in the Veterans Administration
- Late 1002 – Insurance Company Misuse of Current Procedural Terminology (CPT) Codes
- Late 1003 – Protect Communities from Health and Environmental Impacts of Data Centers
- Late 1004 – Urging Federal Action to Rescind Administrative Directives Permitting Unapproved Synthetic Peptides and Enforce Patient Safety
- Late 1005 – Action Regarding CMS Authority to Exclude Entities from Medicare, Medicaid, and Federal Health Care Programs
- Late 1006 – Expanding the AMA A-28 Elections Endorsement Window
- Late 1007 – Opposing Reimbursement Cuts to Modifier 25

Madam Speaker, this concludes the Supplementary Report of the Committee on Rules and Credentials. I would like to thank Barbara Arnold, MD; Emma Dishner, MD; Stuart Glassman, MD, MBA; Jason Jameson, MD; Tristan Mackey, MD; Helene Nepomuceno, MD; and on behalf of the committee those who appeared before the committee.

Barbara Arnold, MD
California

Emma Dishner, MD*
Texas

Stuart Glassman, MD, MBA
American Academy of Physical Medicine and Rehabilitation

Shelley Glover, MD, Chair
Florida

Jason Jameson, MD
American Urological Association

Tristan Mackey, MD*
Resident and Fellow Sectional Delegate

Helene Nepomuceno, MD
Resident and Fellow Sectional Delegate

*Alternate Delegate

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: Late 1001
(I-26)

Introduced by: American Psychiatric Association

Subject: Signed Consent for Antidepressant Use in the Veterans Administration

Referred to: Reference Committee K

Whereas, on September 28 the Veterans Administration announced new requirements for the prescription of certain medications, which included a signed, written consent for the use of antidepressants for anyone under the age of 30, effective January 1, 2027; and

Whereas, the requirement for a signed consent will likely serve as an impediment to prescribing of antidepressants, at the very least causing veterans to wonder why such a consent is necessary; and

Whereas, there is enormous evidence for the efficacy of antidepressant medication, both for the treatment of depression as well as anxiety; and

Whereas, the current black box warning required by the FDA only applies to those up to the age of 24; it is unclear how the age of 30 was determined; and

Whereas, there are numerous other medications with similar warnings concerning suicidal thoughts, such as anticonvulsants, as well as many other black box warnings on other classes of medication; and

Whereas, singling antidepressants out for extra procedural requirements risks reinforcing stigma around mental health treatment and may discourage veterans from initiating or continuing essential care; and

Whereas, the secretary of Health and Human Services testified before Congress that “I know people, including members of my family, who’ve had a much worse time getting off of SSRIs than people having getting off of heroin” and has consistently disparaged their use; and

Whereas, all prescriptions should be discussed with patients at the time of prescribing, including potential benefits, side effects, and risks, though rarely with the requirement of a signed written consent; and

Whereas, this action appears designed to reduce the utilization of antidepressants in the Veterans Administration system, with no clear indication other than a bias against these potentially life-saving medications; therefore be it

RESOLVED, that our American Medical Association express our concern to the Veterans Administration that the action of singling out antidepressant medications for a signed written consent for those under thirty is inappropriate, unjustified, and will discourage the use of these medications in a vulnerable population. (New HOD Policy)

Fiscal Note: Minimal – less than $5,000

Received: 10/21/2026

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RELEVANT AMA POLICY

H-345.984 Awareness, Diagnosis and Treatment of Depression and other Mental Illnesses
Our AMA will work with the National Institute on Mental Health and appropriate medical specialty and mental health advocacy groups to increase public awareness about depression and other mental illnesses, to reduce the stigma associated with depression and other mental illnesses, and to increase patient access to quality care for depression and other mental illnesses. [Res. 502, I-96; Reaffirm & Appended: CSA Rep. 7, I-97; Reaffirmation A-00; Modified: CSAPH Rep. 1, A-10; Modified: Res. 301, A-12; Appended: Res. 303, I-16; Appended: Res. 503, A-17; Reaffirmation: A-19; Reaffirmed: Res. 425, A-22]

H-345.981 Access to Mental Health Services
Our AMA advocates the following steps to remove barriers that keep Americans from seeking and obtaining treatment for mental illness: (1) reducing the stigma of mental illness by dispelling myths and providing accurate knowledge to ensure a more informed public; (2) improving public awareness of effective treatment for mental illness; (3) ensuring the supply of psychiatrists and other well trained mental health professionals, especially in rural areas and those serving children and adolescents; (4) tailoring diagnosis and treatment of mental illness to age, gender, race, culture and other characteristics that shape a person's identity; (5) facilitating entry into treatment by first-line contacts recognizing mental illness, and making proper referrals and/or to addressing problems effectively themselves; and (6) reducing financial barriers to treatment. [CMS Rep. 9, A-01; Reaffirmation A-11; Reaffirmed: CMS Rep. 7, A-11; Reaffirmed: BOT action in response to referred for decision Res. 403, A-12; Reaffirmed in lieu of Res. 804, I-13; Reaffirmed in lieu of Res. 808, I-14; Reaffirmed: Res. 503, A-17; Reaffirmation: I-18; Reaffirmed: CSAPH Rep. 07, A-24]

H-115.971 Safety and Efficacy of Selective Serotonin Reuptake Inhibitors (SSRIs) in Children and Adolescents
Our AMA recognizes that the current product labeling (package insert) of antidepressant drugs, including the Black Box warnings, is a precautionary statement intended to reinforce the need for careful monitoring of patients with depression and other psychiatric disorders during the initiation of treatment. This product labeling should not be interpreted in a way that would decrease access for patients who may benefit from these drugs. [CSA Rep. 10. A-05; Reaffirmed: CSAPH Rep. 1, A-15; Reaffirmed: CSAPH Rep. 01, A-25]

H-25.989 Long-Term Care Prescribing of Atypical Antipsychotic Medications
(1) Our American Medical Association will collaborate with appropriate national medical specialty societies to create educational tools and programs to promote the broad and appropriate implementation of non-pharmacological techniques to manage behavioral and psychological symptoms of dementia in nursing home residents and the cautious use of medications. (2) Our AMA supports efforts to provide additional research on other medications and non-drug alternatives to address behavioral problems and other issues with patients with dementia. (3) Our AMA opposes the proposed requirement that physicians who prescribe medications with "black box warnings on an off-label basis certify in writing that the drug meets the minimum criteria for coverage and reimbursement by virtue of being listed in at least one of the authorized drug compendia used by Medicare." [Res. 819, I-11 Reaffirmed: CMS Rep. 1, A-21]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: Late 1002
(I-26)

Introduced by: Illinois

Subject: Insurance Company Misuse of Current Procedural Terminology (CPT) Codes

Referred to: Reference Committee F

Whereas, our American Medical Association has developed and maintains the Current Procedural and Terminology (CPT) codes to allow for accurate consistent use of medical terminology for administration and billing with associated licensing agreements for its use; and

Whereas, auto-downcoding is an automated process utilized by health insurance companies to change billed CPT® evaluation and management (E/M) codes from high (99215) or moderate (99214) levels to low (99213) levels, then reimbursing only at that lower level; and

Whereas, a large health insurance company and its subsidiaries, may have been systematically downcoding across Illinois, Texas, Montana, Oklahoma, and New Mexico since July 1, 2026, but the extent and targeted focus on specific specialties has been gradually coming to light[1]; and

Whereas, insurers licensing CPT® codes from AMA may have downcoded claims based solely on the diagnosis on the claim even though diagnosis is not a basis for part of the E/M code selection, as defined by AMA[2]; and

Whereas, it is likely that subsidiaries of a company may replicate tactics across multiple markets, suggesting that the issue experienced by these five states may spread more broadly; and

Whereas, our AMA has policy regarding downcoding and the misuse of CPT codes by insurance companies that focuses on legislative advocacy but not directly addressing the terms of use of the licensing agreements; therefore be it

RESOLVED, that our American Medical Association review the terms of its CPT® licensing agreements and assess whether these have been violated by licensees through widespread downcoding (Directive to Take Action); and be it further

RESOLVED, that our AMA consider legal or administrative action against any companies that have violated the terms of use for CPT® codes where appropriate. (New HOD Policy)

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

Received: 10/26/26

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RELEVANT AMA POLICY

Insurance Industry Behaviors D-385.949

Our American Medical Association will step up its ongoing review of the proper use of the AMA CPT Codes in medical billing claims payments and its misuse by the US Health Insurance Industry.

Our AMA will undertake as soon as practical a formal, legal review of ongoing grievous behaviors of the health insurance industry, including a search for potential litigation partners across the medical federation.

Our AMA will communicate with AMA members outcomes in litigating egregious behaviors of the health insurance industry.

Automatic Downcoding of Claims D-320.972

1. Our American Medical Association vigorously opposes health plans using software, algorithms, or methodologies, other than manual review of the patient's medical record, to deny or downcode evaluation and management services, except correct coding protocol denials, based solely on the Current Procedural Terminology/Healthcare Common Procedure Coding System codes, International Classification of Diseases, 10th revision, codes, and/or modifiers submitted on the claim.
2. Our AMA supports that, after review of the patient’s medical record and determination that a lower level of evaluation and management code is warranted, the explanation of benefits, remittance advice documents, or other claim adjudication notices provide notice that clearly indicates a service was downcoded using the proper claim adjustment reason codes and/or remittance advice remark codes.
3. Our AMA will advocate for legislation to provide transparency and prohibit automated denials, other than National Correct Coding Initiative denials, or downcoding of evaluation and management services based solely on the Current Procedural Terminology/Healthcare Common Procedure Coding System codes, International Classification of Diseases, 10th Revision, codes, or modifiers submitted on the claim.
4. Our AMA will further evaluate what legislative and/or legal action is needed to bar insurers from automatic downcoding and to provide transparency on all methodology of processing claims.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: Late 1003
(I-26)

Introduced by: California, Washington, Medical Student Section

Subject: Protect Communities from Health and Environmental Impacts of Data Centers

Referred to: Reference Committee K

Whereas, data centers, also known as server farms, are large-scale industrial facilities that power artificial intelligence (AI), cloud services (email, storage), and other applications, and;

Whereas, the United States is experiencing unprecedented growth in demand for data center development, in large part driven by aggressive investing in AI and the exorbitant amount of AI energy used for nonessential purposes;[1,2,3] and

Whereas, there is growing bipartisan concern about the impacts of data centers on communities and the environment;[4,5] and

Whereas, Executive Order 14179 directs the EPA to scale back environmental regulations to expedite data center permitting and directs the Commerce Department to financially support data center development;[6,7] and

Whereas, data centers require substantial water resources for cooling and often depend on non-renewable energy generation, contributing to water scarcity, thermal pollution, and contamination in surrounding communities;[8] and

Whereas, data centers strain local electrical infrastructure, leading to increased cost of utilities for residents in surrounding communities;[9] and

Whereas, data centers, through heating, ventilation, and air conditioning systems and diesel/gas generators, contribute to local noise pollution, often above the 85 dBA threshold considered harmful to hearing;[10,11,12,13] and

Whereas, data centers using non-renewable energy sources, such as methane gas, diesel, and other fossil fuels, contribute to local air pollution including particulate matter (PM) and nitrogen oxides, which are associated with increased incidence and exacerbation of respiratory diseases such as asthma, chronic obstructive pulmonary disease, and lung cancer;[3,14,15] and

Whereas, more negative health impacts will occur as data centers increase their air and water pollution, driving up healthcare costs and straining our medical system, which will disproportionately impact marginalized and vulnerable populations;[3] and

Whereas, data centers may also contribute to soil and water contamination through fuel storage and generator systems, cooling water discharge, chemical use (e.g., biocides and corrosion inhibitors), and battery storage infrastructure, resulting in potential release of hydrocarbons, heavy metals, PFAS and other toxic substances that may impact groundwater, surface water, and surrounding ecosystems;[16,17,18] and

Whereas, data centers are being constructed disproportionately on the lands of marginalized communities including Indigenous peoples and communities of color, who live near EPA-regulated data centers in greater proportions than the national median and face levels of PM, nitrogen dioxide, and diesel PM above national average;[19,20] and

Whereas, there are land use concerns including the federal government's push to build data centers on public and federal lands and the encroachment on agricultural lands, converting fertile acreage to industrial use and displacing family farms as exemplified in Texas;[21,22,23] and

Whereas, New York state has enacted a one-year moratorium on data centers, to allow time to develop a regulatory framework,[24] and 16 state legislatures are currently considering moratoria on data center permitting and construction to allow additional time to explore their effects on local communities and improve power grid resiliency;[25] and

Whereas, there are no meaningful federal regulations in place nor efforts to determine the health and environmental impacts of data center development and operation on communities; therefore be it

RESOLVED, that our American Medical Association support a national, state and local time-limited pause on the approval of new or expanded data centers of 50 megawatts or more, including campuses and phased projects, until completion of a health impact assessment, implementation of transparent public reporting of resource use and emissions, adoption of enforceable health standards and incorporation of community input, without affecting existing facilities, health care services, or electronic health records (New HOD Policy); and be it further

RESOLVED, that our AMA supports efforts to further study the impacts of data center development and operation on human health, community well-being, natural resource utilization, and critical infrastructure (New HOD Policy); and be it further

RESOLVED, that our AMA supports enforceable standards for new and existing data centers to protect our communities from adverse health and environmental impacts of data center development and operation, including but not limited to:

- energy use,
- water use, scarcity and contamination,
- air quality and generation emissions,
- land use and soil pollution, including setbacks from homes, schools, health care facilities and childcare facilities,
- noise pollution, including low-frequency noise, and
- infrastructure demands, including protecting ratepayers, especially low-income and medical baseline customers, from higher utility costs.

(New HOD Policy); and be it further

RESOLVED, that our AMA supports incorporating health impact and cumulative impact assessment, including effects on children, pregnant and breastfeeding persons, older adults, persons with chronic disease, persons living in rural and tribal communities, outdoor workers and other vulnerable populations into state and local review of proposed data centers, and support independent research on the impacts of data center development and operation on human health, health equity, community well-being, natural resource utilization, and critical infrastructure (New HOD Policy); and be it further

RESOLVED, that our AMA supports health equity in data center development and regulation, prioritizing protections for historically marginalized and disproportionately

impacted communities, including meaningful community engagement in decisions regarding data center siting, permitting, and oversight (New HOD Policy); and be it further

RESOLVED, that our AMA supports meaningful government-to-government consultation and the free, prior, and informed consent of affected Native American Tribes for data centers on Tribal lands, and water sources and recognize Tribal sovereignty over development decisions on Tribal lands. (New HOD Policy)

Fiscal Note: Minimal – less than $5,000

Received: 10/29/26

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RELEVANT AMA POLICY

Noise Pollution H-440.864
Our AMA recognizes noise pollution as a public health hazard, with respect to hearing loss, and supports initiatives to increase awareness of the health risks of loud noise exposure. [Sub. Res. 417, A-08; Reaffirmation A-16]

Pollution Control and Environmental Health H-135.996
Our AMA supports
1. efforts to alert the American people to health hazards of environmental pollution and the need for research and control measures in this area; and 2. its present activities in pollution control and improvement of environmental health. [Sub. Res. 40 A-70; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Modified: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20]

AMA Position on Air Pollution H-135.998
Our AMA urges that:
1. Maximum feasible reduction of all forms of air pollution, including particulates, gases, toxicants, irritants, smog formers, and other biologically and chemically active pollutants, should be sought by all responsible parties.
2. Community control programs should be implemented wherever air pollution produces widespread environmental effects or physiological responses, particularly if these are accompanied by a significant incidence of chronic respiratory diseases in the affected community.
3. Prevention programs should be implemented in areas where the above conditions can be predicted from population and industrial trends.
4. Governmental control programs should be implemented primarily at those local, regional, or state levels which have jurisdiction over the respective sources of air pollution and the population and areas immediately affected, and which possess the resources to bring about equitable and effective control. [BOT Rep. L, A-65; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmation I06; Reaffirmed in lieu of Res. 509, A-09; Reaffirmation A-11; Reaffirmation A-12; Reaffirmation A-14; Reaffirmation A-16; Reaffirmed: BOT Rep. 29, A-19]

Air Pollution and Public Health H-135.941
Our AMA supports increased physician participation in regional and state decision-making regarding air pollution across the United States. [Res. 408, A-08; Reaffirmed in lieu of Res. 509 A-09; Reaffirmed: CSAPH Rep. 01, A-19]

Air Pollution and Public Health D-135.985
Our American Medical Association promotes education among its members and the general public and will support efforts that lead to significant reduction in fuel emissions in all states. Our AMA will declare the need for authorities in all states to expeditiously adopt, and implement effective air pollution control strategies to reduce emissions, and this position will be disseminated to state and specialty societies. [Res. 408, A-08; Reaffirmation A-14; Reaffirmed: CSAPH Rep. 01, A-24]

Declaring Climate Change a Public Health Crisis D-135.966
Our American Medical Association declares climate change a public health crisis that threatens the health and well-being of all individuals. Our AMA will protect patients by advocating for policies that:
● Limit global warming to no more than 1.5 degrees Celsius.
● Reduce US greenhouse gas emissions aimed at a 50 percent reduction in emissions by 2030 and carbon neutrality by 2050.
● Support rapid implementation and incentivization of clean energy solutions and significant investments in climate resilience through a climate justice lens. Our AMA will consider signing on to the Department of Health and Human Services Health Care Pledge and making a commitment to lower its own greenhouse gas emissions. Our AMA encourages the health sector to lead by example in committing to carbon

neutrality by 2050. Our AMA will develop a strategic plan for how we will enact our climate change policies including advocacy priorities and strategies to decarbonize physician practices and the health sector with report back to the House of Delegates at the 2023 Annual Meeting. Our AMA supports the use of international, federal, regional, and state carbon pricing systems as an important tool to reduce global greenhouse gas emissions and achieve net-zero targets. Our AMA recommends that carbon dividends or energy subsidies for low-income households be a key component of any established carbon pricing system, to reduce the potential economic burden on households with lower incomes. [Res. 420, A-22; Appended: CSAPH Rep. 02, I-22; Appended: BOT Rep. 11, I-24]

Environmental Contributors to Disease and Advocating for Environmental Justice D-135.997
Our American Medical Association will advocate for the greater public and private funding for research into the environment causes of disease, and urge the National Academy of Sciences to undertake an authoritative analysis of environmental causes of disease. Our AMA asks the steering committee of the Medicine and Public Health Initiative Coalition to consider environmental contributors to disease and environmental racism as a priority public health issues. Our AMA encourages federal, state, and local agencies to address and remediate environmental injustice, environmental racism, and all other environmental conditions that are adversely impacting health, especially in marginalized communities. Our AMA will lobby Congress to support ongoing initiatives that include reproductive health outcomes and development particularly in minority populations in Environmental Protection Agency Environmental Justice policies. [Res. 402, A-03; Appended: Res. 927, I-11; Reaffirmed in lieu of: Res. 505, A-19; Modified: Res. 415, A23]

AMA to Protect Human Health from the Effects of Climate Change by Ending its Investments in Fossil Fuel Companies D-135.969
Our American Medical Association, AMA Foundation, and any affiliated corporations will work in a timely, incremental, and fiscally responsible manner, to the extent allowed by their legal and fiduciary duties, to end all financial investments or relationships (divestment) with companies that generate the majority of their income from the exploration for, production of, transportation of, or sale of fossil fuels. [BOT Rep. 34, A-18; Reaffirmed: CSAPH Rep. 2, I-22]

Clean Air H-135.979
Our AMA supports cooperative efforts with the Administration, Congress, national, state and local medical societies, and other organizations to achieve a comprehensive national policy and program to address the adverse health effects from environmental pollution factors, including air and water pollution, toxic substances, the "greenhouse effect," stratospheric ozone depletion and other contaminants. [Sub. Res. 43, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmation I-06; Reaffirmation I-07; Reaffirmed in lieu of Res. 507, A-09; Reaffirmed in lieu of Res. 509, A-09; Reaffirmed: CSAPH Rep. 01, A-19]

Clean Air H-135.991
(1) The AMA supports setting the national primary and secondary ambient air quality standards at the level necessary to protect the public health. Establishing such standards at a level "allowing an adequate margin of safety," as provided in current law, should be maintained, but more scientific research should be conducted on the health effects of the standards currently set by the EPA.
(2) The AMA supports continued protection of certain geographic areas (i.e., those with air quality better than the national standards) from significant quality deterioration by requiring strict, but reasonable, emission limitations for new sources.
(4) The AMA believes that more research is needed on the causes and effects of acid rain, and that the procedures to control pollution from another state need to be improved.
(5) The AMA believes that attaining the national ambient air quality standards for nitrogen oxides and carbon monoxide is necessary for the long-term benefit of the public health. Emission **limitations for** motor vehicles should be supported as a long-term goal until appropriate peer-reviewed scientific data demonstrate that the limitations are not required to protect the public health. [BOT Rep. R, A-82; Reaffirmed: CLRPD Rep. A, I-92; Amended: CSA Rep. 8, A-003; ReaffirmationI-06; Reaffirmed in lieu of Res. 509, A-09; Reaffirmation I-09; Reaffirmation A-14; Modified: CSAPH Rep. 01, A-24]

Federal Clean Air Legislation H-135.984
1.Our AMA urges the enactment of comprehensive clear ambient air legislation which will lessen risks to human health.
2. Our AMA will: (a) oppose legislative or regulatory changes that would allow power plants to avoid complying with new source review requirements to install air pollution control equipment when annual pollution emissions increase; and (b) work with other organizations to promote a public relations campaign, strongly expressing our opposition to EPA's Affordable Clean Energy rule and its proposed amendments of the New Source Review requirements under the Clean Air Act. [Res. 142, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmation I07; Reaffirmed in lieu of Res. 507, A-09; Reaffirmed in lieu of Res. 509, A-09; Reaffirmation A-13; Reaffirmation A-14; Appended: Res. 917, I-18]

Furthering Environmental Justice and Equity H-135.905
Our American Medical Association supports prioritizing greenspace access and tree canopy coverage for communities that received a "D" rating from the Home Owners' Loan Corporation, otherwise known as being "redlined," or those that have been impacted by other discriminatory development, loan servicing, and building practices with full participation by the community residents in these decisions. Our AMA supports measures to protect frontline communities from the health harms of proximity to historical and current harmful industrial and mining operations, including fossil fuel extraction, refining and combustion, and large-scale agriculture, such as using the best available technology to reduce local pollution exposure, or health safety buffers from industrial operations. Our AMA supports prioritizing greenspace access and tree canopy coverage for communities that received a "D" rating from the Home Owners' Loan Corporation, otherwise known as being "redlined," or that have been impacted by other discriminatory development and building practice, thereby protecting residents of these communities from displacement. [Res. 416, A-24 → Modified: CSAPH Rep. 07, A-25]

EPA and Green House Gas Regulation H-135.934
1. Our AMA supports the Environmental Protection Agency's authority to promulgate rules to regulate and control green house gas emissions in the United States. 2. Our AMA: (a) strongly supports evidence-based environmental statutes and regulations intended to regulate air and water pollution and to reduce greenhouse gas emissions; and (b) will advocate that environmental health regulations should only be modified or rescinded with scientific justification. [Res. 925, I-10; Reaffirmed in lieu of Res. 526, A-12; Reaffirmed: Res. 421, A-14; Appended: Res. 523, A-17]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: Late 1004
(I-26)

Introduced by: Obesity Medicine Association

Subject: Urging Federal Action to Rescind Administrative Directives Permitting Unapproved Synthetic Peptides and Enforce Patient Safety

Referred to: Reference Committee K

Whereas, our American Medical Association recognizes obesity as a complex chronic disease state requiring evidence-based, scientifically validated medical evaluation and treatment; and

Whereas, existing AMA Policy H-100.939, "FDA Regulation of Unapproved Synthetic Peptides," explicitly recommends that unapproved synthetic peptide products undergo FDA regulatory review, third-party testing, and demonstration of safety and efficacy through well-conducted clinical trials before marketing or clinical use; and

Whereas, on October 28, 2026, the Department of Health and Human Services (HHS) announced an administrative policy shift loosening restrictions on six unproven, unapproved synthetic peptides—including BPC-157, TB-500, Epitalon, KPV, MOTS-c, and Semax—permitting compounding pharmacies to produce and distribute unverified peptide combinations ("stacks") without requiring FDA drug approval or clinical trials [1]; and

Whereas, HHS acknowledged in its announcement that compounded drug products carry inherent risks, lack standard FDA oversight, and have insufficient scientific data demonstrating safety or efficacy; and

Whereas, direct-to-consumer telehealth platforms, wellness clinics, and online dispensaries are rapidly capitalizing on this policy shift to market and dispense unproven peptide formulations for weight management, longevity, and wellness without physical medical examinations, baseline laboratory testing, or ongoing clinical monitoring; and

Whereas, AMA President Willie Underwood III, MD, issued an official statement strongly criticizing this administrative action, warning that "allowing pharmacies to compound unapproved synthetic peptide substances without sufficient evidence of their safety and efficacy puts patients at risk" and that "expanding access without adequate safeguards and oversight could expose patients to serious, preventable harm" [2]; and

Whereas, bypassing federal drug approval standards and encouraging the distribution of experimental, unapproved peptide compounds directly threatens patient safety, exposes the public to batch impurities and unknown adverse reactions, and degrades the evidence-based standard of care for patients with chronic medical conditions; therefore be it

RESOLVED, that our American Medical Association urgently advocate to the Department of Health and Human Services (HHS), the Food and Drug Administration (FDA), and relevant federal regulatory authorities to immediately rescind administrative policies, enforcement discretion directives, or policy shifts that ease restrictions on compounding and distributing

unapproved, non-FDA-reviewed synthetic peptides including those for weight loss, wellness, or anti-aging (Directive to Take Action); and be it further

RESOLVED, that our AMA collaborate with federal agencies, state medical boards, and state boards of pharmacy to enforce strict regulatory oversight and pursue swift enforcement actions against compounding pharmacies, direct-to-consumer telehealth platforms, and online dispensaries distributing unapproved synthetic peptide formulations lacking FDA regulatory review (Directive to Take Action); and be it further

RESOLVED, that our AMA educate physicians, healthcare providers, and the public regarding the severe safety risks, lack of clinical efficacy, and lack of FDA oversight associated with unapproved synthetic peptide compounds and multi-peptide "stacks". (Directive to Take Action)

Fiscal Note: Moderate – between $10,000 - $50,000

Received: 10/30/26

REFERENCES

1. Kovac A. "RFK, Jr., loosens restrictions for six popular peptides, bypassing the FDA." Scientific American. October 28, 2026. https://www.scientificamerican.com/article/rfk-jr-loosens-restrictions-for-six-popular-peptides-bypassing-the-fda/
2. Underwood W III. "American Medical Association Statement on HHS Policy Shift Regarding Unapproved Synthetic Peptides." American Medical Association Press Release. October 28, 2026.

RELEVANT AMA POLICY

Recognition of Obesity as a Disease H-440.842
Our American Medical Association recognizes obesity as a disease state with multiple pathophysiological aspects requiring a range of interventions to advance obesity treatment and prevention.
(BOT Rep. 11, I-06; Reaffirmation A-13; Appended: Sub. Res. 111, A-14; Modified: Sub. Res. 811, I-14; Appended: Res. 201, A-18; BOT Action in response to referred for decision: Res. 415, A-22; Modified: Res. 818, I-22)

FDA Regulation of Unapproved Synthetic Peptides H-100.939
Our American Medical Association recommends that unapproved synthetic peptide products undergo FDA regulatory review, third-party testing, and demonstration of safety and efficacy through well-conducted clinical trials before marketing or clinical use.
(Res. 516, A-26)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: Late 1005
(I-26)

Introduced by: Barbara McAneny, Steve Lee, Kristina Novick, American Association of Public Health Physicians

Subject: Action Regarding CMS Authority to Exclude Entities from Medicare, Medicaid, and Federal Health Care Programs

Referred to: Reference Committee B

Whereas, on October 14, the Department of Health and Human Services (HHS) formally granted the Centers for Medicare and Medicaid Services (CMS) the independent authority to exclude providers, suppliers, and other entities from Medicare, Medicaid, and all other health care programs[1]; and

Whereas, previously, the HHS Office of Inspector General (OIG) was the sole agency authorized to enforce these exclusions, a power it typically exercised only following extensive investigations, with a process for the physician or other entity to offer a defense; and

Whereas, when a physician or other provider of services is excluded from Federal programs, they lose their commercial contracts and therefore for all practice purposes their practice is closed and their career is over; and

Whereas, as the current administration has demonstrated opposition to the delivery of specific parts of health care such as reproductive care and transgender care, there is a reasonable concern that physicians who offer these services could find themselves excluded from Federal programs; and

Whereas, any attempt to punish any physician for delivering evidence-based care is a threat to the autonomy of all physicians, and the restriction on any one specialty can easily become a restriction on any other specialty; and

Whereas, October 14, 2026, was far beyond any resolution deadline for I-26; therefore be it

RESOLVED, that our American Medical Association oppose any unilateral authority granted by the Department of Health and Human Services (HHS) to the Centers for Medicare & Medicaid Services (CMS) to exclude physicians or entities from federal healthcare programs without full administrative due process and rights to appeal (New HOD Policy); and be it further

RESOLVED, that our AMA oppose the use of federal healthcare program exclusion authority targeting physicians or entities for providing lawful, evidence-based care—including reproductive and transgender healthcare—or for non-clinical, political, or ideological reasons (New HOD Policy); and be it further

RESOLVED, that our AMA investigate and pursue appropriate legislative or legal actions to safeguard physician due process following the October 2026 delegation of exclusion authority to CMS (Directive to Take Action); and be it further

RESOLVED, that our AMA report back to the House of Delegates on the October 2026 delegation of exclusion authority to CMS at the 2027 Annual Meeting. (Directive to Take Action)

Fiscal Note: Moderate – between $10,000 - $50,000

Received: 11/2/26

REFERENCES

1. https://www.federalregister.gov/documents/2026/10/14/2026-21001/statement-of-delegation-of-authority

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 1006
(I-26)

Introduced by: New Jersey, Georgia, Florida, Virginia, Kentucky, North Carolina, South Carolina, Alabama, Oklahoma, Tennessee, Puerto Rico, Maryland, Delaware, Mississippi, District of Columbia, Louisiana

Subject: Expanding the AMA A-28 Elections Endorsement Window

Referred to: Reference Committee F

Whereas, one of the principal goals of the Election Task Force(s) was to simplify the election rules to allow a wider diversity of candidates the opportunity to serve the American Medical Association by running for elected office; and

Whereas, the interview for endorsement process has been widely validated by endorsing delegations and candidates alike; and

Whereas, early endorsements give first time Council candidates the confidence to more fully learn about and engage in the AMA elections process; and

Whereas, at AMA I-25, many candidates were interviewed and endorsed by regional and specialty delegations/section councils/caucuses for election endorsements at A-27; and

Whereas, on October 12, 2026, the Speaker informed the HOD that the endorsement window for A-28 would not be open until I-27 (Policy G-610.090), meaning there will be no opportunity for delegations to endorse candidates for A-28 at I-26 or A-27; and

Whereas, there are good questions about whether the AMA HOD should even establish an endorsement window, as any delegation should be free to endorse whom and when they will — even on the day before the election; and

Whereas, the AMA Elections Endorsement Process has become too restrictive and would benefit from further revision; therefore be it

RESOLVED, that our American Medical Association will expand the endorsement window for AMA elections at A-28, which will open at the conclusion of I-26 and close immediately prior to the opening of the campaign window for 2028. (Directive to Take Action)

Fiscal Note: Minimal – less than $5,000

Received: 11/6/26

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: Late 1007
(I-26)

Introduced by: American Academy of Otolaryngology – Head and Neck Surgery

Subject: Opposing Reimbursement Cuts to Modifier 25

Referred to: Reference Committee B

Whereas, the Centers for Medicare & Medicaid Services (CMS) CY 2027 Medicare Physician Fee Schedule (MPFS) final rule cuts payment by 20 percent for the lower-paid service when a significant, separately identifiable office or outpatient evaluation and management (E/M) visit reported with Modifier 25 is furnished on the same day as a procedure with a 0-day global period; and

Whereas, CMS justifies the cut as ending duplicate payment for clinical work already captured in a procedure's valuation, yet Modifier 25 by definition identifies an E/M service that is significant and separately identifiable, above and beyond the usual pre- and post-procedure work; and

Whereas, the AMA/Specialty Society RVS Update Committee (RUC) already accounts for overlap when valuing procedures typically furnished on the same day as an E/M service; and

Whereas, independent, small, and rural practices operate on thin margins and lack the ability to absorb this cut, which threatens to accelerate practice closures, consolidation, and reduced access to care for Medicare patients in the communities that can least afford to lose physicians; and

Whereas, setting a precedent that a separately identifiable service may be discounted simply because it occurs on the same day as another service puts every physician who provides comprehensive, same-day care at risk; and

Whereas, commercial payers have openly supported this policy and will use it as a precedent to move forward with their own payment reductions for Modifier 25; and

Whereas, AMA Policy D-385.956 directs our AMA to advocate to ensure that both the procedure and the E/M service are paid at the non-reduced rate when Modifier 25 is appropriately reported, and the finalization of this cut by CMS, whose payment policies are widely adopted by other payers, demands a specific, immediate, and coordinated response; therefore be it

RESOLVED, that our American Medical Association immediately and aggressively advocate, through all available regulatory, legislative, and legal means, against the Modifier 25 payment reduction finalized in the CY 2027 Medicare Physician Fee Schedule final rule (Directive to Take Action); and be it further

RESOLVED, that our AMA oppose any reduction in payment for a significant, separately identifiable evaluation and management service appropriately reported with Modifier 25 by any and all payers (New HOD Policy); and be it furth

RESOLVED, that our AMA advocate for legislation at the state and federal level that blocks or reverses Modifier 25 payment reductions and prohibits the Centers for Medicare & Medicaid Services from reducing payment for a significant, separately identifiable evaluation and management service appropriately reported with Modifier 25. (Directive to Take Action)

Fiscal Note: Moderate – between $10,000 - $50,000

Received: 11/6/26

REFERENCES

1. Centers for Medicare & Medicaid Services (2026). "Medicare and Medicaid Programs; CY 2027 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies" (CMS-1848-F). Final rule. Federal Register Document 2026-22743. https://www.federalregister.gov/d/2026-22743

RELEVANT AMA POLICY

Opposition to Reduced Payment for the 25 Modifier D-385.956
Our American Medical Association will aggressively and immediately advocate through any legal means possible, including direct payer negotiations, regulations, legislation, or litigation, to ensure when an evaluation and management (E&M) code is appropriately reported with a modifier 25, that both the procedure and E&M codes are paid at the non-reduced, allowable payment rate. [Res. 808, I-17; Reaffirmed: CMS Rep. 07, A-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (I-26)

AGENDA
Reference Committee on Ethics and Bylaws
In-Person Reference Committee Hearing

David Whalen, MD, Chair

RECOMMENDED FOR ADOPTION

1. BOT Report 15 - Gender-Based Pay Equity in Medicine
2. BOT Report 18 - Improving Usability of Electronic Health Records (EHRs) for Transgender and Gender Diverse Patients
3. CEJA Report 01 - Preserving Autonomy in the Patient-Physician Relationship
4. CEJA Report 02 - Clarifying Conscientious Objection
5. CEJA Report 03 - Guidelines on Chaperones for Sensitive Exams
6. CEJA Report 05 - Care of Patients in Legal Custody
7. CEJA Report 07 - Physicians Are Not Providers
8. Resolution 001 - Recognition of Intersex Individuals and their Human Rights
9. Resolution 009 - Ensuring the Appropriate Placement of Children After Parental Deportation

RECOMMENDED FOR ADOPTION AS AMENDED

10. BOT Report 14 - Patient Options to Restrict Secondary Use of Their Healthcare Data
11. BOT Report 22 - Clarifying Conscientious Objection
12. CCB Report 03 - Autonomy of House of Delegate Member Entities: Bylaw Clarification
13. Resolution 005 - Opposing Trading on the Outcomes of Biomedical Research and Clinical Trials
14. Resolution 006 - Ethics of Medical Usury
15. Resolution 008 - Recognition of Moral Injury in the Physician Workforce

RECOMMENDED FOR ADOPTION IN LIEU OF

16. Resolution 007 - Opposing the Required Creation of “Detransition Clinics”

RECOMMENDED FOR REFERRAL

17. CCB Report 01 - Clarifications regarding Establishment and Nominations to AMA Committees
18. CCB Report 02 - Amendments to Bylaws governing the AMA Sections
19. CEJA Report 04 - Supporting Efforts to Strengthen Medical Staffs Through Collective Actions and/or Unionization
20. CEJA Report 06 - Recording Clinical Encounters
21. Resolution 010 - Preserving Human Dignity and Safety by Limiting Unnecessary Restraints and Monitoring

RECOMMENDED FOR NOT ADOPTION

22. Resolution 002 - Surgical Consent

RECOMMENDATION PENDING

23. BOT Report 23 - Specialty Society Representation in the House of Delegates - Five-Year Review
24. *Resolution 003 - Support for Completion of Medical Directives Before Elective Surgeries*
25. *Resolution 004 - Use of Live Animals in Medical Training*
26. *Resolution 011 - Standards for Physician Communication of Executive Health Evaluations*

Please send amendments and any documentation to:
referencecommitteeeb@ama-assn.org

Livestream of Reference Committee Hearing: Zoom Link

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (I-26)

Agenda

Reference Committee B

In-Person Hearing

Anna Brown, MD, Chair

RECOMMENDED FOR ADOPTION

1. Board of Trustees Report 08 — Access to, and Retention of, Electronic Medical Records
2. Board of Trustees Report 21 — Extending and Expanding the AMA Task Force to Preserve the Patient Physician Relationship to Ensure Access and Regulatory Clarity in Gender Affirming Care
3. Resolution 206 — Third-Party Litigation Funding in Medical Liability Claims
4. Resolution 211 — Fair and Clinically Appropriate EMTALA Investigations
5. Resolution 213 — Clear Identification and Differentiation of Physicians and Nonphysicians in Clinical Rosters, Signage, and Listings
6. Resolution 223 — Advancing Physician Payment and Medicare and Medicaid Access for Street Medicine
7. Resolution 224 — Modernize the Medicare Primary Care Exception to Ensure Appropriate Reimbursement for Services Provided by Residents
8. Resolution 225 — Supporting a Common Legal Framework for Medical Capacity Holds
9. Resolution 231 — Medicare and Medicaid Payment Equity for Puerto Rico
10. Resolution 235 — Assisting Physicians in Navigating Changes to Medicaid Medical Frailty Exemptions

RECOMMENDED FOR ADOPTION AS AMENDED

11. Board of Trustees Report 06 — Restoring Balance Billing and Allowing Copay Forgiveness to Preserve Independent Practice and Improve Access to Care
12. Board of Trustees Report 07 — Support for Legislative Changes Allowing Partial Medicare Opt-Out for Physicians
13. Board of Trustees Report 09 — Medicare Should Not Unfairly Penalize Physicians
14. Board of Trustees Report 16 — Ensuring Medical Liability Insurance Transparency and Continuity
15. Board of Trustees Report 17 — Addressing and Reducing Patients Boarding in the Emergency/Reducing Emergency Department Boarding through Payment Reform
16. Resolution 201 — Artificial Intelligence Having Prescriptive Authority
17. Resolution 203 — Set-Aside Federal Funding for Tribal Health Programs

Note: During the reference committee hearing, supplemental material and amendments may be sent to **RefComB@ama-assn.org**.

Supplemental material includes items that have been referenced in testimony such as alternative wording, proposed amendments, and supporting documents. This email address is NOT intended as a means to provide testimony, which should only be presented orally to the Committee.

When you email your amendment, you will receive a response, indicating that staff has received it. If you do not receive a response, we did NOT receive it, and you must resend. Amendments must be formatted correctly with strikethroughs and underlines.

A Zoom webinar link is provided below. Registration is required to view the meeting via Zoom. The link is view-only. Testimony cannot be accepted via Zoom.

https://events.zoom.us/ev/AvhtMhxTmYDoJdm3-1dOmpTo09dmMZsSE8t0k2Rgv5-jBKi9VWhz~AnOnF4ZitTy2BJEu9WlGquZZD-3PRl1tIvWKm8ckZmjxhE-tAjhxFL7NmQ

18. Resolution 204 — Federal Framework for Social Media Access by Minors Under Age 16
19. Resolution 205 — Ensuring Accuracy and Physician Protections for Patient Attribution in Health Plan Quality Measurement and Value-Based Programs
20. Resolution 207 — Protecting Physician-Led Interventional Pain Medicine, Ending Unsupervised Nonphysician Practice, and Ensuring Patient Transparency and Safety
21. Resolution 209 — Protecting GME Subject to Funding Uncertainty
22. Resolution 212 — Medical Staff Approval of Quality-of-Care Issues Prior to Exclusive Contract
23. Resolution 214 — Prohibiting Health Care Sale-Leaseback Transactions
24. Resolution 219 — Opposing the Use of Artificial Intelligence to Produce Child and Adolescent Sexual Exploitative Material
25. Resolution 221 — Preserving Duration of Status for J-1 Physicians in Graduate Medical Education
26. Resolution 226 — Physician-Led Governance of the Use of Augmented Intelligence in Hospital Credentialing, Privileging, and Peer Review
27. Resolution 227 — Increasing Access to Long-Acting Injectable Medications for SUD
28. Resolution 228 — Hospital-Based Substance Use Disorder Care
29. Resolution 229 — Protecting Individual Rights in the Era of Developing Neurotechnologies, Including for Mental Augmentation
30. Resolution 232 — Timely Processing of DEA Practitioner Registrations to Protect Patient Access to Care
31. Resolution 234 — Research Infrastructure & Overcoming Non-Medical Clinical Trial Barriers

RECOMMENDED FOR ADOPTION IN LIEU OF

32. Resolution 220 — Advocating for the Older Americans Act and Community-Based Services for Older Adults

RECOMMENDED FOR REFERRAL

33. Resolution 208 — Facilitating Short-Term Supervised Clinical Training for International Physicians
34. Resolution 215 — Establishing Product Liability for Clinical Augmented Intelligence Failures

RECOMMENDATION FOR REAFFIRMATION IN LIEU OF

35. Resolution 202 — Rapid Response Framework for Unsupported Medical Claims by Public Officials

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36. Resolution 210 — Requiring Physician Oversight for Artificial Intelligence Tools
37. Resolution 216 — Comprehensive Reform of the No Surprises Act Independent Dispute Resolution Process
38. Resolution 217 — Strengthening the Patients First Act and Medicare Physician Payment Reform
39. Resolution 218 — Firearm Manufacturer Accountability for the Cost of Gun Violence
40. Resolution 222 — Increasing Legislative Advocacy and Dedicated National Educational Programming for International Medical Graduates (IMGs)
41. Resolution 230 — Due Process, Transparency, and Accountability for Delegated Third-Party Prior Authorization and Utilization Management Entities
42. Resolution 233 — Medicaid Protections & Continuous Coverage for Active Cancer Care

RECOMMENDATION PENDING

43. Resolution 236 — Standardization of Quality Performance Reporting in Value-Based Payment Arrangements
44. Resolution 237 — Action Regarding CMS Authority to Exclude Entities from Medicare, Medicaid, and Federal Health Care Programs
45. Resolution 238 — Timely Processing of DACA Renewal Applications
46. Resolution 239 — Protecting the Integrity of Public Participation in Federal Health Policymaking
47. Resolution 240 — Minimizing Patient Harm from Autonomous Artificial Intelligence
48. Resolution 241 — Action Regarding CMS Authority to Exclude Entities from Medicare, Medicaid, and Federal Health Care Programs
49. Resolution 242 — Opposing Reimbursement Cuts to Modifier 25

Note: During the reference committee hearing, supplemental material and amendments may be sent to **RefComB@ama-assn.org**.

Supplemental material includes items that have been referenced in testimony such as alternative wording, proposed amendments, and supporting documents. This email address is NOT intended as a means to provide testimony, which should only be presented orally to the Committee.

When you email your amendment, you will receive a response, indicating that staff has received it. If you do not receive a response, we did NOT receive it, and you must resend. Amendments must be formatted correctly with strikethroughs and underlines.

A Zoom webinar link is provided below. Registration is required to view the meeting via Zoom. The link is view-only. Testimony cannot be accepted via Zoom.

https://events.zoom.us/ev/AvhtMhxTmYDoJdm3-1dOmpTo09dmMZsSE8t0k2Rgv5-jBKi9VWhz~AnOnF4ZitTy2BJEu9WlGquZZD-3PRl1tIvWKm8ckZmjxhE-tAjhxFL7NmQ

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (I-26)

AGENDA

Reference Committee C, In-Person Hearing

November 7, 2026 in Northern Hemisphere Salon C

Tate Hinkle, MD, Chair

RECOMMENDED FOR ADOPTION

1. Council on Medical Education Report 2 – Medical Education Systems
2. Council on Medical Education Report 4 – Physician as Medical Professional
3. Council on Medical Education Report 5 – Entry into and transition through the medical education continuum
4. Council on Medical Education Report 8 – Hardship for International Medical Graduates in Humanitarian Crisis or Conflict

RECOMMENDED FOR ADOPTION AS AMENDED

5. Council on Medical Education Report 1 – Medical Education Program and Content
6. Council on Medical Education Report 3 – Professional Regulation of Physicians
7. Council on Medical Education Report 6 – Obligations to Students and Trainees
8. Council on Medical Education Report 7 – Mission of Medical Education
9. Resolution 302 – Augmented Intelligence Use in Assessment Development During Medical Education
10. Resolution 304 – Transparency in AI-Assisted Admissions
11. Resolution 306 – Fee Parity for International Medical Graduates Taking USMLE Examinations Outside the United States

RECOMMENDED FOR REFERRAL

12. Resolution 305 – Certification for Hospice Medical Directors

RECOMMENDATION PENDING

13. *Resolution 301 - Missing Indigenous People Crisis in Medical Education*
14. *Resolution 303 - Transparent Visiting Rotation Fee Disclosure*
15. *Resolution 307 - Promoting Transparency on Fertility Healthcare Policies for Trainees*
16. *Resolution 308 - Update on Financial Transparency of the Revenue Generated by Trainees at Health Systems*
17. *Resolution 309 - Stronger Recognition and Promotion of Accommodations for Neurodivergent Learners*
18. *Resolution 310 - Disparities in Preliminary and Transitional Year GME Funding*
19. *Resolution 311 - Ensuring Flexible Testing Dates by the USMLE and Appropriate Stakeholder Engagement*

Notes:

- Amendments and supplemental material MUST be sent to **referencecommitteec@ama-assn.org**
- For technical assistance, email HODMeetingSupport@ama-assn.org or call 800-337-1599
- Handbook (reports and resolutions)
- Not for Consideration items
- Online Reference Committee (closed)
- Preliminary Report
- Zoom link

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (I-26)

AGENDA
Reference Committee F
In-Person Reference Committee Hearing

Hillary Johnson-Jahangir, MD, PhD, MS, Chair

RECOMMENDED FOR ADOPTION

1. Board of Trustees Report 1 - Study of Grading Systems in AMA Board Reports
2. Council on Long Range Planning and Development Report 2 - Underrepresented in Medicine Advocacy Section Five-Year Review
3. Council on Long Range Planning and Development Report 3 - Integrated Physician Practice Section Five-Year Review
4. Report of the House of Delegates Committee on the Compensation of the Officers
5. Resolution 604 - Increasing Time Between Handbook Release and Opening of Online Reference Committees

RECOMMENDED FOR ADOPTION AS AMENDED

6. Speakers' Report 1 - Election Rule Updates

RECOMMENDED FOR REFERRAL

7. Board of Trustees Report 10 - AMA Reimbursement of Necessary HOD Business Meeting Expenses for Delegates and Alternates
8. Council on Long Range Planning and Development Report 1 - Evaluation of the Size and Structure of the AMA House of Delegates

RECOMMENDED FOR NOT ADOPTION

9. Resolution 601 - Strengthening Board Oversight and Engagement in Major AMA Federal Advocacy
10. Resolution 602 - Enhancing Equity in House of Delegates Resolution Process by Removal of the Resolutions Committee and Broadening of the Interim Meeting's Focus
11. Resolution 603 - Ensuring Relevance and Mission Alignment in House of Delegates Business

RECOMMENDATION PENDING

12. Resolution 605 - Insurance Company Misuse of Current Procedural Terminology (CPT) Codes
13. Resolution 606 - Expanding the AMA A-28 Elections Endorsement Window

**Items in italics will be considered based on HOD action at the Second Opening Session.*

Please email amendment language or additional information to referencecommitteef@ama-assn.org.

Zoom Webinar Link: https://events.zoom.us/ev/AvhtMhxTmYDoJdm3-1dOmpTo09dmMZsSE8t0k2Rgv5-jBKi9VWhz~AnOnF4ZitTy2BJEu9WlGquZZD-3PRl1tIvWKm8ckZmjxhE-tAjhxFL7NmQ

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (I-26)

Agenda

Reference Committee J
In-Person Hearing
David Jakubowicz, MD, Chair

RECOMMENDED FOR ADOPTION

1. Council on Medical Service Report 2 - The Impact of the Inflation Reduction Act on Physician Practices
2. Council on Medical Service Report 3 - Non-Medical Switching of Prescription Drugs
3. Council on Medical Service Report 4 - Determining Fair Market Value when Contracting with Physician Practices
4. Council on Medical Service Report 6 - Study of Physicians Utilizing Ambulatory Surgical Centers and Office-Based Laboratories or Performing Office-Based Surgeries
5. Resolution 801 – Improving the External Appeals Process for Denied Claims
6. Resolution 807 - Continuing Care Retirement Communities (CCRC's)
7. Resolution 808 - Increasing Payment for Patient Portal Messages
8. Resolution 809 - Joint Commission Standards for Medical Staff Self-Governance
9. Resolution 810 - Strengthening Medicare and Accreditation Standards for Organized Medical Staff Independence
10. Resolution 811 - Government Support of Adaptive Sports Programming
11. Resolution 812 - Protect Patient Choice and Physician Privileges in Hospitals Merger and Acquisitions
12. Resolution 813 - Small Medical Practice Website and other Digital Service Compliance with ADA Regulation
13. Resolution 818 - Proposed Revised D-385.958 - Patient Satisfaction Surveys and Quality Parameters as Criteria for Physician Payment

RECOMMENDED FOR ADOPTION AS AMENDED

14. Board of Trustees Report 11 – Opposing Unilateral Downcoding of Physician Services by Insurance Companies
15. Council on Medical Service Report 1 - Transparency with the Term "Emergency Department"
16. Council on Medical Service Report 5 - Improving Marketplace Affordability through Premium Tax Credits
17. Resolution 802 – Payer Coverage and Tax-Advantaged Access for Physical Activity Professionals, Services, and Programs
18. Resolution 803 - Coverage of Embryonic Monogenic Disorder Screening as a Medically Necessary Benefit
19. Resolution 805 - Meaningful Enforcement of Prohibitions on the Corporate Practice of Medicine
20. Resolution 806 - Proration of Liability Insurance Premiums for Senior Physicians Based on Hours Worked
21. Resolution 817 - Proposed revised H-450.982, Patient Satisfaction, Patient Experience, and Quality of Care
22. Resolution 819 - Modifiers Indicating Independent Non-Physician Practitioner Use of Physician Consults and Transfers
23. Resolution 820 - Strengthening Emergency Interfacility Transfer Infrastructure

Amendments and supplemental materials MUST be sent to ReferenceCommitteeJ@ama-assn.org. Please include the Resolution or Report number in the subject line. Do not send testimony to this email address. This address is only operational for the duration of the Reference Committee A hearing.

A Zoom webinar link is provided below. Registration is required to view the zoom. This link is view-only. Testimony cannot be accepted via Zoom.
https://events.zoom.us/ev/AvhtMhxTmYDoJdm3-1dOmpTo09dmMZsSE8t0k2Rgv5-jBKi9VWhz~AnOnF4ZitTy2BJEu9WlGquZZD-3PRl1tlvWKm8ckZmjxhE-tAjhxFL7NmQ

RECOMMENDED FOR ADOPTION IN LIEU OF

24. Resolution 804 - Medicare Coverage of Continuous Glucose Monitoring for Non-Insulin-Treated Type 2 Diabetes
25. Resolution 814 – Coverage of SMART Therapy for Asthma
26. Resolution 815 – Improving Technology to Combat Automated and Artificial Intelligence-Directed Downcoding of Evaluation and Management Services by Health Insurance Companies
    Resolution 816 – Enhancing Advocacy to Combat Automated Insurance Downcoding of EM Services

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (I-26)

AGENDA

Reference Committee K
In-Person Reference Committee Hearing

Mary E. LaPlante, MD, Chair

RECOMMENDED FOR ADOPTION

1. BOT 03 – Reduce Environmental Impact of Medical Journals
2. BOT 04 – Informed Consent for Genetic Testing
3. CSAPH 02 – Urging Comprehensive Research and Safety Testing of Industry-Engineered Food Additives (IEFAs), Including High Fructose Corn Syrup
4. CSAPH 03 – Establishing Fire Risk Standards for Civilian and Non-Industrial Clothing
5. CSAPH 04 –Deprescribing in Clinical Practice
6. CSAPH 05 – Battlefield Acupuncture
7. Resolution 903 – Improving Health Outcomes in Native Hawaiian Populations
8. Resolution 905 – Integrating Drowning Prevention Counseling and Resource Referral into Pediatric Preventive Care
9. Resolution 906 – Establishing Menstrual Products as a Standard of Inpatient Care
10. Resolution 907 – Affirming Support for the National Institutes of Health Advisory Councils
11. Resolution 908 – Improving Access to Phenotype-Matched Blood for Transfusion-Dependent Patients
12. Resolution 912 – Reducing Medical Waste Through Electronic Instructions for Use (e-IFU) for Surgical and Medical Device Products
13. Resolution 919 – Protecting the Use of Evidence-Based Psychotropic Medications for the Treatment of Psychiatric Conditions
14. Resolution 921 – Transgender and Gender Diverse Cancer Research
15. Resolution 922 – Eliminating Tax Barriers to Equitable Clinical Trial Participation
16. Resolution 923 – Research the Community Health Impacts of Data Centers
17. Resolution 924 – Ensuring Evidence-Based Nutrition Guidance in Public Health and Clinical Practice
18. Resolution 925 – Opposition to Mandatory Testosterone Testing for Active Duty Servicemembers
19. Resolution 928 – Electric Bike and Scooter Safety, Regulation, and Enforcement

Zoom link to hearing (view only webinar): https://events.zoom.us/ejl/AvhtMhxTmYDoJdm3-1dOmpTo09dmMZsSE8t0k2Rqv5-jBKi9VWhz~A1cJXoHbJwRwmFPv-qhx1sURHuJXk3tOv-e2bZt-r3oKQTSmJZ-oRp61RBIbJEqS2gd-aRdP2kQU43jS5dit-Bmzac_Qzkrg-Mtfd-4zZJjg

During the reference committee hearing, supplemental material may be sent to referencecommitteek@ama-assn.org. Supplemental material includes items that have been referenced in testimony such as alternative wording, proposed amendments, and supporting documents. This email address is NOT intended as a means to provide testimony, which should be only be presented in on the Online Reference Committee or orally to the committee. This address is only operational for the duration of the reference committee hearing.

20. Resolution 929 – Strengthening Physician Education and Standardized Protocols for Human Rabies Post-Exposure Prophylaxis
21. Resolution 931 – Allocation, Liability Protections, & Generic Drug Shortages

RECOMMENDED FOR ADOPTION AS AMENDED

22. BOT 12 – Rethink the Medicare Annual Wellness Visit
23. CSAPH 01 – Drug Shortages: 2026 Update
24. Resolution 901 – The Establishment of Mandatory National Reporting of Naegleria Fowleri and Other Amebic Encephalitides
25. Resolution 910 – Consolidating and Modernizing AMA Policy on Alcohol Excise Taxation
26. Resolution 916 – Opposition to Recreational Nicotine Products in Federal Correctional Facilities
27. Resolution 917 – Modernizing Sunscreen Regulation to Advance Skin Cancer Prevention and Public Health
28. Resolution 920 – Improving Protection for Patient Medical Records and Health Care
29. Resolution 932 – Recognizing the Challenge of Tobacco Use in the Era of Commercial E-Cigarettes and Nicotine Products

RECOMMENDED FOR ADOPTION IN LIEU OF

30. BOT 05 – Increasing Access through Federated Healthcare Data Architecture and Resolution 902 – Illegal Electronic Health Record Sharing and Patient Trust
31. Resolution 904 – Regulation of Organ Transplant Open Offers and Resolution 927 – Patient Safety and Clinical Authority in Deceased Organ Donation and Procurement
32. Resolution 909 – Public Emergency Alert Reporting Requirements on Private Platforms
33. Resolution 914 – National Strategy to Close the Women's Health Gap
34. Resolution 915 – Ensuring Expert and Lived Experience Input in Federal National Health
35. Resolution 918 – Strengthening the Radiation Protection Standard
36. Resolution 930 – Supporting the Use of Firearm Suppressors to Prevent Hearing Loss
37. Resolution 933 – Preventing Silicosis Associated with Engineered Stone Countertops

Zoom link to hearing (view only webinar): https://events.zoom.us/ejl/AvhtMhxTmYDoJdm3-1dOmpTo09dmMZsSE8t0k2Rgv5-jBKi9VWhz~A1cJXoHbJwRwmFPv-qhx1sURHuJXk3tOv-e2bZt-r3oKQTSmJZ-oRp61RBIbJEqS2gd-aRdP2kQU43jS5dit-Bmzac_Qzkrg-Mtfd-4zZJjg

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RECOMMENDED FOR REAFFIRMATION IN LIEU OF

38. Resolution 926 – Support for One Health Approaches to Protect Human, Animal, and Environmental Health

RECOMMENDATION PENDING

39. *Resolution 911 – Annual Alcohol Report and Comprehensive Review of AMA Alcohol Policy*
40. *Resolution 934 – Protecting Evidence-Based Family Planning Services in Title X-Funded Programs*
41. *Resolution 935 – Opposition to EPA Rules Delaying and Rescinding Federal PFAS Drinking Water Standards*
42. *Resolution 936 – Signed Consent for Antidepressant Use in the Veterans Administration*
43. *Resolution 937 – Protect Communities from Health and Environmental Impacts of Data Centers*
44. *Resolution 938 – Urging Federal Action to Rescind Administrative Directives Permitting Unapproved Synthetic Peptides and Enforce Patient Safety*

** Items in italics will be considered based on HOD action at the Second Opening Session.*

Zoom link to hearing (view only webinar): https://events.zoom.us/ejl/AvhtMhxTmYDoJdm3-1dOmpTo09dmMZsSE8t0k2Rgv5-jBKi9VWhz~A1cJXoHbJwRwmFPv-qhx1sURHuJXk3tOv-e2bZt-r3oKQTSmJZ-oRp61RBIbJEqS2gd-aRdP2kQU43jS5dit-Bmzac_Qzkrg-Mtfd-4zZJjg

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Reference Committee on Ethics and Bylaws

Report(s) of the Board of Trustees

14	Patient Options to Restrict Secondary Use of Their Healthcare Data
15	Gender-Based Pay Equity in Medicine
18	Improving Usability of Electronic Health Records (EHRs) for Transgender and Gender Diverse Patients
22	Clarifying Conscientious Objection
23*	Specialty Society Representation in the House of Delegates - Five-Year Review

Report(s) of the Council on Constitution and Bylaws

01	Clarifications regarding Establishment and Nominations to AMA Committees
02	Amendments to Bylaws governing the AMA Sections
03	Autonomy of House of Delegate Member Entities: Bylaw Clarification

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

01	Preserving Autonomy in the Patient-Physician Relationship
02	Clarifying Conscientious Objection
03	Guidelines on Chaperones for Sensitive Exams
04	Supporting Efforts to Strengthen Medical Staffs Through Collective Actions and/or Unionization
05	Care of Patients in Legal Custody
06	Recording Clinical Encounters
07	Physicians Are Not Providers

Resolutions

001	Recognition of Intersex Individuals and their Human Rights
002	Surgical Consent
005	Opposing Trading on the Outcomes of Biomedical Research and Clinical Trials
006	Ethics of Medical Usury
007	Opposing the Required Creation of “Detransition Clinics”
008	Recognition of Moral Injury in the Physician Workforce
009	Ensuring the Appropriate Placement of Children After Parental Deportation
010	Preserving Human Dignity and Safety by Limiting Unnecessary Restraints and Monitoring

*Contained in Meeting Tote

Reference Committee B

Report(s) of the Board of Trustees

06 Restoring Balance Billing and Allowing Copay Forgiveness to Preserve Independent Practice and Improve Access to Care
07 Support for Legislative Changes Allowing Partial Medicare Opt-Out for Physicians
08 Access to, and Retention of, Electronic Medical Records
09 Medicare Should Not Unfairly Penalize Physicians
16 Ensuring Medical Liability Insurance Transparency and Continuity
17 Addressing and Reducing Patients Boarding in the Emergency/Reducing Emergency Department Boarding through Payment Reform
21 Extending and Expanding the AMA Task Force to Preserve the Patient Physician Relationship to Ensure Access and Regulatory Clarity in Gender Affirming Care

Resolutions

201 Artificial Intelligence Having Prescriptive Authority
202 Rapid Response Framework for Unsupported Medical Claims by Public Officials
203 Set-Aside Federal Funding for Tribal Health Programs
204 Federal Framework for Social Media Access by Minors Under Age 16
205 Ensuring Accuracy and Physician Protections for Patient Attribution in Health Plan Quality Measurement and Value-Based Programs
206 Third-Party Litigation Funding in Medical Liability Claims
207 Protecting Physician-Led Interventional Pain Medicine, Ending Unsupervised Nonphysician Practice, and Ensuring Patient Transparency and Safety
208 Facilitating Short-Term Supervised Clinical Training for International Physicians
209 Protecting GME Subject to Funding Uncertainty
210 Requiring Physician Oversight for Artificial Intelligence Tools
211 Fair and Clinically Appropriate EMTALA Investigations
212 Medical Staff Approval of Quality-of-Care Issues Prior to Exclusive Contract
213 Clear Identification and Differentiation of Physicians and Nonphysicians in Clinical Rosters, Signage, and Listings
214 Prohibiting Health Care Sale-Leaseback Transactions
215 Establishing Product Liability for Clinical Augmented Intelligence Failures
216 Comprehensive Reform of the No Surprises Act Independent Dispute Resolution Process
217 Strengthening the Patients First Act and Medicare Physician Payment Reform
218 Firearm Manufacturer Accountability for the Cost of Gun Violence
219 Opposing the Use of Artificial Intelligence to Produce Child and Adolescent Sexual Exploitative Material
220 Advocating for the Older Americans Act and Community-Based Services for Older Adults
221 Preserving Duration of Status for J-1 Physicians in Graduate Medical Education
222 Increasing Legislative Advocacy and Dedicated National Educational Programming for International Medical Graduates (IMGs)

223	Advancing Physician Payment and Medicare and Medicaid Access for Street Medicine
224	Modernize the Medicare Primary Care Exception to Ensure Appropriate Reimbursement for Services Provided by Residents
225	Supporting a Common Legal Framework for Medical Capacity Holds
226	Physician-Led Governance of the Use of Augmented Intelligence in Hospital Credentialing, Privileging, and Peer Review
227	Increasing Access to Long-Acting Injectable Medications for SUD
228	Hospital-Based Substance Use Disorder Care
229	Protecting Individual Rights in the Era of Developing Neurotechnologies, Including for Mental Augmentation
230	Due Process, Transparency, and Accountability for Delegated Third-Party Prior Authorization and Utilization Management Entities
231	Medicare and Medicaid Payment Equity for Puerto Rico
232	Timely Processing of DEA Practitioner Registrations to Protect Patient Access to Care
233	Medicaid Protections & Continuous Coverage for Active Cancer Care
234	Research Infrastructure & Overcoming Non-Medical Clinical Trial Barriers
235	Assisting Physicians in Navigating Changes to Medicaid Medical Frailty Exemptions
236*	Standardization of Quality Performance Reporting in Value-Based Payment Arrangements
237*	Action Regarding CMS Authority to Exclude Entities from Medicare, Medicaid, and Federal Health Care Programs
238*	Timely Processing of DACA Renewal Applications
239*	Protecting the Integrity of Public Participation in Federal Health Policymaking
240*	Minimizing Patient Harm from Autonomous Artificial Intelligence

*Contained in Meeting Tote

Reference Committee C

Report(s) of the Council on Medical Education

01	Medical Education Program and Content
02	Medical Education Systems
03	Professional Regulation of Physicians
04	Physician as Medical Professional
05	Entry into and transition through the medical education continuum
06	Obligations to Students and Trainees
07	Mission of Medical Education
08	Hardship for International Medical Graduates in Humanitarian Crisis or Conflict

Resolutions

302	Augmented Intelligence Use in Assessment Development During Medical Education
304	Transparency in AI-Assisted Admissions
305	Certification for Hospice Medical Directors
306	Fee Parity for International Medical Graduates Taking USMLE Examinations Outside the United States
311*	Ensuring Flexible Testing Dates by the USMLE and Appropriate Stakeholder Engagement

*Contained in Meeting Tote

Reference Committee F

Report(s) of the Board of Trustees

01 Study of Grading Systems in AMA Board Reports

10 AMA Reimbursement of Necessary HOD Business Meeting Expenses for Delegates and Alternates

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

01 Evaluation of the Size and Structure of the AMA House of Delegates

02 Underrepresented in Medicine Advocacy Section Five-Year Review

03 Integrated Physician Practice Section Five-Year Review

Report(s) of the Speakers

01 Election Rule Updates

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

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

Resolutions

601 Strengthening Board Oversight and Engagement in Major AMA Federal Advocacy

602 Enhancing Equity in House of Delegates Resolution Processes by Removal of the Resolutions Committee and Broadening of the Interim Meeting's Focus

603 Ensuring Relevance and Mission Alignment in House of Delegates Business

604 Increasing Time Between Handbook Release and Opening of Online Reference Committees

Reference Committee J

Report(s) of the Board of Trustees

11 Opposing Unilateral Downcoding of Physician Services by Insurance Companies

Report(s) of the Council on Medical Service

01 Transparency with the Term "Emergency Department"
02 The Impact of the Inflation Reduction Act on Physician Practices
03 Non-Medical Switching of Prescription Drugs
04 Determining Fair Market Value when Contracting with Physician Practices
05 Improving Marketplace Affordability through Premium Tax Credits
06 Study of Physicians Utilizing Ambulatory Surgical Centers and Office-Based Laboratories or Performing Office-Based Surgeries

Resolutions

801 Improving the External Appeals Process for Denied Claims
802 Payer Coverage and Tax-Advantaged Access for Physical Activity Professionals, Services, and Programs
803 Coverage of Embryonic Monogenic Disorder Screening as a Medically Necessary Benefit
804 Medicare Coverage of Continuous Glucose Monitoring for Non-Insulin-Treated Type 2 Diabetes
805 Meaningful Enforcement of Prohibitions on the Corporate Practice of Medicine
806 Proration of Liability Insurance Premiums for Senior Physicians Based on Hours Worked
807 Continuing Care Retirement Communities (CCRC's)
808 Increasing Payment for Patient Portal Messages
809 Joint Commission Standards for Medical Staff Self-Governance
810 Strengthening Medicare and Accreditation Standards for Organized Medical Staff Independence
811 Government Support of Adaptive Sports Programming
812 Protect Patient Choice and Physician Privileges in Hospitals Merger and Acquisitions
813 Small Medical Practice Website and other Digital Service Compliance with ADA Regulation
814 Coverage of SMART Therapy for Asthma
815 Improving Technology to Combat Automated and Artificial Intelligence-Directed Downcoding of Evaluation and Management Services by Health Insurance Companies
816 Enhancing Advocacy to Combat Automated Insurance Downcoding of EM Services
817 Proposed revised H-450.982, Patient Satisfaction, Patient Experience, and Quality of Care
818 Proposed Revised D-385.958 - Patient Satisfaction Surveys and Quality Parameters as Criteria for Physician Payment
819 Modifiers Indicating Independent Non-Physician Practitioner Use of Physician Consults and Transfers
820 Strengthening Emergency Interfacility Transfer Infrastructure

Reference Committee K

Report(s) of the Board of Trustees

03 Reduce Environmental Impact of Medical Journals
04 Informed Consent for Genetic Testing
05 Increasing Access through Federated Healthcare Data Architecture
12 Rethink the Medicare Annual Wellness Visit

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

01 Drug Shortages: 2026 Update
02 Urging Comprehensive Research and Safety Testing of Industry-Engineered Food Additives (IEFAs), Including High Fructose Corn Syrup
03 Establishing Fire Risk Standards for Civilian and Non-Industrial Clothing
04 Deprescribing in Clinical Practice
05 Battlefield Acupuncture

Resolutions

901 The Establishment of Mandatory National Reporting of Naegleria Fowleri and Other Amebic Encephalitides
902 Illegal Electronic Health Record Sharing and Patient Trust
903 Improving Health Outcomes in Native Hawaiian Populations
904 Regulation of Organ Transplant Open Offers
905 Integrating Drowning Prevention Counseling and Resource Referral into Pediatric Preventive Care
906 Establishing Menstrual Products as a Standard of Inpatient Care
907 Affirming Support for the National Institutes of Health Advisory Councils
908 Improving Access to Phenotype-Matched Blood for Transfusion-Dependent Patients
909 Public Emergency Alert Reporting Requirements on Private Platforms
910 Consolidating and Modernizing AMA Policy on Alcohol Excise Taxation
912 Reducing Medical Waste Through Electronic Instructions for Use (e-IFU) for Surgical and Medical Device Products
913 Withdrawn
914 National Strategy to Close the Women's Health Gap
915 Ensuring Expert and Lived Experience Input in Federal National Health Plans
916 Opposition to Recreational Nicotine Products in Federal Correctional Facilities
917 Modernizing Sunscreen Regulation to Advance Skin Cancer Prevention and Public Health
918 Strengthening the Radiation Protection Standard
919 Protecting the Use of Evidence-Based Psychotropic Medications for the Treatment of Psychiatric Conditions
920 Improving Protection for Patient Medical Records and Health Care
921 Transgender and Gender Diverse Cancer Research
922 Eliminating Tax Barriers to Equitable Clinical Trial Participation
923 Research the Community Health Impacts of Data Centers
924 Ensuring Evidence-Based Nutrition Guidance in Public Health and Clinical Practice
925 Opposition to Mandatory Testosterone Testing for Active Duty Servicemembers
926 Support for One Health Approaches to Protect Human, Animal, and Environmental Health
927 Patient Safety and Clinical Authority in Deceased Organ Donation and Procurement

Reference Committee K

928	Electric Bike and Scooter Safety, Regulation, and Enforcement
929	Strengthening Physician Education and Standardized Protocols for Human Rabies Post-Exposure Prophylaxis
930	Supporting the Use of Firearm Suppressors to Prevent Hearing Loss
931	Allocation, Liability Protections, & Generic Drug Shortages
932	Recognizing the Challenge of Tobacco use in the Era of Commercial E-Cigarettes and Nicotine Products
933	Preventing Silicosis Associated with Engineered Stone Countertops
934*	Protecting Evidence-Based Family Planning Services in Title X-Funded Programs
935*	Opposition to EPA Rules Delaying and Rescinding Federal PFAS Drinking Water Standards

*Contained in Meeting Tote

REPORT OF THE BOARD OF TRUSTEES

BOT Report 23-I-26

Subject:	Specialty Society Representation in the House of Delegates - Five-Year Review
Presented by:	Toluwalaṣé A. Ajayi, MD, Chair
Referred to:	Reference Committee on Ethics and Bylaws

The Board of Trustees (BOT) has completed its review of the specialty organizations seated in the House of Delegates (HOD) required to submit information and materials for the 2026 American Medical Association (AMA) Interim Meeting in compliance with the five-year review process established by the House of Delegates in Policy G-600.020, "Summary of Guidelines for Admission to the House of Delegates for Specialty Societies," and AMA Bylaw 8.5, "Periodic Review Process."

Organizations are required to demonstrate continuing compliance with the guidelines established for representation in the HOD. Compliance with the five responsibilities of professional interest medical associations and national medical specialty organizations is also required as set out in AMA Bylaw 8.2, "Responsibilities of National Medical Specialty Societies and Professional Interest Medical Associations."

The following organizations were reviewed for the 2026 Interim Meeting:

American Academy of Insurance Medicine
American Academy of Sleep Medicine
American Society for Gastrointestinal Endoscopy
American Society for Radiation Oncology
American Society for Surgery of the Hand
American Society of Plastic Surgeons
American Urological Association
AMSUS The Society of Federal Health Professionals

The American Association of Physicians of Indian Origin was also reviewed at this time because it failed to meet the requirements in June of 2026 and was granted a one-year grace period.

Each organization was required to submit materials demonstrating compliance with the guidelines and requirements along with appropriate membership information. A summary of each group's membership data is attached to this report (Exhibit A). A summary of the guidelines for specialty society representation in the AMA HOD (Exhibit B), the five responsibilities of national medical specialty organizations and professional medical interest associations represented in the HOD (Exhibit C), and the AMA Bylaws pertaining to the five-year review process (Exhibit D) are also attached.

The materials submitted indicate that: American Academy of Insurance Medicine, American Academy of Sleep Medicine, American Association of Physicians of Indian Origin, American Society for Gastrointestinal Endoscopy, American Society for Radiation Oncology, American

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Society for Surgery of the Hand, American Society of Plastic Surgeons, and American Urological Association meet all guidelines and are in compliance with the five-year review requirements of specialty organizations represented in the HOD.

The materials submitted indicate that AMSUS The Society of Federal Health Professionals did not meet all guidelines and is not in compliance with the five-year review requirements of specialty organizations represented in the AMA HOD.

RECOMMENDATIONS

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

1. The American Academy of Insurance Medicine, American Academy of Sleep Medicine, American Association of Physicians of Indian Origin, American Society for Gastrointestinal Endoscopy, American Society for Radiation Oncology, American Society for Surgery of the Hand, American Society of Plastic Surgeons, and American Urological Association retain representation in the American Medical Association House of Delegates. (Directive to Take Action)

2. Having failed to meet the requirements for continued representation in the AMA House of Delegates as set forth in the AMA Bylaw B-8.5.2 AMSUS The Society of Federal Health Professionals be placed on probation and be given one year to work with AMA membership staff to increase their AMA membership. (Directive to Take Action)

Fiscal Note: Minimal.

APPENDIX

Exhibit A - Summary Membership Information

Organization	**AMA Membership of Organization's Total Eligible Membership**
American Academy of Insurance Medicine*	37 of 137 (27%)
American Academy of Sleep Medicine	1,174 of 4,708 (25%)
American Association of Physicians of Indian Origin	2,261 of 13,530 (17%)
American Society for Gastrointestinal Endoscopy*	1,903 of 7,984 (24%)
American Society for Radiation Oncology	757 of 3,361 (21%)
American Society for Surgery of the Hand	591 of 2,945 (20%)
American Society of Plastic Surgeons	1,555 of 7,328 (21%)
American Urological Association*	1,558 of 9,599 (16%)
AMSUS The Society of Federal Health Professionals	Did not submit materials

* *Represented in the House of Delegates at the 1990 Annual Meeting*

Exhibit B - Summary of Guidelines for Admission to the House of Delegates for Specialty Societies (Policy G-600.020)

Policy G-600.020

1. The organization must not be in conflict with the Constitution and Bylaws of the American Medical Association with regard to discrimination in membership.

2. The organization must:

   (a) represent a field of medicine that has recognized scientific validity;
   (b) not have board certification as its primary focus; and
   (c) not require membership in the specialty organization as a requisite for board certification.

3. The organization must meet one of the following criteria:

   (a) a specialty organization must demonstrate that it has 1,000 or more AMA members; or
   (b) a specialty organization must demonstrate that it has a minimum of 100 AMA members and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of the AMA; or
   (c) a specialty organization must demonstrate that it was represented in the House of Delegates at the 1990 Annual Meeting and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of the AMA.

4. The organization must be established and stable; therefore, it must have been in existence for at least five years prior to submitting its application.

5. Physicians should comprise the majority of the voting membership of the organization.

6. The organization must have a voluntary membership and must report as members only those physician members who are current in payment of applicable dues, and eligible to serve on committees or the governing body.

7. The organization must be active within its field of medicine and hold at least one meeting of its members per year.

8. The organization must be national in scope. It must not restrict its membership geographically and must have members from a majority of the states.

9. The organization must submit a resolution or other official statement to show that the request is approved by the governing body of the organization.

10. If international, the organization must have a US branch or chapter, and this chapter must be reviewed in terms of all of the above guidelines.

Exhibit C

8.2 Responsibilities of National Medical Specialty Societies and Professional Interest Medical Associations. Each national medical specialty society and professional interest medical association represented in the House of Delegates shall have the following responsibilities:

8.2.1 To cooperate with the AMA in increasing its AMA membership.

8.2.2 To keep its delegate(s) to the House of Delegates fully informed on the policy positions of the society or association so that the delegates can properly represent the society or association in the House of Delegates.

8.2.3 To require its delegate(s) to report to the society on the actions taken by the House of Delegates at each meeting.

8.2.4 To disseminate to its membership information as to the actions taken by the House of Delegates at each meeting.

8.2.5 To provide information and data to the AMA when requested.

Exhibit D – AMA Bylaws on Specialty Society Periodic Review

8 - Representation of National Medical Specialty Societies and Professional Interest Medical Associations in the House of Delegates

8.5 **Periodic Review Process.** Each specialty society and professional interest medical association represented in the House of Delegates must reconfirm its qualifications for representation by demonstrating every 5 years that it continues to meet the current guidelines required for granting representation in the House of Delegates, and that it has complied with the responsibilities imposed under Bylaw 8.2. The SSS may determine and recommend that societies currently classified as specialty societies be reclassified as professional interest medical associations. Each specialty society and professional interest medical association represented in the House of Delegates must submit the information and data required by the SSS to conduct the review process. This information and data shall include a description of how the specialty society, or the professional interest medical association has discharged the responsibilities required under Bylaw 8.2.

8.5.1 If a specialty society or a professional interest medical association fails or refuses to provide the information and data requested by the SSS for the review process, so that the SSS is unable to conduct the review process, the SSS shall so report to the House of Delegates through the Board of Trustees. In response to such report, the House of Delegates may terminate the representation of the specialty society or the professional interest medical association in the House of Delegates by majority vote of delegates present and voting or may take such other action as it deems appropriate.

8.5.2 If the SSS report of the review process finds the specialty society or the professional interest medical association to be in noncompliance with the current guidelines for representation in the House of Delegates or the responsibilities under Bylaw 8.2, the specialty society or the professional interest medical association will have a grace period of one year to bring itself into compliance.

8.5.3 Another review of the specialty society's or the professional interest medical association's compliance with the current guidelines for representation in the House of Delegates and the responsibilities under Bylaw 8.2 will then be conducted, and the SSS will submit a report to the House of Delegates through the Board of Trustees at the end of the one-year grace period.

8.5.3.1 If the specialty society or the professional interest medical association is then found to be in compliance with the current guidelines for representation in the House of Delegates and the responsibilities under Bylaw 8.2, the specialty society or the professional interest medical association will continue to be represented in the House of Delegates and the current review process is completed.

8.5.3.2 If the specialty society or the professional interest medical association is then found to be in noncompliance with the current guidelines for representation in the House of Delegates, or the responsibilities under Bylaw 8.2, the House may take one of the following actions:

8.5.3.2.1 The House of Delegates may continue the representation of the specialty society or the professional interest medical association in the House of Delegates, in which case the result will be the same as in Bylaw 8.5.3.1.

8.5.3.2.2 The House of Delegates may terminate the representation of the specialty society or the professional interest medical association in the House of Delegates. The specialty society or the professional interest medical association shall remain a member of the SSS, pursuant to the provisions of the Standing Rules of the SSS. The specialty society or the professional interest medical association may apply for reinstatement in the House of Delegates, through the SSS, when it believes it can comply with all of the current guidelines for representation in the House of Delegates.

REVISED

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 3-I-26

Subject: Professional Regulation of Physicians

Presented by: Shannon M. Kilgore, MD, Chair

Referred to: Reference Committee C

Adopted at the 2024 American Medical Association (AMA) Interim meeting, AMA Policy D-295.299, "Updates to Recommendations for Future Directions for Medical Education," states:

> "Our American Medical Association will study the restructuring of AMA Policy H-295.995, 'Recommendations for Future Directions for Medical Education,' to consolidate existing AMA policies in these areas where appropriate and to recommend new language for the future of medical education, in a series of seven future reports based on the topics of:
>
> - Mission of medical education.
> - Professional regulation.
> - Entry into and transition through the medical education continuum.
> - Medical education curricula.
> - Physician as medical professional.
> - Medical education systems.
> - Obligations to students and trainees."

This report addresses the theme of professional regulation, referred to in this report as "professional regulation of physicians."

BACKGROUND

The above policy was initially introduced via the Council on Medical Education's self-initiated report, CME 2-I-24, with the intention of proposing a framework to consolidate and modernize AMA medical education policy. During their research for the CME 2-I-24 report, the Council noted the breadth of medical education policies, including Policy H-295.995, "Recommendations for the Future Directions for Medical Education" that contains 33 clauses and had not been reassessed in its entirety since 1982. CME 2-I-24 provided the following commentary regarding "professional regulation of physicians":

> "Medical education maintains commitment to the concept that the regulation of the medical profession should be guided by physicians. A 2015 memorandum of understanding between the Accreditation Council for Graduate Medical Education (ACGME), American Osteopathic Association, and American Association of Colleges of Osteopathic Medicine began a five-year transition to single U.S. graduate medical education (GME) accreditation, which finalized in 2020, though some express concerns. AMA policy currently supports work toward a single licensure exam (Single Licensing Exam Series for Osteopathic and Allopathic Medical Students D-275.947), and inequities between Doctors of Osteopathic Medicine (DOs) and Doctors of Medicine (MDs) continue to be addressed.

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> "Significant overall shifts in how standardized assessments are designed and discussed have also taken place since the 1980s. This includes the notion of competence as actual competencies linked to patient outcomes rather than personality traits, an understanding that did not develop until the late 1990s and early 2000s, with awareness of assessor bias and the limitations of assessments emerging in scholarly literature even later. In 2021, the United States Medical Licensing Examination (USMLE) Step 2 Clinical Skills (CS) was permanently discontinued after a COVID-19 related 2020 suspension. In 2022, the USMLE Step 1 exam converted from numeric to pass-fail."

Citations denoted above are provided in CME 2-I-24. For parity between allopathic and osteopathic learners, it is also important to note regarding the above that in 2022, the Comprehensive Osteopathic Medical Licensing Examination of the United States (COMLEX-USA) Level 1 also changed from numeric scores to pass/fail, and the National Board of Osteopathic Medical Examiners (NBOME) replaced the old CS exam with the new Core Competency Capstone for DOs (C3DO) and Comprehensive Competency Verification (CCV) pathways, effective for the class of 2029.

In order to provide consistency across the seven reports, guardrails were established:

- Policies explored include the entirety of the medical education continuum, including pre-medical education, UME, GME, and CME.
- The scope of each report will focus on updating a selection of existing related policies for accuracy as well as consolidation.
- Though the reports seek to consolidate existing policy and improve accuracy of language only, the recommendations may also make note of areas where future reports might be warranted to develop additional AMA policy on important topics not currently represented.
- Each report utilizes the well-established Appendix table format as seen in the annual Sunset Review reports.

To begin the process of selecting relevant policies for the seven reports, AMA Policy Finder was utilized. Starting on the home page, the "Search" button was selected. It provided a list of "policy topics," one of which was "medical education." By selecting this filter, it identified a total of 244 relevant policies. Implemented in September 2025, this process generated a numerical, comprehensive list of 244 policies to be categorized across the seven reports. A single policy is not listed in more than one report. Among them, seven policies were deemed not for inclusion in these reports given their length and/or complexity; 237 policies remained for categorization.

Of the 237 policies, 26 were sorted into this report. They address policies related to regulatory bodies, competency linked to patient care, self-regulation (non-interference), accreditations, credentialing, assessments (i.e., USMLE/COMLEX), and the process of developing standards/requirements. This report does not address policies where the main point of the policy fell outside of the purview of "professional regulation of physicians," even if tangentially related. Such topics are addressed in the other six reports.

DISCUSSION

Policies considered

As mentioned earlier, 26 policies related to this theme were reviewed for this report. Among them, the Council determined that the following 17 policies remain relevant and should be retained:

- Remediation Programs for Physicians D-295.325
- Update on Development of Branch Campuses of International Medical Schools D-295.996

- Physician Reentry D-300.984
- Reporting of Total Attempts of USMLE Step 1 and COMLEX-USA Level 1 Examinations H-295.841
- Physician Participation in the AMA Physician's Recognition Award H-300.959
- Residency Review Committee Representation and Requirements H-310.972
- Accreditation of Graduate Medical Education Programs H-310.997
- Disclosure of Compliance Issues Related to Joint Providership D-300.974
- Reduced Continuing Medical Education (CME) Fees for Retired Physicians D-300.994
- Registration of Accredited CME Sponsors D-300.999
- Dissemination of Information Regarding CME Activities H-300.952
- Inappropriate Use of Social Security Numbers in CME Accreditation H-300.946
- Restructuring of Continuing Medical Education Credits H-300.955
- Protocol for Recognition of State Medical Society Accreditation Programs H-300.968
- Unification of Continuing Education Credits H-300.974
- Community Hospital Continuing Medical Education H-300.983
- National Accreditation of AMA as Provider of Continuing Medical Education H-300.992

One policy reviewed, Residency Program Responsibility for Resident Education H-295.915, was rescinded by the A-26 Sunset report during the process of writing this report and therefore no longer needs to be acted upon in this report.

The remaining policies are listed in the appendices with recommended actions. They are:

- Independent Regulation of Physician Licensing Exams D-295.939
- Opposition to Increased CME Provider Fees D-300.980
- Proposed Fee Increase by the Accreditation Council for Continuing Medical Education D-300.981
- Evaluation of Increasing Resident Review Committee Requirements D-310.962
- Unification of Education Credits H-300.976
- Restoring Integrity to Continuing Medical Education H-300.988
- Federal Intervention in the Setting of Educational Standards H-295.921
- Legislative Threats to the Voluntary Accreditation Process H-295.947

Gaps identified

This review process has illuminated opportunities where policies could be re-examined and reframed in the future to be more forward-thinking. For example, the Council identified the possible need for a policy related to physician reentry as well as further study on how legislative restrictions and government regulatory agencies impact AMA efforts. Such topics may be addressed in future reports, educational sessions, or other mechanisms as determined by this Council and/or the HOD.

RELEVANT AMA POLICIES

There are multiple AMA polices impacted by this report:

Appendix A individually lists current policy language side-by-side with recommended actions (e.g., amend, rescind) related to that specific policy. These actions are collectively addressed in Recommendation 1 of this report.

Appendix B provides the language for related groups of current policy. Your Council recommends combining/consolidating these policies into alternate language for clarity and conciseness which is presented in Recommendation 2 of this report. The content of the original policies was maintained whenever possible, as was the spirit of the original policies.

CONCLUSION

This report reviewed 26 of the 237 policies originally identified and categorized as focusing on medical education and offered multiple recommendations for consideration. In this way, your Council is working to modernize and update our policy compendium as it relates to medical education and make it easier to identify and understand our policies moving forward.

RECOMMENDATIONS

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

1. The House of Delegates policies listed in Appendix A of this report be acted upon in the manner indicated and the remainder of this report be filed. (Directive to Take Action)
2. That policies Federal Intervention in the Setting of Educational Standards H-295.921 and Legislative Threats to the Voluntary Accreditation Process H-295.947 (policy language available in Appendix B) be rescinded and the following policy be adopted:

   LEGISLATIVE THREATS TO MEDICAL EDUCATION STANDARDS

   The AMA strongly opposes:
   a) federal intervention, through legislative restrictions, that would limit the authority of professional accrediting bodies to design and implement appropriate educational standards for the training of physicians;
   b) infringements and mandates on medical school curricular requirements through state and federal legislative efforts, and recommends that state medical societies should carefully monitor such activities and notify the AMA when such intrusions take place;
   c) legislation that would dismantle national accrediting agencies and that would substitute state standards for a uniform level of national standards in medical education, and
   d) legislation that would limit professional participation in the setting and evaluation of quality standards in medical education.

Fiscal Note: Minimal

APPENDIX A: POLICIES AND RECOMMENDED ACTIONS

Title and Policy Number	Text and Timeline	Recommendation
Independent Regulation of Physician Licensing Exams D-295.939	1. Our American Medical Association will continue to work with the National Board of Medical Examiners to ensure that the AMA is given appropriate advance notice of any major potential changes in the examination system. 2. Our AMA will continue to collaborate with the organizations who create, validate, monitor, and administer the United States Medical Licensing Examination. 3. Our AMA will continue to promote and disseminate the rules governing USMLE in its publications. 4. Our AMA will continue its dialog with and be supportive of the process of the Committee to Evaluate the USMLE Program (CEUP). 5. Our AMA will work with American Osteopathic Association and National Board of Osteopathic Medical Examiners to stay apprised of any major potential changes in the Comprehensive Osteopathic Medical Licensing Examination (COMLEX). CME Rep. 10, A-08 Modified: CME Rep. 01, A-18 Reaffirmation: A-22	Amend policy D-295.939 by addition and deletion to read as follows: 1. Our American Medical Association ~~will continue to~~ works with ~~the National Board of Medical Examiners~~ relevant organizations to ensure that the AMA is given appropriate advance notice of any major potential changes in the United States Medical Licensing Examination (USMLE) and Comprehensive Osteopathic Medical Licensing Examination (COMLEX-USA) examination systems. ~~2. Our AMA will continue to collaborate with the organizations who create, validate, monitor, and administer the United States Medical Licensing Examination.~~ ~~3. Our AMA will continue to promote and disseminate the rules governing USMLE in its publications.~~ ~~4. Our AMA will continue its dialog with and be supportive of the process of the Committee to Evaluate the USMLE Program (CEUP).~~ ~~5. Our AMA will work with American Osteopathic Association and National Board of Osteopathic Medical Examiners to stay apprised of any major potential changes in the Comprehensive Osteopathic Medical Licensing Examination (COMLEX).~~ *Rationale: Amendment to clause 1 makes clauses 2 and 5 redundant. Clauses 3 and 4 are no longer relevant as the Committee to Evaluate the USMLE Program (CEUP) was disbanded.*

Title and Policy Number	Text and Timeline	Recommendation
Opposition to Increased CME Provider Fees D-300.980	1. Our American Medical Association will: a. continue to work with the ACCME to: i. Reduce the financial burden of institutional accreditation and state recognition. ii. Reduce bureaucracy in these processes. iii. Improve continuing medical education. iv. Encourage the ACCME to show that accreditation criteria improve patient care. b. continue to work with the ACCME to i. Mandate meaningful involvement of state medical societies in the policies that affect recognition. ii. Reconsider the fee increases to be paid by the state-accredited providers to ACCME. 2. Our AMA will continue to work with the ACCME to accomplish the directives in policy D-300.980, "Opposition to Increased Continuing Medical Education (CME) Provider Fees." CME Rep. 14, A-10 Appended: CME Rep. 9, A-11 Modified: CCB/CLRPD Rep. 4, A-12 Modified: CCB/CLRPD Rep. 2, A-14 Appended: Res. 302, A-17 Modified: CME Rep. 1, A-21	Amend policy D-300.980 by addition and deletion with a change in title to read as follows: ~~OPPOSITION TO INCREASED CME PROVIDER FEES~~CONTINUING MEDICAL EDUCATION ACCREDITATION 1. Our American Medical Association will: a. continue to work with the ACCME to: i. Reduce the financial burden of institutional accreditation and state recognition. ii. Reduce bureaucracy in these processes. iii. Improve continuing medical education. iv. Encourage the ACCME to show that accreditation criteria improve patient care. ~~b.~~ continue to work with the ACCME to ~~i. M~~mandate meaningful involvement of state medical societies in the policies that affect recognition. ~~ii. Reconsider the fee increases to be paid by the state-accredited providers to ACCME.~~ ~~2. Our AMA will continue to work with the ACCME to accomplish the directives in policy D-300.980, "Opposition to Increased Continuing Medical Education (CME) Provider Fees."~~ Our AMA will investigate and recommend ways by which physicians may receive appropriate, accredited continuing medical education other than through ACCME-accredited activities. *Rationale: Clause b(ii) is outside the purview of the AMA. Clause 2 is redundant. Addition is consolidated from D-300.981 below.*

Title and Policy Number	Text and Timeline	Recommendation
Proposed Fee Increase by the Accreditation Council for Continuing Medical Education D-300.981	Our AMA will strongly urge the Accreditation Council for Continuing Medical Education (ACCME) to reconsider the proposed fee increase and, if the ACCME refuses to reconsider the proposed fee increase, our AMA will investigate and recommend ways by which physicians may receive appropriate, accredited continuing medical education other than through ACCME-accredited activities. Res. 312, A-09 Reaffirmed: CME Rep. 01, A-19	Rescind policy D-300.981. *Rationale: First part of policy was accomplished by notifying the ACCME of this adopted policy. Second part of policy is recommended to be appended to D-300.980 above.*
Evaluation of Increasing Resident Review Committee Requirements D-310.962	Our American Medical Association will work with and monitor the Accreditation Council for Graduate Medical Education and American Osteopathic Association in studying residency/fellowship documentation requirements for program accreditation and the impact of these documentation requirements on program directors and residents with recommendations for improvement. Res. 315, A-08 Reaffirmed: CME Rep. 01, A-18	Amend policy D-310.962 by addition and deletion to read as follows: Our American Medical Association will collaborate ~~work~~ with ~~and monitor~~ the Accreditation Council for Graduate Medical Education ~~and American Osteopathic Association~~ in ~~studying~~ evaluating residency/fellowship documentation requirements for program accreditation and the impact of these documentation requirements on program directors and residents with recommendations for improvement as needed. *Rationale: The AMA is in communication with ACGME on this and related matters. AOA is no longer the appropriate organization to list here. AMA does not monitor ACGME.*
Unification of Education Credits H-300.976	It is the policy of the AMA to develop, in cooperation with national specialty organizations and state medical associations, uniform nationwide standards for continuing medical education credits recognized by all medical associations and specialty societies. Policy Timeline: Res. 102, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CME Rep. 2, A-10; Reaffirmed: CME Rep. 01, A-20	Amend policy H-300.976 by addition and deletion to read as follows: ~~It is the policy of the~~ AMA will ~~develop~~, in cooperation with national specialty organizations and state medical associations, uniform nationwide standards for continuing medical education credits recognized by all medical associations and specialty societies. *Rationale: Cleaner phrasing.*

Title and Policy Number	Text and Timeline	Recommendation
Restoring Integrity to Continuing Medical Education H-300.988	1. Our American Medical Association supports retention of the definitions of continuing medical education in the Physicians' Recognition Award ("Continuing medical education consists of educational activities which serve to maintain, develop, or increase the knowledge, skills, and professional performance and relationships that a physician uses to provide services for patients, the public, or the profession. The content of CME is that body of knowledge and skills generally recognized and accepted by the profession as within the basic medical sciences, the discipline of clinical medicine, and the provision of health care to the public."). 2. Our AMA urges members of the medical profession to be attentive to the distinction between continuing medical education and continuing education which is not related directly to their professional activities. 3. Our AMA believes that accredited sponsors should designate as continuing medical education only those continuing education activities which meet the definition of continuing medical education. 4. Our AMA encourages the ACCME and state medical associations on the state level to weigh seriously, in considering the sponsor's continued accreditation, instances where an accredited sponsor identifies non-continuing medical education activities as continuing medical education. 5. Our AMA encourages state medical boards to accept for credit continuing education which relates directly to the professional activities of physicians, although each state with mandatory continuing medical education for reregistration of license has the	Amend policy H-300.988, Clause 4 by addition and deletion, with a change in title, to read as follows: INTEGRITY IN CONTINUING MEDICAL EDUCATION~~RESTORING INTEGRITY TO CONTINUING MEDICAL EDUCATION~~ 4. Our AMA encourages ~~the ACCME and state medical associations on the state level to weigh seriously, in considering the sponsor's continued accreditation,~~ oversight bodies to monitor instances where an accredited sponsor identifies non-continuing medical education activities as continuing medical education and intervene accordingly. *Rationale: Cleaner phrasing.*

Title and Policy Number	Text and Timeline	Recommendation
	prerogative of defining the continuing education it will accept for credit. Policy Timeline: CME Rep. A, A-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CME Rep. 2, A-03; Modified: CME Rep. 2, A-13; Reaffirmation: A-22	

APPENDIX B: CURRENT TEXT OF LEGISLATIVE POLICIES RECOMMENDED FOR RECISION

Federal Intervention in the Setting of Educational Standards H-295.921

The AMA strongly opposes federal intervention, through legislative restrictions, that would limit the authority of professional accrediting bodies to design and implement appropriate educational standards for the training of physicians. The AMA strongly opposes infringements and mandates on medical school curricular requirements through state and federal legislative efforts, and also recommends that state medical societies should carefully monitor such activities and notify the AMA when such intrusions take place.

Res. 323, A-95 Appended: CME Rep. 4, I-97 Reaffirmed: CME Rep. 2, A-07 Reaffirmed: CME Rep. 01, A-17

Legislative Threats to the Voluntary Accreditation Process H-295.947

It is the policy of our American Medical Association to strongly oppose legislation which would:

1. Dismantle national accrediting agencies and which would substitute state standards for a uniform level of national standards in medical education.

2. Limit professional participation in the setting and evaluation of quality standards in medical education.

Res. 225, I-91 Modified: Sunset Report, I-01 Reaffirmed: BOT Rep. 22, A-11 Reaffirmed: BOT Rep. 7, A-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 236
(I-26)

Introduced by: Integrated Physician Practice Section

Subject: Standardization of Quality Performance Reporting in Value-Based Payment Arrangements

Referred to: Reference Committee B

Whereas, physicians, healthcare providers, and facilities increasingly participate in value-based payment arrangements across Medicare, Medicaid, commercial insurers, and other payers in which reimbursement is linked to measures of quality, outcomes, utilization, patient experience, and cost; and

Whereas, health insurers and other payers frequently use different quality measures, measure specifications, attribution, and risk-adjustment methodologies, performance thresholds, reporting requirements, and reporting formats, creating substantial administrative burden for physicians; and

Whereas, inconsistent and opaque reporting methodologies can make it difficult for physicians and physician organizations to understand their performance, identify opportunities for improvement, compare performance across patient populations and time periods, and understand how quality performance affects reimbursement; and

Whereas, there is a cost burden to managing different dashboards, tracking and managing varying outcomes measures and reporting methodologies that translate into real financial costs for physicians, their practices, and the healthcare facilities they work in; and

Whereas, greater standardization of quality performance reporting could reduce duplicative reporting and administrative burden, improve transparency and comparability, facilitate timely quality improvement, and allow physicians, healthcare providers, and facilities to devote greater resources to patient care; and

Whereas, a standardized quality performance reporting framework would not require all payers to adopt identical value-based payment methodologies or financial arrangements but could establish a common standard for the definition, calculation, attribution, benchmarking, and reporting of quality performance information; and

Whereas, quality performance information should be timely, accurate, clinically meaningful, and auditable, with transparent processes that allow physicians and physician organizations to review, validate, dispute, and seek correction of material errors; therefore be it

RESOLVED, that our American Medical Association advocate at the state and federal level for the development and adoption of a standardized quality performance reporting framework across all public and private payers that promotes consistent and actionable information and preserves flexibility for population-specific, program-specific differences when clinically or operationally warranted, while limiting duplicative reporting requirements and unnecessary administrative burdens (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate that standardized quality performance reporting frameworks provide transparent, accessible, and accountable information regarding the measures and specifications used, including the applicable measure version and effective date, attribution and risk-adjustment methodologies, applicable benchmarks and comparison populations, underlying data sources, current and longitudinal performance, and methods for calculating composite scores or other performance measures and ensure quality performance information should be timely, accurate, clinically meaningful, and auditable, with transparent processes that allow physicians and physician organizations to review, validate, dispute, and seek correction of material errors. (Directive to Take Action)

Fiscal Note: Moderate – between $10,000 - $50,000

Received: 11/6/26

References:

1. https://www.federalregister.gov/documents/2026/10/14/2026-21001/statement-of-delegation-of-authority

RELEVANT AMA POLICY

Quality of Care - Essentials and Guidelines for Quality Assessment H-450.995

(1) Including favorable outcome as one characteristic, the AMA believes that medical care of high quality should: (a) produce the optimal possible improvement in the patient's physiologic status, physical function, emotional and intellectual performance and comfort at the earliest time possible consistent with the best interests of the patient;
(b) emphasize the promotion of health, the prevention of disease or disability, and the early detection and treatment of such conditions;
(c) be provided in a timely manner, without either undue delay in initiation of care, inappropriate curtailment or discontinuity, or unnecessary prolongation of such care;
(d) seek to achieve the informed cooperation and participation of the patient in the care process and in decisions concerning that process;
(e) be based on accepted principles of medical science and the proficient use of appropriate technological and professional resources;
(f) be provided with sensitivity to the stress and anxiety that illness can generate, and with concern for the patient's overall welfare;
(g) make efficient use of the technology and other health system resources needed to achieve the desired treatment goal; and
(h) be sufficiently documented in the patient's medical record to enable continuity of care and peer evaluation.

(2) The AMA believes that the following guidelines for quality assessment should be incorporated into any peer review system. (a) The criteria utilized to assess the degree to which medical care exhibits the essential elements of quality should be developed and concurred in by the professionals whose performance will be reviewed.
(b) Such criteria can be derived from any one of the three basic variables of care: structure, process, or outcome. However, emphasis in the review process should be on statistically verifying linkages between specific elements of structure and process, and favorable outcomes, rather than on isolated examination of each variable.
(c) To better isolate the effects of structure and process on outcome, outcome studies should be conducted on a prospective as well as a retrospective basis to the degree possible.
(d) The evaluation of "intermediate" rather than "final" outcomes is an acceptable technique in quality assessment.
(e) Blanket review of all medical care provided is neither practical nor needed to assure high quality of care. Review can be conducted on a targeted basis, a sampling basis, or a combination of both, depending on the goals of the review process. However, judgment as to performance of specific practitioners should be based on assessment of overall practice patterns, rather than solely on

examination of single or isolated cases. By contrast, when general assessment of the quality of care provided by a given health care system or across systems is desired, random sampling of all care episodes may be the more appropriate approach.
(f) Both explicit and implicit criteria are useful in assessing the quality of care.
(g) Prior consultation as appropriate, concurrent and retrospective peer review are all valid aspects of quality assessment.
(h) Any quality assessment program should be linked with a quality assurance system whereby assessment results are used to improve performance.
(i) The quality assessment process itself should be subject to continued evaluation and modification as needed.
Citation: CMS Rep. A, A-86; Reaffirmed: CMS Rep. E, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11; Reaffirmed: BOT Action in response to referred for decision: Res. 718, A-17

Development of Quality Measures with Appropriate Exclusions and Review Processes H-450.927

1. Our American Medical Association will advocate for quality measures, including those in the Hospital Inpatient Quality Reporting Program, to have appropriate exclusions to ensure patient and clinical differences are accounted for and do not interfere with clinical decision making, and for denominators of quality measures to be appropriately defined to ensure patients for whom the treatment may not be appropriate are adjusted for or excluded.
2. Our AMA will advocate for CMS to allow for any proposed quality measures to be reviewed by the appropriate medical specialty societies prior to adoption.

Citation: BOT Action in response to referred for decision:L Res. 811, I-16; Reaffirmed: A-22

Quality Management H-450.966

1. Our AMA continues to advocate for quality management provisions that are consistent with AMA policy.
2. Our AMA seeks an active role in any public or private sector efforts to develop national medical quality and performance standards and measures.
3. Our AMA continues to facilitate meetings of public and private sector organizations as a means of coordinating public and private sector efforts to develop and evaluate quality and performance standards and measures.
4. Our AMA emphasizes the importance of all organizations developing, or planning to develop, quality and performance standards and measures to include actively practicing physicians and physician organizations in the development, implementation, and evaluation of such efforts.
5. Our AMA urges national medical specialty societies and state medical associations to participate in relevant public and private sector efforts to develop, implement, and evaluate quality and performance standards and measures.
6. Our AMA advocates that the following principles be used to guide the development and evaluation of quality and performance standards and measures under federal and state health system reform efforts:
    a. Standards and measures shall have demonstrated validity and reliability.
    b. Standards and measures shall reflect current professional knowledge and available medical technologies.
    c. Standards and measures shall be linked to health outcomes and/or access to care.
    d. Standards and measures shall be representative of the range of health care services commonly provided by those being measured.
    e. Standards and measures shall be representative of episodes of care, as well as team-based care.
    f. Standards and measures shall account for the range of settings and practitioners involved in health care delivery.
    g. Standards and measures shall recognize the informational needs of patients and physicians.
    h. Standards and measures shall recognize variations in the local and regional health care needs of different patient populations.
    i. Standards and measures shall recognize the importance and implications of patient choice and preference.

j. Standards and measures shall recognize and adjust for factors that are not within the direct control of those being measured.
k. Data collection needs related to standards and measures shall not result in undue administrative burden for those being measured.

Citation: BOT Rep. 35, A-94; Reaffirmed: CMS Rep. 10, I-95; Reaffirmed: CMS Rep. 7, A-05; Modified: CMS Rep. 6, A-13; Reaffirmed in lieu of Res 714, A-14; Reaffirmed in lieu of Res. 814, I-14; Reaffirmed in lieu of Res. 2087, A-15; Reaffirmed in lieu of Res. 223, A-15; Reaffirmed in lieu of Res. 203, I-15; Reaffirmed in lieu of Res. 216, I-15; Reaffirmed: BOT Rep. 20, A-16; Reaffirmed: CMS Rep. 02, I-17; Reaffirmed: A-22; Reaffirmed: CMS Rep. 07, A-25

Health Plan "Report Cards" H-450.961

1. Our American Medical Association supports the development and appropriate use of health plan performance standards.
2. Our AMA urges all organizations that are developing, or planning to develop, health plan performance measures to include actively practicing physicians, physician organizations, and consumers in the development, evaluation and refinement of such measures.
3. Our AMA urges all organizations that are developing health plan performance measures to work toward greater uniformity both in the content of such measures and in the formulas used for calculating performance results.
4. Our AMA encourages national medical specialty societies and state medical associations to participate in the development, evaluation, and refinement of health plan performance measures.
5. Our AMA advocates that individual health plans, government entities, private sector accreditation organizations and others that develop performance measures for use in programs to evaluate the performance of health plans adhere to the following principles:
    a. Health plan performance measures shall be developed for a variety of users, including health care purchasers, physicians and other health care providers, and the public.
    b. The involvement of actively practicing physicians and physician organizations in the development, evaluation, refinement, and use of health plan performance measures shall be essential.
    c. Health plan performance measures shall include an appropriate mix of process-oriented and outcomes-oriented measures.
    d. Health plan performance measures shall be representative of the full range of services typically provided by health plans, including preventive services.
    e. The limitations of data sources used in health plan performance measures shall be clearly identified and acknowledged.
    f. Valid health plan performance data collection and analysis methodologies, including establishment of statistically significant sample sizes for areas being measured, shall be developed.
    g. Performance data used to compare performance among health plans shall be adjusted for severity of illness, differences in case-mix, and other variables such as age, sex, and occupation and socioeconomic status.
    h. Health plan performance data that are self-reported by health plans shall be verified through external audits.
    i. The methods and measures used to evaluate health plan performance shall be disclosed to health plans, physicians and other health care providers, and the public.
    j. Health plans being evaluated shall be provided with an adequate opportunity to review and respond to proposed health plan performance data interpretations and disclosures prior to their publication or release.
    k. Effective safeguards to protect against the unauthorized use or disclosure of health plan performance data shall be developed.
    l. The validity and reliability of health plan performance measures shall be evaluated regularly.

Citation: CMS Rep. 10, I-95; Reaffirmed: CMS Rep. 7, A-05; Reaffirmed; A-11; Reaffirmed: CMS Rep. 1, A-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 237
(I-26)

Introduced by: Private Practice Physicians Section

Subject: Action Regarding CMS Authority to Exclude Entities from Medicare, Medicaid, and Federal Health Care Programs

Referred to: Reference Committee B

Whereas, on October 14, the Department of Health and Human Services (HHS) formally granted the Centers for Medicare and Medicaid Services (CMS) the independent authority to exclude providers, suppliers, and other entities from Medicare, Medicaid, and all other health care programs (1); and

Whereas, previously, the HHS Office of Inspector General (OIG) was the sole agency authorized to enforce these exclusions, a power it typically exercised only following extensive investigations, with a process for the physician or other entity to offer a defense; and

Whereas, as the current administration has demonstrated opposition to the delivery of specific parts of health care such as reproductive care and transgender care, there is a reasonable concern that physicians who offer these services could find themselves excluded from Federal programs; and

Whereas, any attempt to punish any physician for delivering evidence-based care is a threat to the autonomy of all physicians, and the restriction on any one specialty can easily become a restriction on any other specialty; and

Whereas, October 14, 2026, was far beyond any resolution deadline for I-26; therefore be it

RESOLVED, that our American Medical Association oppose any unilateral authority granted by the Department of Health and Human Services (HHS) to the Centers for Medicare & Medicaid Services (CMS) to exclude physicians or entities from federal healthcare programs without full administrative due process and rights to appeal (New HOD Policy); and be it further

RESOLVED, that our AMA oppose the use of federal healthcare program exclusion authority targeting physicians or entities for providing lawful, evidence-based care—including reproductive and transgender healthcare—or for non-clinical, political, or ideological reasons (New HOD Policy); and be it further

RESOLVED, that our AMA investigate and pursue appropriate legislative or legal actions to safeguard physician due process following the October 2026 delegation of exclusion authority to the Centers for Medicare & Medicaid Services (Directive to Take Action); and be it further

RESOLVED, that our AMA report back to the House of Delegates on the October 2026 delegation of exclusion authority to CMS at the 2027 Annual Meeting. (Directive to Take Action).

Fiscal Note: Moderate – between $10,000 - $50,000

Received: 11/6/26

REFERENCES

1. https://www.federalregister.gov/documents/2026/10/14/2026-21001/statement-of-delegation-of-authority

RELEVANT AMA POLICY

Exclusion of Physicians by Managed Care Health Plans H-285.992
The AMA will seek federal legislation and/or support the efforts of state medical societies to seek state legislation which would prohibit health care plans that have attained a certain percentage of patient enrollment or market power from denying a physician the right to enter into a contractual agreement with the health care plan if the physician is qualified and is willing to meet the terms and conditions established in that contractual agreement.
Citation: Res, 724, A-93; Reaffirmed: BOT Rep. 28, A-03; Reaffirmed: CMS Rep. 4, A-13; Reaffirmed: A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 238
(I-26)

Introduced by: Resident and Fellow Section, Underrepresented in Medicine Advocacy Section

Subject: Timely Processing of DACA Renewal Applications

Referred to: Reference Committee B

Whereas, Deferred Action for Childhood Arrivals (DACA) is a program created in 2012 that protects individuals who were brought to the United States (US) as undocumented children from deportation and provides them with work authorization[1-3]; and

Whereas, to be eligible for DACA, individuals must have entered the US before reaching 16 years of age and must have arrived before June 15, 2007; on average, DACA recipients were seven years old at entry to the US and lived in the US for 20 years prior to the initiation of DACA[1-3]; and

Whereas, as of June 2025, approximately 27,000 healthcare workers and support staff were current DACA recipients, including nearly 200 medical students, residents, and physicians[4]; and

Whereas, the AMA estimates that each medical student, resident, or physician who is a DACA recipient and who retains work eligibility cares for between 1,533 and 4,600 patients annually[4,5]; and

Whereas, DACA recipient health professionals often work in rural and underserved locations, helping alleviate the strain on the US healthcare system in particularly under-resourced areas[6]; and

Whereas, every two years, DACA recipients must resubmit an application to the United States Citizenship and Immigration Services (USCIS) in order to maintain their lawful deferred action status under DACA, which protects them from deportation, and renew their work permits[7]; and

Whereas, the USCIS approved only 53,855 DACA renewals in the first half of fiscal year (FY) 2026, a 63% decrease from the nearly 145,000 renewals approved in the first half of FY 2025, and there are currently 120,000 pending DACA renewal applications—the highest number pending ever—compared to only 37,000 pending renewals at the same point last year[1]; and

Whereas, the number of DACA recipients in September 2024 was 538,000 but has decreased steadily to 455,000 in March 2026, a drop of nearly 83,000 individuals, with an increasingly accelerating rate of loss of DACA recipients[1]; and

Whereas, although the number of active DACA recipients has previously fluctuated over time, the recent decline has been notably sustained and pronounced, which experts attribute to the reduction in processing of and prolonged processing time for DACA recipients' renewals[1]; and

Whereas, DACA recipients report financial and emotional strain from the extraordinarily delays in processing their submitted renewals, with no satisfactory response to repeated inquiries to the USCIS about the extended processing time[6,8-10]; and

Whereas, after lengthy lapses, DACA recipients and immigrant rights groups have sued the administration for records and information[9,10]; and

Whereas, the months-long delay in renewal processing can put legal DACA recipients in a perilous financial situation, disrupts trainees' education, and jeopardizes the already strained healthcare workforce; lapse in DACA status due to these delays after timely submission has resulted in detention and even deportation of DACA recipients[6,8,11-14]; and

Whereas, the AMA has previously affirmed support for DACA recipients and recognized their contributions to the healthcare workforce (H-65.932; H-255.959; D-255.980; D-295.302; D-350.986); DACA recipients are our colleagues, coworkers, and patients, and they deserve the dignity and the protections the law was written to provide them; therefore be it

RESOLVED, that our American Medical Association will advocate for timely processing of Deferred Action for Childhood Arrivals (DACA) renewal requests and employment authorization applications, including sufficient federal administrative capacity and processes to minimize lapses in deferred action and work authorization caused by processing delays (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for policies that protect DACA recipients from interruptions in employment, training, or clinical practice resulting from delays in the adjudication of timely filed DACA renewal requests. (Directive to Take Action)

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

Received: 11/6/26

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RELEVANT AMA POLICY

Reducing the Harmful Impacts of Immigration Status on Health H-65.932

1. Our American Medical Association supports protecting the human right to seek asylum.
2. Our AMA supports pathways to citizenship for undocumented immigrants who entered the US as minors, including Deferred Action for Childhood Arrivals (DACA), temporary protected status (TPS) recipients, and Dreamers.
3. Our AMA supports family reunification pathways for children and adult immigrants from other countries if their parent/guardian, spouse, or child/dependent has documented status in the U.S.
4. Our AMA supports deferral of deportation (and if applicable, employment authorization, driver's licenses, and identification documents) for people with disabilities and significantly limiting chronic illness, people who work in healthcare and social care, and relatives of people with documented or DACA status, and people without violent felonies.
5. Our AMA supports federal and state efforts to remove immigration enforcement from workplaces and employment consideration, including the removal of E-Verify mandates.

[Res. 004, A-25; Reaffirmed: Res. 252, A-26]

Immediate Action to Prevent Further Immigrant Deaths H-160.878

1. Our American Medical Association supports efforts to ensure health care facilities effectively serve as sensitive locations, without deterring immigrants seeking care, by supporting policies that:
    a. make immigration status and place of birth protected health information;
    b. prohibit immigration agents from entering nonpublic, patient-sensitive areas of health care facilities without a warrant signed by a judge;
    c. encourage health care facilities to adopt minimum enforceable guidelines for interactions with immigration enforcement authorities; and
    d. oppose mandated inquiries about patient immigration status in health care facilities.
2. Our AMA will advocate in an urgent, timely manner to protect immigrant health, safety, and access to care as directed by HOD policies related to the deportation, detention, and health and safety for all immigrants, migrants, refugees, detainees, and asylum seekers.

[Res. 252, A-26]

Protecting and Promoting Long Term Care Workforce Amidst Immigration Challenges H-255.959

1. Our American Medical Association opposes administrative or regulatory actions that exacerbate staffing shortages or threaten access to long term care when such actions are not accompanied by adequate workforce supply and training, immigration pathways, and funding support.
2. Our AMA supports immigration policies that protect, retain, and expand the long-term care workforce, including timely work authorization, efficient visa processing, and protections against abrupt workforce disruptions for immigrant health care workers.

]Res. 231, A-26]

Protecting Resident Physicians with Pending Immigration Status and Ensuring Safe Participation in Professional Activities D-255.964

1. Our American Medical Association urgently advocates on behalf of non-US citizen physicians and trainees with pending visa adjudication, including those who have recently matched.
2. Our AMA supports the development and dissemination of a list of federal and national resources for medical schools and residency and fellowship programs in helping medical students, residents, and fellows with indeterminate visa statuses.

[Res. 250, A-26]

Impact of Immigration Barriers on the Nation's Health D-255.980

1. Our American Medical Association recognizes the valuable contributions and affirms our support of international medical students and international medical graduates and their participation in U.S. medical schools, residency and fellowship training programs and in the practice of medicine.
2. Our AMA will oppose laws and regulations that would broadly deny entry or re-entry to the United States of persons who currently have legal visas, including permanent resident status (green card) and student visas, based on their country of origin and/or religion.
3. Our AMA will oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion.
4. Our AMA will advocate for the immediate reinstatement of premium processing of H-1B visas for physicians and trainees to prevent any negative impact on patient care.
5. Our AMA will advocate for the timely processing of visas for all physicians, including residents, fellows, and physicians in independent practice.
6. Our AMA will work with other stakeholders to study the current impact of immigration reform efforts on residency and fellowship programs, physician supply, and timely access of patients to health care throughout the U.S.

[Alt. Res. 308, A-17; Modified: CME Rep. 01, A-18; Reaffirmation: A-19; Reaffirmed: CME Rep. 4, A-21; Reaffirmed: Res. 234, A-22; Reaffirmed: Res. 210, A-23; Reaffirmed: Res. 207, A-26; Reaffirmed: Res. 226, A-26]

Increased Inclusivity and Admission Policies Clarification for DACA-Eligible Medical School and Residency Applicants D-295.302

a.) Our American Medical Association will commend the Association of American Medical Colleges (AAMC) for its collection of data on medical schools that accept applicants eligible for Deferred Action for Childhood Arrivals (DACA) and encourage ongoing data collection.
b.) Our AMA will request that the AAMC expand its data collection to include financial assistance options for DACA-eligible students.
c.) Our AMA will publicize and disseminate this information to interested parties.
[Res. 308, A-23]

Immigration Status is a Public Health Issue D-350.975

1. Our American Medical Association declares that immigration status is a public health issue that requires a comprehensive public health response and solution.
2. Our AMA recognizes interpersonal, institutional, structural, and systemic factors that negatively affect immigrants' health.
3. Our AMA will promote the development and implementation of educational resources for healthcare professionals to better understand health and healthcare challenges specific for the immigrant population.
4. Our AMA will support the development and implementation of public health policies and programs that aim to improve access to healthcare and minimize systemic health barriers for immigrant communities.

[Res. 904, I-22; Reaffirmed: Res. 210, A-23]

Evaluation of DACA-Eligible Medical Students, Residents and Physicians in Addressing Physician Shortages D-350.986

1. Our American Medical Association will study the issue of Deferred Action for Childhood Arrivals-eligible medical students, residents, and physicians and consider the opportunities for their participation in the physician profession and report its findings to the House of Delegates.

2. Our AMA will issue a statement in support of current US healthcare professionals, including those currently training as medical students or residents and fellows, who are Deferred Action for Childhood Arrivals recipients.
[Res. 305, A-15; Appended: Late Res. 1001, I-16; Reaffirmation: A-19]

Mass Deportation as a Public Health Issue H-440.793

1. Our American Medical Association recognizes mass deportation of immigrants, asylum seekers, refugees, and others with or seeking an immigration benefit as a public health issue, and recognizes the long-term mental and physical health implications of deportation on individuals, families, and communities.
2. Our AMA opposes deportation of health care workers and medically vulnerable patients solely based on their documentation status.
3. Our AMA opposes the large-scale internment of individuals targeted for deportation efforts.

[Res. 931, I-24; Reaffirmed: Res. 216, A-26; Reaffirmed: Res. 252, A-26]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 239
(I-26)

Introduced by: Resident and Fellow Section

Subject: Protecting the Integrity of Public Participation in Federal Health Policymaking

Referred to: Reference Committee B

Whereas, transparent, accountable, and apolitical public comment processes are essential to meaningful public participation and democratic governance[1-3]; and

Whereas, public comment processes provide physicians, patients, researchers, medical organizations, community leaders, and other relevant parties a critical opportunity to contribute evidence, expertise, and lived experience to the development of federal health policy[1,3,4]; and

Whereas, federal policies governing health care, biomedical research, public health, medical education, and the physician workforce can profoundly affect patient outcomes, scientific progress, access to care, and physician practice[5,6]; and

Whereas, legitimate and lawful reasons may exist to redact protected information, withhold impermissible content, or consolidate duplicate comments, including to protect privacy and confidentiality as well as address threats, spam, unlawful content, or copyright restrictions[7]; and

Whereas, in August 2026, 42 public comments concerning a proposed Office of Management and Budget (OMB) overhaul of federal grantmaking were reported to have been removed from public display on Regulations.gov after initially being posted, without a publicly stated explanation for their removal, raising questions regarding transparency, accountability, and the integrity of the federal public comment process[8,9]; and

Whereas, at least 10 of the removed comments reportedly referenced that the daughter of OMB Director Russell Vought, who has cystic fibrosis, had benefited from Trikafta (and her diagnosis and treatment had been made public in advocacy by her family), a therapy whose development was supported in part by federally funded biomedical research[8,10]; and

Whereas, our American Medical Association has existing policy addressing political interference in scientific peer review (D-460.956) but lacks policy establishing standards for transparency, preservation, and auditability of public comments in federal health-related policymaking; therefore be it

RESOLVED, that our American Medical Association support transparent, viewpoint-neutral standards for publication, redaction, withholding, and removal of public comments in federal health policymaking (New HOD Policy); and be it further

RESOLVED, that our AMA advocate that federal health agencies publicly document the basis for removing, withholding, or redacting public comments and preserve an auditable record of such actions, consistent with applicable privacy, safety, and legal protections. (Directive to Take Action)

Fiscal Note: Moderate – between $10,000 - $50,000

Received: 11/6/26

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RELEVANT AMA POLICY

OMB Proposed Rule: Regulation for Federal Financial Assistance D-460.956

1. Our American Medical Association expresses its strong support for the scientific peer review process, academic journal independence and the immense value of merit-based scientific investments unimpeded by political interference.
2. Our AMA will submit comments during the public comment period expressing our strong concerns with the proposed rule titled "Regulation for Federal Financial Assistance" (91 Federal Register 32198) issued on May 29, 2026.
3. Our AMA will consider taking legal action to challenge implementation of the proposed Office of Management and Budget (OMB) rule titled "Regulation for Federal Financial Assistance" (91 Federal Register 32198) issued on May 29, 2026.

[Res. 254, A-26]

Supporting the Health of Our Democracy H-65.936

1. Our American Medical Association supports policies that ensure safe and equitable access to voting and opposes the institutional barriers to the process of voter registration.
2. Our AMA encourages physicians and medical trainees to vote, eliminate barriers to their participation in the electoral process, and support their and other healthcare workers' engagement in all voter registration efforts in healthcare settings, including emergency absentee ballot procedures for qualifying patients, visitors, and healthcare workers.
3. Our AMA supports the use of independent, nonpartisan commissions to draw districts for both federal and state elections.

[Res. 019, A-24]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 240
(I-26)

Introduced by: Young Physicians Section

Subject: Minimizing Patient Harm from Autonomous Artificial Intelligence

Referred to: Reference Committee B

Whereas, recent claims by the government and industry representatives raise urgent concern and warrant consideration of this late resolution at the Interim 2026 YPS Assembly[1,2]; and

Whereas, on September 22, 2026 HHS Secretary Robert F. Kennedy Jr. stated that artificial intelligence (AI) "can give you a second opinion that is much better informed than any doctor in the country", and he relayed a claim by OpenAI founder Sam Altman that "it would be malpractice" if physicians diagnosed or prescribed without consulting AI, resulting in six national physician organizations, including the AMA, issuing a joint statement reiterating physician leadership in the responsible development and use of AI, but without specific demands[1,2,3]; and

Whereas, recent misleading claims of AI equivalence or superiority to physicians based on its performance on limited or simulated clinical tasks –including "The first AI system legally authorized to practice medicine" and "The first ever end-to-end AI doctor"– have dangerous implications for patient safety, public trust, and the physician-patient relationship[4,5,6,7]; and

Whereas, Delaware House Bill 191 passed and enacted in 2026 prohibits non-human entities, including AI agents, from being certified to practice medicine or assigned titles reserved for physicians, and while it provides a legislative model to protect patients from misrepresentation of AI systems as licensed healthcare professionals, was limited in its scope[8]; and

Whereas, autonomous AI substitution of physicians negatively alters the healthcare team and physician-patient relationship that depend upon individualized assessment and communication, shared decision-making, clinical judgment, and professional accountability, for which the AMA recognizes physicians as being the best qualified by their education and training[3,9]; and

Whereas, AMA actions and statements to-date have failed to protect patients and physicians from: interests that seek to equate the limited scope of AI systems to the role of physicians, liability arising from use and non-use of AI recommendations, AI patient data safety and consent lapses, and rapid AI implementation in healthcare[3,4,10,11,12]; therefore be it

RESOLVED, that our American Medical Association vocally oppose granting (or equating) artificial intelligence systems or other non-human entities with physician licensure, professional titles, or certification to practice medicine; and amend existing policy H-480.931, "Assessing the Intersection Between AI and Health Care" by addition:

i. Medical specialty societies, clinical experts, and informaticists are best positioned and should identify the most appropriate uses of AI-enabled technologies relevant to their clinical expertise and set the standards for AI use in their specific domain. [See Augmented Intelligence in Health Care H-480.940 at (2)]

j. Artificial intelligence systems or other non-human entities should not be equated with physician licensure, professional titles, or certification to practice medicine (Directive to Take Action); and be it further

RESOLVED, that our AMA create and disseminate model legislation that, at a minimum:

- Prohibits misrepresentation of non-human entities with titles reserved for physicians,
- Defines distinctions between authorization of medical technology and professional licensure,
- Prohibits non-human entities from performing clinical tasks traditionally associated with the practice of medicine without real-world evidence of superior safety and efficacy and board eligible/certified physician oversight,
- Prohibits artificial intelligence (AI) developers from prospectively collecting clinical patient data for proprietary or research purposes without explicit authorization by the patient,
- Creates a liability framework protecting physicians' independent decision-making from liability arising from non-use of AI recommendations or non-use of AI tools in general,
- Creates a robust supervision framework for physician oversight of AI clinical decision-making with adequate physician reimbursement for such supervision (Directive to Take Action); and be it further

RESOLVED, that our AMA amend current policy D-480.947, "Prohibiting the Independent Practice of Medicine by Artificial Intelligence" by addition:

1. Our American Medical Association advocates for legislation and regulation related to the use of augmented and/or artificial intelligence (AI) in autonomous or semiautonomous circumstances in healthcare (including diagnostics, prescriptions, care management, or other functions) requiring that such tools must:
    a. integrate with the physician-led team and be used at the direction of the treating physician,
    b. respect the continuity of care and best practices related to transitions of care,
    c. have transparent, auditable data demonstrating safety and efficacy,
    d. be subject to relevant and appropriate regulations (including but not limited to those related to liability and documentation), and
    e. adhere to our AMA policy on Augmented Intelligence in Health Care; and be it further
2. Our AMA will study emerging concepts around the regulation and licensure of autonomous and semiautonomous augmented and/or artificial intelligence performing clinical functions, their potential impact on the profession and the physician-patient relationship, and the changing implications of autonomous artificial intelligence in clinical care, including proposals to license or certify non-human entities to assume roles of healthcare professionals. (Modify Current HOD Policy)

Fiscal Note:

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RELEVANT AMA POLICY

D-35.985, Support for Physician Led, Team Based Care

1. Our American Medical Association reaffirms, will proactively advance at the federal and state level, and will encourage state and national medical specialty societies to promote policies H-35.970, H-35.973, H-35.974, H-35.988, H-35.989, H-35.992, H-35.993, H-160.919, H-160.929, H-160.947, H-160.949, H-160.950, H-360.987, H 405.969 and D-35.988.
2. Our AMA will identify and review available data to analyze the effects on patients? access to care in the opt-out states (states whose governor has opted out of the federal Medicare physician supervision requirements for anesthesia services) to determine whether there has been any increased access to care in those states.
3. Our AMA will identify and review available data to analyze the type and complexity of care provided by all non-physician providers, including CRNAs in the opt-out states (states whose governor has opted out of the federal Medicare physician supervision requirements for anesthesia services), compared to the type and complexity of care provided by physicians and/or the anesthesia care team.
4. Our AMA will advocate to policymakers, insurers and other groups, as appropriate, that they should consider the available data to best determine how non-physicians can serve as a complement to address the nation's primary care workforce needs.
5. Our AMA will continue to recognize non-physician providers as valuable components of the physician-led health care team.
6. Our AMA will continue to advocate that physicians are best qualified by their education and training to lead the health care team.
7. Our AMA will call upon the Robert Wood Johnson Foundation to publicly announce that the report entitled, "Common Ground: An Agreement between Nurse and Physician Leaders on Interprofessional Collaboration for the Future of Patient Care" was premature; was not released officially; was not signed; and was not adopted by the participants.

H-480.939, Augmented Intelligence in Health Care

Our American Medical Association supports the use and payment of augmented intelligence (AI) systems that advance the quadruple aim. AI systems should enhance the patient experience of care and outcomes, improve population health, reduce overall costs for the health care system while increasing value, and support the professional satisfaction of physicians and the health care team. To that end our AMA will advocate that:

1. Oversight and regulation of health care AI systems must be based on risk of harm and benefit accounting for a host of factors, including but not limited to: intended and reasonably expected use(s); evidence of safety, efficacy, and equity including addressing bias; AI system methods; level of automation; transparency; and, conditions of deployment.
2. Payment and coverage for all health care AI systems must be conditioned on complying with all appropriate federal and state laws and regulations, including, but not limited to those governing patient safety, efficacy, equity, truthful claims, privacy, and security as well as state medical practice and licensure laws.
3. Payment and coverage for health care AI systems intended for clinical care must be conditioned on
    a. clinical validation.
    b. alignment with clinical decision-making that is familiar to physicians.
    c. high-quality clinical evidence.
4. Payment and coverage for health care AI systems must
    a. be informed by real world workflow and human-centered design principles.
    b. enable physicians to prepare for and transition to new care delivery models.
    c. support effective communication and engagement between patients, physicians, and the health care team.
    d. seamlessly integrate clinical, administrative, and population health management functions into workflow.
    e. seek end-user feedback to support iterative product improvement.
5. Payment and coverage policies must advance affordability and access to AI systems that are designed for small physician practices and patients and not limited to large practices and institutions. Government-conferred exclusivities and intellectual property laws are meant to foster innovation, but constitute interventions into the free market, and therefore, should be appropriately balanced with the need for competition, access, and affordability.
6. Physicians should not be penalized if they do not use AI systems while regulatory oversight, standards, clinical validation, clinical usefulness, and standards of care are in flux. Furthermore, our AMA opposes:
    a. Policies by payers, hospitals, health systems, or governmental entities that mandate use of health care AI systems as a condition of licensure, participation, payment, or coverage.
    b. The imposition of costs associated with acquisition, implementation, and maintenance of healthcare AI systems on physicians without sufficient payment.
7. Liability and incentives should be aligned so that the individual(s) or entity(ies) best positioned to know the AI system risks and best positioned to avert or mitigate harm do so through design, development, validation, and implementation. Our AMA will further advocate:
    a. Where a mandated use of AI systems prevents mitigation of risk and harm, the individual or entity issuing the mandate must be assigned all applicable liability.

   b. Developers of autonomous AI systems with clinical applications (screening, diagnosis, treatment) are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users.
   c. Health care AI systems that are subject to non-disclosure agreements concerning flaws, malfunctions, or patient harm (referred to as gag clauses) must not be covered or paid and the party initiating or enforcing the gag clause assumes liability for any harm.
8. Our AMA, national medical specialty societies, and state medical associations:
   a. Identify areas of medical practice where AI systems would advance the quadruple aim.
   b. Leverage existing expertise to ensure clinical validation and clinical assessment of clinical applications of AI systems by medical experts.
   c. Outline new professional roles and capacities required to aid and guide health care AI systems.
   d. Develop practice guidelines for clinical applications of AI systems.
9. There should be federal and state interagency collaboration with participation of the physician community and other stakeholders in order to advance the broader infrastructural capabilities and requirements necessary for AI solutions in health care to be sufficiently inclusive to benefit all patients, physicians, and other health care stakeholders. (New HOD Policy)
10. AI is designed to enhance human intelligence and the patient-physician relationship rather than replace it.

H-480.391, Assessing the Intersection Between AI and Health Care

1. General Governance
   a. Health care AI must be designed, developed, and deployed in a manner which is ethical, equitable, responsible, accurate, transparent, and evidence-based.
   b. Use of AI in health care delivery requires clear national governance policies to regulate its adoption and utilization, ensuring patient safety, and mitigating inequities. Development of national governance policies should include interdepartmental and interagency collaboration.
   c. Compliance with national governance policies is necessary to develop AI in an ethical and responsible manner to ensure patient safety, quality, and continued access to care. Voluntary agreements or voluntary compliance is not sufficient.
   d. AI systems should be developed and evaluated with a specific focus on mitigating bias and promoting health equity, ensuring that the deployment of these technologies does not exacerbate existing disparities in health care access, treatment, or outcomes.
   e. Health care AI requires a risk-based approach where the level of scrutiny, validation, and oversight should be proportionate to the overall potential of disparate harm and consequences the AI system might introduce [See also Augmented Intelligence in Health Care H-480.939 at (1)]
   f. AI risk management should minimize potential negative impacts of health care AI systems while providing opportunities to maximize positive impacts.
   g. Clinical decisions influenced by AI must be made with specified qualified human intervention points during the decision-making process. A qualified human is defined as a licensed physician with the necessary qualifications and training to independently provide the same medical service without the aid of AI. As the potential for patient harm increases, the point in time when a physician should utilize their clinical judgment to interpret or act on an AI recommendation should occur earlier in the care plan. With few exceptions, there generally should be a qualified human in the loop when it comes to medical decision making capable of intervening or overriding the output of an AI model.
   h. Health care practices and institutions should not utilize AI systems or technologies that introduce overall or disparate risk that is beyond their capabilities to mitigate. Implementation and utilization of AI should avoid exacerbating clinician burden and should be designed and deployed in harmony with the clinical workflow and, in institutional settings, consistent with AMA Policy H-225.940 - Augmented Intelligence and Organized Medical Staff.
   i. Medical specialty societies, clinical experts, and informaticists are best positioned and should identify the most appropriate uses of AI-enabled technologies relevant to their clinical expertise and set the standards for AI use in their specific domain. [See Augmented Intelligence in Health Care H-480.940 at (2)]
2. When to Disclose: Transparency in Use of Augmented Intelligence-Enabled Systems and Technologies That Impact Medical Decision Making at the Point of Care
   a. Decisions regarding transparency and disclosure of the use of AI should be based upon a risk- and impact-based approach that considers the unique circumstance of AI and its use case. The need for transparency and disclosure is greater where the performance of an AI-enabled technology has a greater risk of causing harm to a patient.
      i. AI disclosure should align and meet ethical standards or norms.
      ii. Transparency requirements should be designed to meet the needs of the end users. Documentation and disclosure should enhance patient and physician knowledge without increasing administrative burden.
      iii. When AI is used in a manner which impacts access to care or impacts medical decision making at the point of care, that use of AI should be disclosed and documented to both physicians and/or patients in a culturally and linguistically appropriate manner. The opportunity for a patient or their caregiver to request additional review from a licensed clinician should be made available upon request.
      iv. When AI is used in a manner which directly impacts patient care, access to care, medical decision making, or the medical record, that use of AI should be documented in the medical record.
   b. AI tools or systems cannot augment, create, or otherwise generate records, communications, or other content on behalf of a physician without that physician's consent and final review.
   c. When AI or other algorithmic-based systems or programs are utilized in ways that impact patient access to care, such as by payors to make claims determinations or set coverage limitations, use of those systems or programs must be disclosed to impacted parties.
   d. The use of AI-enabled technologies by hospitals, health systems, physician practices, or other entities, where patients engage directly with AI, should be clearly disclosed to patients at the beginning of the encounter or interaction with the AI-enabled technology. Where patient-facing content is generated by AI, the use of AI in generating that content should be disclosed or otherwise noted within the content.

3. What to Disclose: Required Disclosures by Health Care Augmented Intelligence-Enabled Systems and Technologies
    a. When AI-enabled systems and technologies are utilized in health care, the following information should be disclosed by the AI developer to allow the purchaser and/or user (physician) to appropriately evaluate the system or technology prior to purchase or utilization:
        i. Regulatory approval status.
        ii. Applicable consensus standards and clinical guidelines utilized in design, development, deployment, and continued use of the technology.
        iii. Clear description of problem formulation and intended use accompanied by clear and detailed instructions for use.
        iv. Intended population and intended practice setting.
        v. Clear description of any limitations or risks for use, including possible disparate impact.
        vi. Description of how impacted populations were engaged during the AI lifecycle.
        vii. Detailed information regarding data used to train the model:
            1. Data provenance.
            2. Data size and completeness.
            3. Data timeframes.
            4. Data diversity.
            5. Data labeling accuracy.
        viii. Validation Data/Information and evidence of:
            1. Clinical expert validation in intended population and practice setting and intended clinical outcomes.
            2. Constraint to evidence-based outcomes and mitigation of “hallucination”/“confabulation” or other output error.
            3. Algorithmic validation.
            4. External validation processes for ongoing evaluation of the model performance, e.g., accounting for AI model drift and degradation.
            5. Comprehensiveness of data and steps taken to mitigate biased outcomes.
            6. Other relevant performance characteristics, including but not limited to performance characteristics at peer institutions/similar practice settings.
            7. Post-market surveillance activities aimed at ensuring continued safety, performance, and equity.
        ix. Data Use Policy:
            1. Privacy.
            2. Security.
            3. Special considerations for protected populations or groups put at increased risk.
        x. Information regarding maintenance of the algorithm, including any use of active patient data for ongoing training.
        xi. Disclosures regarding the composition of design and development team, including diversity and conflicts of interest, and points of physician involvement and review.
    b. Purchasers and/or users (physicians) should carefully consider whether or not to engage with AI-enabled health care technologies if this information is not disclosed by the developer. As the risk of AI being incorrect increases risks to patients (such as with clinical applications of AI that impact medical decision making), disclosure of this information becomes increasingly important. [See also Augmented Intelligence in Health Care H-480.939]

4. Generative Augmented Intelligence
    a. Generative AI should: (a) only be used where appropriate policies are in place within the practice or other health care organization to govern its use and help mitigate associated risks; and (b) follow applicable state and federal laws and regulations (e.g., HIPAA-compliant Business Associate Agreement).
    b. Appropriate governance policies should be developed by health care organizations and account for and mitigate risks of:
        i. Incorrect or falsified responses; lack of ability to readily verify the accuracy of responses or the sources used to generate the response.
        ii. Training data set limitations that could result in responses that are out of date or otherwise incomplete or inaccurate for all patients or specific populations.
        iii. Lack of regulatory or clinical oversight to ensure performance of the tool.
        iv. Bias, discrimination, promotion of stereotypes, and disparate impacts on access or outcomes.
        v. Data privacy.
        vi. Cybersecurity.
        vii. Physician liability associated with the use of generative AI tools.
    c. Health care organizations should work with their AI and other health information technology (health IT) system developers to implement rigorous data validation and verification protocols to ensure that only accurate, comprehensive, and bias managed datasets inform generative AI models, thereby safeguarding equitable patient care and medical outcomes. [See Augmented Intelligence in Health Care H-480.940 at (3)(d)]
    d. Use of generative AI should incorporate physician and staff education about the appropriate use, risks, and benefits of engaging with generative AI. Additionally, physicians and healthcare organizations should engage with generative AI tools only when adequate information regarding the product is provided to physicians and other users by the developers of those tools.
    e. Clinicians should be aware of the risks of patients engaging with generative AI products that produce inaccurate or harmful medical information (g., patients asking chatbots about symptoms) and should be prepared to counsel patients on the limitations of AI-driven medical advice.
    f. Data and prompts contributed by users should primarily be used by developers to improve the user experience and AI tool quality and not simply increase the AI tool’s market value or revenue generating potential.
5. Physician Liability for Use of Augmented Intelligence-Enabled Technologies

a. Current AMA policy states that liability and incentives should be aligned so that the individual(s) or entity(ies) best positioned to know the AI system risks and best positioned to avert or mitigate harm do so through design, development, validation, and implementation. [See Augmented Intelligence in Health Care H-480.939]
    i. Where a mandated use of AI systems prevents mitigation of risk and harm, the individual or entity issuing the mandate must be assigned all applicable liability.
    ii. Developers of autonomous AI systems with clinical applications (screening, diagnosis, treatment) are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users.
    iii. Health care AI systems that are subject to non-disclosure agreements concerning flaws, malfunctions, or patient harm (referred to as gag clauses) must not be covered or paid and the party initiating or enforcing the gag clause assumes liability for any harm.
b. When physicians do not know or have reason to know that there are concerns about the quality and safety of an AI-enabled technology, they should not be held liable for the performance of the technology in question.
c. Liability protections for physicians using AI-enabled technologies should align with both current and future AMA medical liability reform policies.

6. Data Privacy and Augmented Intelligence
    a. Entity Responsibility:
        i. Entities, e.g., AI developers, should make information available about the intended use of generative AI in health care and identify the purpose of its use. Individuals should know how their data will be used or reused, and the potential risks and benefits.
        ii. Individuals should have the right to opt-out, update, or request deletion of their data from generative AI tools. These rights should encompass AI training data and disclosure to other users of the tool.
        iii. Generative AI tools should not reverse engineer, reconstruct, or reidentify an individual's originally identifiable data or use identifiable data for nonpermitted uses, e.g., when data are permitted to conduct quality and safety evaluations. Preventive measures should include both legal frameworks and data model protections, e.g., secure enclaves, federated learning, and differential privacy.
    b. User Education:
        i. Users should be provided with training specifically on generative AI. Education should address:
            1. Legal, ethical, and equity considerations.
            2. Risks such as data breaches and re-identification.
            3. Potential pitfalls of inputting sensitive and personal data.
            4. The importance of transparency with patients regarding the use of generative AI and their data.

[See H-480.940, Augmented Intelligence in Health Care, at (4) and (5)]

7. Augmented Intelligence Cybersecurity
    a. AI systems must have strong protections against input manipulation and malicious attacks.
    b. Entities developing or deploying health care AI should regularly monitor for anomalies or performance deviations, comparing AI outputs against known and normal behavior.
    c. Independent of an entity's legal responsibility to notify a health care provider or organization of a data breach, that entity should also act diligently in identifying and notifying the individuals themselves of breaches that impact their personal information.
    d. Users should be provided education on AI cybersecurity fundamentals, including specific cybersecurity risks that AI systems can face, evolving tactics of AI cyber attackers, and the user's role in mitigating threats and reporting suspicious AI behavior or outputs.
8. Mitigating Misinformation in AI-Enabled Technologies
    a. AI developers should ensure transparency and accountability by disclosing how their models are trained and the sources of their training data. Clear disclosures are necessary to build trust in the accuracy and reliability of the information produced by AI systems.
    b. Algorithms should be developed to detect and flag potentially false and misleading content before it is widely disseminated.
    c. Developers of AI should have mechanisms in place to allow for reporting of mis- and disinformation generated or propagated by AI-enabled systems.
    d. Developers of AI systems should be guided by policies that emphasize rigorous validation and accountability for the content their tools generate, and, consistent with AMA Policy H-480.939(7), are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users.
    e. Academic publications and journals should establish clear guidelines to regulate the use of AI in manuscript submissions. These guidelines should include requiring the disclosure that AI was used in research methods and data collection, requiring the exclusion of AI systems as authors, and should outline the responsibility of the authors to validate the veracity of any referenced content generated by AI.
    f. Education programs are needed to enhance digital literacy, helping individuals critically assess the information they encounter online, particularly in the medical field where mis- and disinformation can have severe consequences.

9. Payor Use of Augmented Intelligence and Automated Decision-Making Systems
    a. Use of automated decision-making systems that determine coverage limits, make claim determinations, and engage in benefit design should be publicly reported, based on easily accessible evidence-based clinical guidelines (as opposed to proprietary payor criteria), and disclosed to both patients and their physician in a way that is easy to understand.
    b. Payors should only use automated decision-making systems to improve or enhance efficiencies in coverage and payment automation, facilitate administrative simplification, and reduce workflow burdens. Automated decision-making systems should never create or exacerbate overall or disparate access barriers to needed benefits by increasing denials, coverage limitations, or limiting benefit offerings. Use of automated decision-making systems

should not replace the individualized assessment of a patient's specific medical and social circumstances and payors' use of such systems should allow for flexibility to override automated decisions. Payors should always make determinations based on particular patient care needs and not base decisions on algorithms developed on "similar" or "like" patients.

c. Payors using automated decision-making systems should disclose information about any algorithm training and reference data, including where data were sourced and attributes about individuals contained within the training data set (e.g., age, race, gender). Payors should provide clear evidence that their systems do not discriminate, increase inequities, and that protections are in place to mitigate bias.
d. Payors using automated decision-making systems should identify and cite peer-reviewed studies assessing the system's accuracy measured against the outcomes of patients and the validity of the system's predictions.
e. Any automated decision-making system recommendation that indicates limitations or denials of care, at both the initial review and appeal levels, should be automatically referred for review to a physician (a) possessing a current and valid non-restricted license to practice medicine in the state in which the proposed services would be provided if authorized and (b) be of the same specialty as the physician who typically manages the medical condition or disease or provides the health care service involved in the request prior to issuance of any final determination. Prior to issuing an adverse determination, the treating physician must have the opportunity to discuss the medical necessity of the care directly with the physician who will be responsible for determining if the care is authorized.
f. Individuals impacted by a payor's automated decision-making system, including patients and their physicians, must have access to all relevant information (including the coverage criteria, results that led to the coverage determination, and clinical guidelines used).
g. Payors using automated decision-making systems should be required to engage in regular system audits to ensure use of the system is not increasing overall or disparate claims denials or coverage limitations, or otherwise decreasing access to care. Payors using automated decision-making systems should make statistics regarding systems' approval, denial, and appeal rates available on their website (or another publicly available website) in a readily accessible format with patient population demographics to report and contextualize equity implications of automated decisions. Insurance regulators should consider requiring reporting of payor use of automated decision-making systems so that they can be monitored for negative and disparate impacts on access to care. Payor use of automated decision-making systems must conform to all relevant state and federal laws.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 311
(I-26)

Introduced by: Medical Student Section

Subject: Ensuring Flexible Testing Dates by the USMLE and Appropriate Stakeholder Engagement

Referred to: Reference Committee C

Whereas, the United States Medical Licensing Examination (USMLE) serves as the national pathway to physician licensure and plays a central role in medical student progression, residency applications, graduation timelines, and entry into the physician workforce; and

Whereas, the USMLE program announced that beginning in 2029, Step 1, Step 2 CK, and Step 3 examinations will transition from year-round administration to a Designated Testing Dates model with a combined total of approximately 45 testing dates annually[1,2]; and

Whereas, the Step examination testing schedule is determined jointly by the Federation of State Medical Boards (FSMB), National Board of Medical Examiners (NBME), and the USMLE Composite Committee; and

Whereas, the current Step examination testing schedule offers examinations year-round excluding the first 14 days of January and major local holidays; and

Whereas, the proposed Designated Testing Dates model substantially reduces testing flexibility with the suggested calendar[3] offering only 17 dates for Step 1, 14 for Step 2 CK, and 14 for Step 3; and

Whereas, medical students rely on flexible testing windows to accommodate curricular differences, clinical rotations, research years, dual-degree programs, illness, disability accommodations, ensuring test day readiness, and other factors; and

Whereas, limiting testing windows may lead to substantially increased failure rates due to students feeling forced to take the exam when they are not ready, ill, or to meet academic milestone requirements for medical school; and

Whereas, during the COVID-19 pandemic, temporary closures and capacity restrictions at Prometric testing centers displaced approximately 17,000 USMLE examinees, resulted in widespread examination cancellations and rescheduling challenges, and prompted the USMLE program to pursue supplemental and alternative testing options to expand examination capacity[4-6]; and

Whereas; the demonstrated consequences of constrained USMLE testing capacity underscore the importance of maintaining sufficient testing capacity, scheduling flexibility, and contingency mechanisms before implementing a substantial reduction in the number of available annual testing dates[4-6]; and

Whereas, the USMLE receives thousands of requests for test accommodations annually, with requests increasing substantially in recent years, and advises examinees to submit accommodation requests approximately 60 business days before their intended examination date to allow sufficient time for reviewing and scheduling[7]; and

Whereas, medical students with disabilities experience disparities in access to USMLE Step 1 accommodations based on disability type, timing of diagnoses, and institutional access to specialized disability-resource professionals, demonstrating that the existing accommodation process may present additional barriers for examinees with disabilities[8]; and

Whereas, a reduction in the number of available USMLE testing dates may *disproportionately* affect examinees requiring accommodations, particularly those whose approved accommodations require additional testing time, additional breaks, or testing across multiple days, by limiting their ability to identify testing dates and locations that can accommodate their individualized needs; and

Whereas, delays in USMLE testing may disrupt medical students' academic progression, graduation planning, and transitions into residency and licensure[9]; therefore be it

RESOLVED, that our American Medical Association support:

a. a broad distribution of flexible testing dates throughout the year for each United States Medical Licensing Examination (USMLE) Step examination to accommodate diverse medical school and residency program curricula and unforeseen personal emergencies & circumstances, to ensure examinees can test when they are adequately prepared without undue stress; and
b. a defied emergency and hardship rescheduling process, distinct from the standard testing calendar, especially but not limited to when USMLE testing dates are limited in number or availability, to accommodate illness, disability-related needs, and unforeseen personal circumstances (New HOD Policy); and be it further

RESOLVED, that our AMA support and encourage the USMLE program and its sponsoring organizations, the Federation of State Medical Boards, and the National Board of Medical Examiners, with extensive involvement, review, and feedback by affected stakeholders, to comprehensively study, evaluate, and report, both prior to and following any implementation of the USMLE Designated Testing Dates model or any future alternative models:

a. The educational, logistical, financial, and workforce impacts, examination access, scheduling delays, travel burden, costs of examinees, residency application timelines, and
b. Differential impacts on students from historically marginalized or disadvantaged backgrounds, and
c. Assessment of its effects on medical students, residents, residency programs, and state medical licensing processes. (Directive to Take Action)

Fiscal Note: Minimal – less than $5,000

Date Received: 11/5/26

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RELEVANT AMA POLICY

Independent Regulation of Physician Licensing Exams D-295.939
(1) Our American Medical Association will continue to work with the National Board of Medical Examiners to ensure that the AMA is given appropriate advance notice of any major potential changes in the examination system. (2) Our AMA will continue to collaborate with the organizations who create, validate, monitor, and administer the United States Medical Licensing Examination. (3) Our AMA will continue to promote and disseminate the rules governing USMLE in its publications. (4) Our AMA will continue its dialog with and be supportive of the process of the Committee to Evaluate the USMLE Program (CEUP). (5) Our AMA will work with American Osteopathic Association and National Board of Osteopathic Medical Examiners to stay apprised of any major potential changes in the Comprehensive Osteopathic Medical Licensing Examination (COMLEX). [CME Rep. 10, A-08; Modified: CME Rep. 01, A-18; Reaffirmation: A-22]

Reporting of Total Attempts of USMLE Step 1 and COMLEX-USA Level 1 Examinations H-295.841
(1) Our AMA encourages the National Board of Medical Examiners (NBME) and National Board of Osteopathic Medical Examiners (NBOME) to continue evaluating barriers for students related to testing centers (e.g., rescheduling, cost, etc.). (2) Our AMA encourages medical schools to assist examinees in scheduling of USMLE® and COMLEX-USA® exams and consider opportunities for flexibility. [CME Rep. 06, A-25]

Evaluate Barriers to Medical Education for Trainees with Disabilities D-90.990
…(3) Our AMA encourages the National Board of Medical Examiners (NBME), National Board of Osteopathic Medical Examiners (NBOME), and member boards of the American Board of Medical Specialties and the American Osteopathic Association to evaluate and enhance their processes for reviewing requests for accommodations from applicants with disabilities in order to reduce delays in completion of licensing and initial board certification examinations. This should include an assessment of the experience of those applicants and the development of a transparent communication process that keeps applicants informed about the expected timeline to address their requests. These processes should require neither proof of accommodation nor proof of poor academic performance prior to the time at which a need for accommodation was requested. (4) Our AMA encourages research and broad dissemination of results in the area of disabilities accommodation in the medical environment that includes: the efficacy of established accommodations; innovative accommodation models that either reduce barriers or provide educational approaches to facilitate the avoidance of barriers; impact of disabled learners and physicians on the delivery of health care to patients with disabilities; and research on the safety of established and potential accommodations for use in clinical programs and practice. (5)

Our AMA will collaborate with the NBME and the NBOME to facilitate a timely accommodations application. [CME Rep. 2, I-21; Appended - BOT Action in response to referred for decision: Res. 314, A-21; Appended: Res. 302, I-23]

Discouraging the Use of Licensing Exams for Internal Promotion in Medical Schools H-275.958
It is the policy of the AMA to encourage the discontinuation of the use of the USMLE Step 1 Exam as a requirement for the promotion of medical students to the clinical phase. [Res. 289, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CME Rep. 2, A-10; Modified: CME Rep. 01, A-20]

Proposed Single Examination for Licensure H-275.962
Our AMA: (1) endorses the concept of a single examination for medical licensure; (2) urges the NBME and the FSMB to place responsibility for developing Steps I and II of the new single examination for licensure with the faculty of U.S. medical schools working through the NBME; (3) continues its vigorous support of the LCME and its accreditation of medical schools and supports monitoring the impact of a single examination on the effectiveness of the LCME; (4) urges the NBME and the FSMB to establish a high standard for passing the examination; (5) strongly recommends and supports actively pursuing efforts to assure that the standard for passing be criterion-based; that is, that passing the examination indicate a degree of knowledge acceptable for practicing medicine; and (6) will work with the appropriate stakeholders to study the advantages, disadvantages, and practicality of combining the USMLE Step 1 and Step 2 CK exams into a single licensure exam measuring both foundational science and clinical knowledge competencies. [CME Rep. B, I-89; Reaffirmed: Sunset Report, A-00; Modified: CME Rep. 2, A-10; Reaffirmed: BOT Rep. 3, I-14; Appended: Res. 309, A-17]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 934
(I-26)

Introduced by: Resident and Fellow Section

Subject: Protecting Evidence-Based Family Planning Services in Title X-Funded Programs

Referred to: Reference Committee K

Whereas, Title X of the Public Health Service Act is the only federal program dedicated solely to providing family planning and related preventive health services;[1-6] and

Whereas, Title X is intended to provide a broad range of effective family planning methods and services, including highly effective contraceptive methods and services;[1-6] and

Whereas, Title X-funded health centers provide essential preventive and reproductive health services to millions of patients, disproportionately serving individuals with low incomes and those who face barriers to accessing health care;[1-7] and

Whereas, access to comprehensive contraceptive counseling and the full range of effective contraceptive methods has been shown to reduce unintended pregnancy and improve reproductive health outcomes;[1-8] and

Whereas, a 2022 analysis of 384 community health centers across 20 states found that Title X-funded clinics provided the most effective contraceptive methods, including intrauterine devices and implants, at higher rates than non-Title X clinics, with an even greater difference among adolescents;[4] and

Whereas, the US Department of Health and Human Services, which administers Title X funding, announced new funding application requirements in April 2026, including “expanding access to fertility-awareness–based methods (often referred to as natural family planning)” and “affirm[ing] marriage and parenthood as meaningful and valued components of adult life, particularly in counseling adolescents on long-term reproductive goals”;[10,11] and

Whereas, these program requirements make access to Title X funding conditional on the provision of non-evidence based clinical counseling;[12,13] and

Whereas, on July 28, Planned Parenthood filed a lawsuit challenging the new application changes and on August 27, officials from 23 states also filed a lawsuit to block the Title X funding application changes, demonstrating that this is a timely and active issue;[14,15] therefore be it

RESOLVED, that our American Medical Association oppose federal Title X funding criteria that restrict, discourage, or otherwise condition funding on counseling that deviates from evidence-based approaches (New HOD Policy); and be it further

RESOLVED, that our AMA advocate that Title X funding requirements preserve and support the clinical judgment of physicians and other qualified health professionals to provide individualized

counseling and care based on the patient's medical circumstances, reproductive goals, preferences, and informed decisions (Directive to Take Action); and be it further

RESOLVED, that our AMA collaborate with relevant medical specialty societies, state medical societies, public health organizations, and patient advocacy organizations to monitor changes to Title X requirements and the public health consequences of these changes. (Directive to Take Action)

Fiscal Note: Moderate – between $10,000 - $50,000

Received: 11/6/26

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RELEVANT AMA POLICY

Preserving Access to Reproductive Health Services D-5.999

1. Our American Medical Association recognizes that healthcare, including reproductive health services like contraception and abortion, is a human right.
2. Our AMA opposes limitations on access to evidence-based reproductive health services, including fertility treatments, contraception, and abortion.
3. Our AMA will work with interested state medical societies and medical specialty societies to vigorously advocate for broad, equitable access to reproductive health services, including fertility treatments, fertility preservation, contraception, and abortion.

4. Our AMA supports shared decision-making between patients and their physicians regarding reproductive healthcare.
5. Our AMA opposes any effort to undermine the basic medical principle that clinical assessments, such as viability of the pregnancy and safety of the pregnant person, are determinations to be made only by healthcare professionals with their patients.
6. Our AMA opposes the imposition of criminal and civil penalties or other retaliatory efforts, including adverse medical licensing actions and the termination of medical liability coverage or clinical privileges against patients, patient advocates, physicians, other healthcare workers, and health systems for receiving, assisting in, referring patients to, or providing reproductive health services.
7. Our AMA will advocate for legal protections for patients who cross state lines to receive reproductive health services, including contraception and abortion, or who receive medications for contraception and abortion from across state lines, and legal protections for those that provide, support, or refer patients to these services.
8. Our AMA will advocate for legal protections for medical students and physicians who cross state lines to receive education in or deliver reproductive health services, including contraception and abortion.

Family Planning Clinic Funds H-75.992
Our American Medical Association supports the concept of adequate funding for family planning programs.

Preconception Care H-425.976
1. Our American Medical Association supports the 10 recommendations developed by the Centers for Disease Control and Prevention for improving preconception health care that state:
    1. Individual responsibility across the lifespan--each woman, man, and couple should be encouraged to have a reproductive life plan.
    2. Consumer awareness--increase public awareness of the importance of preconception health behaviors and preconception care services by using information and tools appropriate across various ages; literacy, including health literacy; and cultural/linguistic contexts.
    3. Preventive visits--as a part of primary care visits, provide risk assessment and educational and health promotion counseling to all women of childbearing age to reduce reproductive risks and improve pregnancy outcomes.
    4. Interventions for identified risks--increase the proportion of women who receive interventions as follow-up to preconception risk screening, focusing on high priority interventions (i.e., those with evidence of effectiveness and greatest potential impact).
    5. Inter-conception care--use the inter-conception period to provide additional intensive interventions to women who have had a previous pregnancy that ended in an adverse outcome (i.e., infant death, fetal loss, birth defects, low birth weight, or preterm birth).
    6. Pre-pregnancy checkup--offer, as a component of maternity care, one pre-pregnancy visit for couples and persons planning pregnancy.
    7. Health insurance coverage for women with low incomes--increase public and private health insurance coverage for women with low incomes to improve access to preventive women's health and pre-conception and inter-conception care.
    8. Public health programs and strategies--integrate components of pre-conception health into existing local public health and related programs, including emphasis on inter-conception interventions for women with previous adverse outcomes.
    9. Research--increase the evidence base and promote the use of the evidence to improve preconception health.
    10. Monitoring improvements--maximize public health surveillance and related research mechanisms to monitor preconception health.

2. Our AMA supports the education of physicians and the public about the importance of preconception care as a vital component of a woman's reproductive health.
3. Our AMA supports the use of pregnancy intention screening and contraceptive screening in appropriate women and men as part of routine well-care and recommend it be appropriately documented in the medical record.

4. Our AMA will work with interested parties to encourage discussion of family planning counseling with all individuals with reproductive potential as part of routine health maintenance.

Truth and Transparency in Pregnancy Counseling Centers H-420.954

1. It is our American Medical Association's position that any entity that represents itself as offering health-related services should uphold the standards of truthfulness, transparency, and confidentiality that govern health care professionals.
2. Our AMA urges the development of effective oversight for entities offering pregnancy-related health services and counseling.
3. Our AMA advocates that any entity offering crisis pregnancy services
    a. truthfully describe the services they offer or for which they refer—including prenatal care, family planning, termination, or adoption services—in communications on site and in their advertising, and before any services are provided to an individual patient.
    b. be transparent with respect to their funding and sponsorship relationships.
4. Our AMA advocates that any entity licensed to provide medical or health services to pregnant people.
    a. ensure that care is provided by appropriately qualified, licensed personnel.
    b. abide by federal health information privacy laws.
5. Our AMA urges that public funding only support programs that provide complete, non-directive, medically accurate health information to support patients' informed, voluntary decisions.

Sexuality Education, Sexual Violence Prevention, Abstinence, and Distribution of Condoms in Schools H-170.968

1. Our American Medical Association supports the concept of sexuality education in the home, when possible, as well as developmentally appropriate sexuality education programming in the schools at all levels, at local option and direction.
2. Our AMA urges schools at all education levels to implement comprehensive, developmentally appropriate sexuality education programs that:
    a. are based on rigorous, peer reviewed science;
    b. incorporate sexual violence prevention;
    c. show promise for delaying the onset of sexual activity and a reduction in sexual behavior that puts adolescents at risk for contracting human immunodeficiency virus (HIV) and other sexually transmitted diseases and for becoming pregnant;
    d. include an integrated strategy for making condoms and other effective barrier protection methods available to students and for providing both factual information and skill-building related to reproductive biology, sexual abstinence, sexual responsibility, contraceptives including condoms, alternatives in birth control, and other issues aimed at prevention of pregnancy and sexual transmission of diseases;
    e. utilize classroom teachers and other professionals who have shown an aptitude for working with young people and who have received special training that includes addressing the needs of LGBTQ+ youth;
    f. appropriately and comprehensively address the sexual behavior of all people, inclusive of sexual and gender minorities;
    g. include ample involvement of parents, health professionals, and other concerned members of the community in the development of the program;
    h. are part of an overall health education program; and
    i. include culturally competent materials that are language-appropriate for Limited English Proficiency (LEP) pupils;
3. Our AMA will continue to monitor future research findings related to emerging initiatives that include abstinence-only, school-based sexuality education, and consent communication to prevent dating violence while promoting healthy relationships, and school-based condom availability programs that address sexually transmitted diseases and pregnancy prevention for young people and report back to the House of Delegates as appropriate.

4. Our AMA will work with the United States Surgeon General to design programs that address communities of color and youth in high risk situations within the context of a comprehensive school health education program.
5. Our AMA opposes the sole use of abstinence-only education, as defined by the 1996 Temporary Assistance to Needy Families Act (P.L. 104-193), within school systems.
6. Our AMA endorses comprehensive family life education in lieu of abstinence-only education, unless research shows abstinence-only education to be superior in preventing negative health outcomes.
7. Our AMA supports federal funding of comprehensive sex education programs that stress the importance of preventing unwanted teenage pregnancy and sexually transmitted infections via comprehensive education, including contraceptive choices, abstinence, and safer sex, and opposes federal funding of community-based programs that do not show evidence-based benefits.
8. Our AMA extends its support of comprehensive family-life education to community-based programs promoting abstinence as the best method to prevent teenage pregnancy and sexually-transmitted diseases while also discussing the roles of condoms and birth control, as endorsed for school systems in this policy.
9. Our AMA supports the development of sexual education curriculum that integrates dating violence prevention through lessons on healthy relationships, sexual health, and conversations about consent.
10. Our AMA encourages physicians and all interested parties to develop best-practice, evidence-based, guidelines for sexual education curricula that are developmentally appropriate as well as medically, factually, and technically accurate.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 935
(I-26)

Introduced by: Resident and Fellow Section

Subject: Opposition to EPA Rules Delaying and Rescinding Federal PFAS Drinking Water Standards

Referred to: Reference Committee K

Whereas, per- and polyfluoroalkyl substances (PFAS) are persistent synthetic chemicals that do not readily break down in the environment or the human body, and have been associated with cancer, liver damage, immune system effects, thyroid disease, and adverse reproductive and developmental outcomes;[1] and

Whereas, the 2024 PFAS National Primary Drinking Water Regulation established the first legally enforceable Maximum Contaminant Levels (MCLs) for five types of PFAS, including perfluorooctanoic acid (PFOA), perfluorooctane sulfonic acid (PFOS), perfluorohexane sulfonic acid (PFHxS), perfluorononanoic acid (PFNA), and hexafluoropropylene oxide dimer acid (HFPO-DA, commonly known as GenX Chemicals);[1] and

Whereas, long-term exposure to PFHxS above the regulatory level is associated with immune, thyroid, and liver dysfunction, as well as developmental effects following repeated exposure during pregnancy and/or childhood;[2] and

Whereas, PFNA exposure is associated with health effects including elevated cholesterol levels and immune and liver effects, as well as developmental effects following repeated exposure during pregnancy and/or childhood, and HFPO-DA exposure with immune, liver, and kidney effects, potential concern for cancer, and developmental effects following repeated exposure during pregnancy and/or childhood;[2] and

Whereas, the 2024 National Primary Drinking Water Regulation established a Hazard Index MCL for perfluorobutane sulfonic acid (PFBS) where it co-occurs as part of mixtures with other PFAS where the combined levels of two or more PFAS requires action;[1] and

Whereas, the First–Ever National Drinking Water Standard would protect an estimated 100 million people served by U.S. public water systems and would prevent thousands of deaths;[3] and

Whereas, on May 20, 2026, the U.S. Environmental Protection Agency published two proposed rules that would: 1) extend the compliance deadline for the PFOA and PFOS MCLs by two years, from April 26, 2029, to April 26, 2031, for water systems that request the extension; and (2) rescind the drinking water regulatory determinations and MCLs for PFHxS, PFNA, HFPO-DA, and the associated PFBS Hazard Index mixture[4-7]; and

Whereas, the EPA's stated basis for the proposed rescission is a changed legal interpretation of the sequencing required by Section 1412(b)(1)(E) of the Safe Drinking Water Act, and not new scientific evidence that these PFAS no longer pose the health risks previously identified;[5-8] and

Whereas, delaying enforceable compliance deadlines and rescinding regulatory determinations for these PFAS substances would delay critically needed health protections for years into the future without scientific justification;[7,8] therefore be it

RESOLVED, that our American Medical Association amend policy H-135.916 “Per- and Polyfluoroalkyl Substances (PFAS) and Human Health” by addition to read as follows:

1. Our American Medical Association supports continued research on the impact of perfluoroalkyl and polyfluoroalkyl chemicals on human health.
2. Our AMA supports legislation and regulation seeking to address contamination, exposure, classification, and clean-up of PFAS substances.
3. Our AMA will advocate for states, at minimum, to follow guidelines presented in the Environmental Protection Agency’s Drinking Water Health Advisories for perfluorooctanoic acid (PFOA) and perfluorooctane sulfonic acid (PFOS), with consideration of the appropriate use of Minimal Risk Levels (MRLs) presented in the CDC/ATSDR Toxicological Profile for PFAS.
4. Our AMA will amplify physician and public education around the adverse health effects of PFAS chemicals and potential mitigation and prevention efforts.
5. Our AMA will oppose the EPA’s proposed rescission of the drinking water regulatory determinations and Maximum Contaminant Levels for perfluorohexane sulfonic acid (PFHxS), perfluorononanoic acid (PFNA), hexafluoropropylene oxide dimer acid (HFPO-DA/GenX), and the Hazard Index for mixtures of two or more PFAS).
6. Our AMA will advocate that any modification, delay, or rescission of enforceable federal drinking water standards for PFAS substances be based on peer-reviewed scientific evidence.

(Modify Current HOD Policy)

Fiscal Note: Minimal – less than $5,000

Received: 11/6/26

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RELEVANT AMA POLICY

Per- and Polyfluoroalkyl Substances (PFAS) and Human Health H-135.916

1. Our American Medical Association supports continued research on the impact of perfluoroalkyl and polyfluoroalkyl chemicals on human health.
2. Our AMA supports legislation and regulation seeking to address contamination, exposure, classification, and clean-up of PFAS substances.
3. Our AMA will advocate for states, at minimum, to follow guidelines presented in the Environmental Protection Agency's Drinking Water Health Advisories for perfluorooctanoic acid (PFOA) and perfluorooctane sulfonic acid (PFOS), with consideration of the appropriate use of Minimal Risk Levels (MRLs) presented in the CDC/ATSDR Toxicological Profile for PFAS.
4. Our AMA will amplify physician and public education around the adverse health effects of PFAS chemicals and potential mitigation and prevention efforts.

[Res. 901, I-19; Modified: Res. 428, A-24]

Resolutions not for Consideration

011*	Standards for Physician Communication of Executive Health Evaluations
003	Support for Completion of Medical Directives Before Elective Surgeries
004	Use of Live Animals in Medical Training
301	Missing Indigenous People Crisis in Medical Education
303	Transparent Visiting Rotation Fee Disclosure
307	Promoting Transparency on Fertility Healthcare Policies for Trainees
308	Update on Financial Transparency of the Revenue Generated by Trainees at Health Systems
309	Stronger Recognition and Promotion of Accommodations for Neurodivergent Learners
310	Disparities in Preliminary and Transitional Year GME Funding
911	Annual Alcohol Report and Comprehensive Review of AMA Alcohol Policy

*Contained in Meeting Tote

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 011
(I-26)

Introduced by: Resident and Fellow Section, Underrepresented in Medicine Advocacy Section

Subject: Standards for Physician Communication of Executive Health Evaluations

Referred to: Reference Committee on Ethics and Bylaws

Whereas, physicians have an ethical responsibility to communicate health information accurately, truthfully, and in a manner that promotes public trust while respecting patient privacy;[1-5] and

Whereas, the health of the President and Vice President of the United States is a matter of legitimate public interest because these officials perform unique constitutional responsibilities with significant implications for national security and public welfare;[6-10] and

Whereas, public disclosure of presidential and vice presidential health information has historically varied substantially in scope, format, and clinical detail with no nationally recognized physician-developed standards regarding the minimum content of publicly released health summaries;[9,11-12] and

Whereas, evidence-based standards for physician communication regarding executive health evaluations could improve public understanding, reduce inconsistent reporting, and preserve appropriate patient privacy and national security;[6-7,11,13] and

Whereas, Congress is actively considering legislation to establish an independent commission authorized under Section 4 of the 25th Amendment to assist in determining presidential inability, of which executive health information would be needed as a vital data point, thus underscoring the timely need for physician-developed, evidence-based standards regarding the communication and interpretation of such information;[14-17] therefore be it

RESOLVED, that our American Medical Association develop best practices for physician-authored public summaries of presidential and vice-presidential health evaluations that promote accuracy, transparency, consistency, and national security whilst safeguarding patient privacy, distinguishing objective clinical findings from physician opinion, and identifying minimum recommended standards for public disclosure (Directive to Take Action); and be it further

RESOLVED, that our AMA encourage collaboration with appropriate national medical specialty societies, ethics organizations, and experts in executive medicine to develop consensus recommendations regarding physician communication of executive health information. (New HOD Policy)

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

Received: 11/6/26

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RELEVANT AMA POLICY

Source and Quality of Medications Critical to National Health and Security H-100.946

1. Our American Medical Association supports studies that identify the extent to which the United States is dependent on foreign supplied pharmaceuticals and chemical substrates,
2. Our AMA supports legislative and regulatory initiatives that help to ensure proper domestic capacity, production and quality of pharmaceutical and chemical substrates as a matter of public well-being and national security.
3. Our AMA encourages the development and enforcement of standards that make the sources of pharmaceuticals and their chemical substrates used in the United States of America transparent to prescribers and the general public.

AMA Code of Medical Ethics - 8.12 Ethical Physician Conduct in the Media

Physicians who participate in the media can offer effective and accessible medical perspectives leading to a healthier and better informed society. However, ethical challenges present themselves when the worlds of medicine, journalism, and entertainment intersect. In the context of the media marketplace, understanding the role as a physician being distinct from a journalist, commentator, or media personality is imperative. Physicians involved in the media environment should be aware of their ethical obligations to patients, the public, and the medical profession; and that their conduct can affect their medical colleagues, other health care professionals, as well as institutions with which they are affiliated. They should also recognize that members of the audience might not understand the unidirectional nature of the relationship and might think of themselves as patients. Physicians should: (a) Always remember that they are physicians first and foremost, and must uphold the values, norms, and integrity of the medical profession. (b) Encourage audience members to seek out qualified physicians to address the unique questions and concerns they have about their respective care when providing general medical advice. (c) Be aware of how their medical training, qualifications, experience, and advice are being used by media forums and how this information is being communicated to the viewing public. (d) Understand that as physicians, they will be taken as authorities when they engage with the media and therefore should ensure that the medical information they provide is: (i) accurate; (ii) inclusive of known risks and benefits; (iii) commensurate with their medical expertise; (iv) based on valid scientific evidence and insight gained from professional experience. (e) Confine their medical advice to their area(s) of expertise, and should clearly distinguish the limits of their medical knowledge where appropriate. (f) Refrain from making clinical diagnoses about individuals (e.g., public officials, celebrities, persons in the news) they have not had the

opportunity to personally examine. (g) Protect patient privacy and confidentiality by refraining from the discussion of identifiable information, unless given specific permission by the patient to do so. (h) Fully disclose any conflicts of interest and avoid situations that may lead to potential conflicts.

Summary of Fiscal Notes I-26

Report(s) of the Board of Trustees

01	Study of Grading Systems in AMA Board Reports	Minimal
02	American Medical Association Optimal Health Outcomes Annual Report	
03	Reduce Environmental Impact of Medical Journals	Minimal
04	Informed Consent for Genetic Testing	Minimal
05	Increasing Access through Federated Healthcare Data Architecture	Minimal
06	Restoring Balance Billing and Allowing Copay Forgiveness to Preserve Independent Practice and Improve Access to Care	Minimal
07	Support for Legislative Changes Allowing Partial Medicare Opt-Out for Physicians	Minimal
08	Access to, and Retention of, Electronic Medical Records	Minimal
09	Medicare Should Not Unfairly Penalize Physicians	Minimal
10	AMA Reimbursement of Necessary HOD Business Meeting Expenses for Delegates and Alternates	Minimal
11	Opposing Unilateral Downcoding of Physician Services by Insurance Companies	Minimal
12	Rethink the Medicare Annual Wellness Visit	Minimal
13	Enhancing the Work of the Center for Digital Health and AI	
14	Patient Options to Restrict Secondary Use of Their Healthcare Data	Minimal
15	Gender-Based Pay Equity in Medicine	Minimal
16	Ensuring Medical Liability Insurance Transparency and Continuity	Minimal
17	Addressing and Reducing Patients Boarding in the Emergency/Reducing Emergency Department Boarding through Payment Reform	Minimal
18	Improving Usability of Electronic Health Records (EHRs) for Transgender and Gender Diverse Patients	Minimal
19	2026 AMA Advocacy Efforts	
20	AMA Efforts on Medicare Payment Reform	
21	Extending and Expanding the AMA Task Force to Preserve the Patient Physician Relationship to Ensure Access and Regulatory Clarity in Gender Affirming Care	
22	Clarifying Conscientious Objection	
23	Specialty Society Representation in the House of Delegates - Five-Year Review	Minimal

Report(s) of the Council on Constitution and Bylaws

01	Clarifications Regarding Establishment and Nominations to AMA Committees	
02	Amendments to Bylaws Governing the AMA Sections	
03	Autonomy of House of Delegate Member Entities: Bylaw Clarification	

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

01	Preserving Autonomy in the Patient-Physician Relationship	Minimal
02	Clarifying Conscientious Objection	Minimal
03	Guidelines on Chaperones for Sensitive Exams	Minimal
04	Supporting Efforts to Strengthen Medical Staffs Through Collective Actions and/or Unionization	Minimal
05	Care of Patients in Legal Custody	Minimal
06	Recording Clinical Encounters	Minimal

07	Physicians Are Not Providers	Minimal

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

01	Evaluation of the Size and Structure of the AMA House of Delegates	Modest
02	Underrepresented in Medicine Advocacy Section Five-Year Review	Minimal
03	Integrated Physician Practice Section Five-Year Review	Minimal

Report(s) of the Council on Medical Education

01	Medical Education Program and Content	Minimal
02	Medical Education Systems	Minimal
03	Professional Regulation of Physicians	Minimal
04	Physician as Medical Professional	Minimal
05	Entry into and transition through the medical education continuum	Minimal
06	Obligations to Students and Trainees	Minimal
07	Mission of Medical Education	Minimal
08	Hardship for International Medical Graduates in Humanitarian Crisis or Conflict	Minimal

Report(s) of the Council on Medical Service

01	Transparency with the Term “Emergency Department”	Minimal
02	The Impact of the Inflation Reduction Act on Physician Practices	Minimal
03	Non-Medical Switching of Prescription Drugs	Minimal
04	Determining Fair Market Value when Contracting with Physician Practices	Minimal
05	Improving Marketplace Affordability through Premium Tax Credits	Minimal
06	Study of Physicians Utilizing Ambulatory Surgical Centers and Office-Based Laboratories or Performing Office-Based Surgeries	Minimal

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

01	Drug Shortages: 2026 Update	Minimal
02	Urging Comprehensive Research and Safety Testing of Industry-Engineered Food Additives (IEFAs), Including High Fructose Corn Syrup	Minimal
03	Establishing Fire Risk Standards for Civilian and Non-Industrial Clothing	Minimal
04	Deprescribing in Clinical Practice	Minimal
05	Battlefield Acupuncture	Minimal

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

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

Report(s) of the Speakers

01	Election Rule Updates
02	Recommended Policy Reconciliations

Summary of Fiscal Notes I-26

Resolutions

001	Recognition of Intersex Individuals and their Human Rights	Minimal
002	Surgical Consent	Modest
005	Opposing Trading on the Outcomes of Biomedical Research and Clinical Trials	Modest
006	Ethics of Medical Usury	Modest
007	Opposing the Required Creation of "Detransition Clinics"	Minimal
008	Recognition of Moral Injury in the Physician Workforce	Modest
009	Ensuring the Appropriate Placement of Children After Parental Deportation	Modest
010	Preserving Human Dignity and Safety by Limiting Unnecessary Restraints and Monitoring	Minimal
201	Artificial Intelligence Having Prescriptive Authority	Modest
202	Rapid Response Framework for Unsupported Medical Claims by Public Officials	Modest
203	Set-Aside Federal Funding for Tribal Health Programs	Minimal
204	Federal Framework for Social Media Access by Minors Under Age 16	Moderate
205	Ensuring Accuracy and Physician Protections for Patient Attribution in Health Plan Quality Measurement and Value-Based Programs	Moderate
206	Third-Party Litigation Funding in Medical Liability Claims	Modest
207	Protecting Physician-Led Interventional Pain Medicine, Ending Unsupervised Nonphysician Practice, and Ensuring Patient Transparency and Safety	Moderate
208	Facilitating Short-Term Supervised Clinical Training for International Physicians	Moderate
209	Protecting GME Subject to Funding Uncertainty	Moderate
210	Requiring Physician Oversight for Artificial Intelligence Tools	Minimal
211	Fair and Clinically Appropriate EMTALA Investigations	Modest
212	Medical Staff Approval of Quality-of-Care Issues Prior to Exclusive Contract	Moderate
213	Clear Identification and Differentiation of Physicians and Nonphysicians in Clinical Rosters, Signage, and Listings	Minimal
214	Prohibiting Health Care Sale-Leaseback Transactions	Moderate
215	Establishing Product Liability for Clinical Augmented Intelligence Failures	Moderate
216	Comprehensive Reform of the No Surprises Act Independent Dispute Resolution Process	Moderate
217	Strengthening the Patients First Act and Medicare Physician Payment Reform	Moderate
218	Firearm Manufacturer Accountability for the Cost of Gun Violence	Modest
219	Opposing the Use of Artificial Intelligence to Produce Child and Adolescent Sexual Exploitative Material	Modest
220	Advocating for the Older Americans Act and Community-Based Services for Older Adults	Moderate
221	Preserving Duration of Status for J-1 Physicians in Graduate Medical Education	Moderate
222	Increasing Legislative Advocacy and Dedicated National Educational Programming for International Medical Graduates (IMGs)	Moderate
223	Advancing Physician Payment and Medicare and Medicaid Access for Street Medicine	Minimal
224	Modernize the Medicare Primary Care Exception to Ensure Appropriate Reimbursement for Services Provided by Residents	Modest
225	Supporting a Common Legal Framework for Medical Capacity Holds	Moderate
226	Physician-Led Governance of the Use of Augmented Intelligence in Hospital Credentialing, Privileging, and Peer Review	Moderate
227	Increasing Access to Long-Acting Injectable Medications for SUD	Modest

228	Hospital-Based Substance Use Disorder Care	Modest
229	Protecting Individual Rights in the Era of Developing Neurotechnologies, Including for Mental Augmentation	Modest
230	Due Process, Transparency, and Accountability for Delegated Third-Party Prior Authorization and Utilization Management Entities	Modest
231	Medicare and Medicaid Payment Equity for Puerto Rico	Moderate
232	Timely Processing of DEA Practitioner Registrations to Protect Patient Access to Care	Moderate
233	Medicaid Protections & Continuous Coverage for Active Cancer Care	Modest
234	Research Infrastructure & Overcoming Non-Medical Clinical Trial Barriers	Modest
235	Assisting Physicians in Navigating Changes to Medicaid Medical Frailty Exemptions	Moderate
236	Standardization of Quality Performance Reporting in Value-Based Payment Arrangements	Moderate
237	Action Regarding CMS Authority to Exclude Entities from Medicare, Medicaid, and Federal Health Care Programs	Moderate
238	Timely Processing of DACA Renewal Applications	Modest
239	Protecting the Integrity of Public Participation in Federal Health Policymaking	Moderate
240	Minimizing Patient Harm from Autonomous Artificial Intelligence	Minimal
302	Augmented Intelligence Use in Assessment Development During Medical Education	Minimal
304	Transparency in AI-Assisted Admissions	Minimal
305	Certification for Hospice Medical Directors	Minimal
306	Fee Parity for International Medical Graduates Taking USMLE Examinations Outside the United States	Minimal
601	Strengthening Board Oversight and Engagement in Major AMA Federal Advocacy	Minimal
602	Enhancing Equity in House of Delegates Resolution Processes by Removal of the Resolutions Committee and Broadening of the Interim Meeting's Focus	Minimal
603	Ensuring Relevance and Mission Alignment in House of Delegates Business	Minimal
604	Increasing Time Between Handbook Release and Opening of Online Reference Committees	Minimal
801	Improving the External Appeals Process for Denied Claims	Minimal
802	Payer Coverage and Tax-Advantaged Access for Physical Activity Professionals, Services, and Programs	Modest
803	Coverage of Embryonic Monogenic Disorder Screening as a Medically Necessary Benefit	Modest
804	Medicare Coverage of Continuous Glucose Monitoring for Non-Insulin-Treated Type 2 Diabetes	Minimal
805	Meaningful Enforcement of Prohibitions on the Corporate Practice of Medicine	Minimal
806	Proration of Liability Insurance Premiums for Senior Physicians Based on Hours Worked	Moderate
807	Continuing Care Retirement Communities (CCRC's)	Modest
808	Increasing Payment for Patient Portal Messages	Minimal
809	Joint Commission Standards for Medical Staff Self-Governance	Modest
810	Strengthening Medicare and Accreditation Standards for Organized Medical Staff Independence	Moderate
811	Government Support of Adaptive Sports Programming	Modest

Summary of Fiscal Notes I-26

812	Protect Patient Choice and Physician Privileges in Hospitals Merger and Acquisitions	Modest
813	Small Medical Practice Website and other Digital Service Compliance with ADA Regulation	Moderate
814	Coverage of SMART Therapy for Asthma	Modest
815	Improving Technology to Combat Automated and Artificial Intelligence-Directed Downcoding of Evaluation and Management Services by Health Insurance Companies	Moderate
816	Enhancing Advocacy to Combat Automated Insurance Downcoding of EM Services	Moderate
817	Proposed revised H-450.982, Patient Satisfaction, Patient Experience, and Quality of Care	Minimal
818	Proposed Revised D-385.958 - Patient Satisfaction Surveys and Quality Parameters as Criteria for Physician Payment	Modest
819	Modifiers Indicating Independent Non-Physician Practitioner Use of Physician Consults and Transfers	Minimal
820	Strengthening Emergency Interfacility Transfer Infrastructure	Modest
901	The Establishment of Mandatory National Reporting of Naegleria Fowleri and Other Amebic Encephalitides	Modest
902	Illegal Electronic Health Record Sharing and Patient Trust	Modest
903	Improving Health Outcomes in Native Hawaiian Populations	Minimal
904	Regulation of Organ Transplant Open Offers	Minimal
905	Integrating Drowning Prevention Counseling and Resource Referral into Pediatric Preventive Care	Modest
906	Establishing Menstrual Products as a Standard of Inpatient Care	Modest
907	Affirming Support for the National Institutes of Health Advisory Councils	Minimal
908	Improving Access to Phenotype-Matched Blood for Transfusion-Dependent Patients	Minimal
909	Public Emergency Alert Reporting Requirements on Private Platforms	Minimal
910	Consolidating and Modernizing AMA Policy on Alcohol Excise Taxation	Modest
912	Reducing Medical Waste Through Electronic Instructions for Use (e-IFU) for Surgical and Medical Device Products	Moderate
913	Withdrawn	
914	National Strategy to Close the Women's Health Gap	Moderate
915	Ensuring Expert and Lived Experience Input in Federal National Health Plans	Minimal
916	Opposition to Recreational Nicotine Products in Federal Correctional Facilities	Modest
917	Modernizing Sunscreen Regulation to Advance Skin Cancer Prevention and Public Health	Modest
918	Strengthening the Radiation Protection Standard	Modest
919	Protecting the Use of Evidence-Based Psychotropic Medications for the Treatment of Psychiatric Conditions	Modest
920	Improving Protection for Patient Medical Records and Health Care	Modest
921	Transgender and Gender Diverse Cancer Research	Minimal
922	Eliminating Tax Barriers to Equitable Clinical Trial Participation	Minimal
923	Research the Community Health Impacts of Data Centers	Modest
924	Ensuring Evidence-Based Nutrition Guidance in Public Health and Clinical Practice	Modest
925	Opposition to Mandatory Testosterone Testing for Active Duty Servicemembers	Modest

926	Support for One Health Approaches to Protect Human, Animal, and Environmental Health	Modest
927	Patient Safety and Clinical Authority in Deceased Organ Donation and Procurement	Moderate
928	Electric Bike and Scooter Safety, Regulation, and Enforcement	Moderate
929	Strengthening Physician Education and Standardized Protocols for Human Rabies Post-Exposure Prophylaxis	Minimal
930	Supporting the Use of Firearm Suppressors to Prevent Hearing Loss	Minimal
931	Allocation, Liability Protections, & Generic Drug Shortages	Modest
932	Recognizing the Challenge of Tobacco use in the Era of Commercial E-Cigarettes and Nicotine Products	Minimal
933	Preventing Silicosis Associated with Engineered Stone Countertops	Minimal
934	Protecting Evidence-Based Family Planning Services in Title X-Funded Programs	Moderate
935	Opposition to EPA Rules Delaying and Rescinding Federal PFAS Drinking Water Standards	Minimal