

**IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION**

PATIENTRIGHTSADVOCATE.ORG, INC.,
Plaintiff,

v.

Case No.

AMERICAN MEDICAL ASSOCIATION,
Defendant.

COMPLAINT

1. PatientRightsAdvocate.org, Inc. (PRA) is a 501(c)(3) nonprofit, non-partisan organization that provides a voice for consumers—patients, employees, employers, and taxpayers—to have competition, transparency, and meaningful choices in healthcare. As part of that mission, PRA strives to provide all participants in the American healthcare system with access to the rules of the road, namely the laws that determine the pricing and billing for their healthcare. PRA brings this action against the American Medical Association (AMA) to clarify that PRA is entitled to make the reference work *Current Procedural Terminology* (CPT) freely and openly available to the public.

2. CPT plays a critical role in healthcare billing and pricing. CPT establishes a comprehensive set of five-digit codes for classifying medical procedures. Federal law *requires* healthcare providers, payers, and physicians to use CPT codes in virtually every electronic healthcare transaction. Federal law and at least 45 States also require use of CPT when submitting claims for reimbursement under Medicare, Medicaid, and other government programs. Indeed, Medicare directly incorporates CPT's classifications into its reimbursement formula, which in turn influences the rates that private insurers pay. Public access to CPT is thus essential to allow patients, employers, policymakers, regulators, and researchers to understand billing and reimbursement procedures for the ever-growing share of the economy that is spent on healthcare.

3. At present, however, the public cannot freely access *CPT* or discuss its content. The AMA, a trade association and lobbying group for physicians, claims *CPT* as its private property. To obtain a physical copy from the AMA, members of the public must pay \$137.89. And that's not all. The AMA maintains that copies of *CPT* purchased by the public are for "personal use" only. If any person wants to use, reference, or display *CPT* content, the AMA asserts he must obtain its permission and pay for the privilege.

4. Officials in every branch of the federal government have objected to the AMA's conduct. In 1997, the Ninth Circuit held that the AMA's copyright in *CPT* was unenforceable because the AMA's conduct amounted to copyright misuse. *Prac. Mgmt. Info. Corp. v. AMA*, 121 F.3d 516, 520-21 (9th Cir. 1997), *cert. denied*, 524 U.S. 952 (1998). In 2025, Senator Bill Cassidy of Louisiana accused the AMA of "abus[ing] [its] government-backed monopoly by charging exorbitant fees to anyone using the CPT code set." Letter from Sen. Bill Cassidy to Bobby Mukkamala, President, AMA at 2 (Oct. 6, 2025), perma.cc/HSN4-R9EN (*Cassidy Letter*). And the Centers for Medicare & Medicaid Services (CMS) is currently accepting comments on whether "alternatives exist to CPT-4 for CMS to consider as part of the national coding standard for physician services," given the "longstanding concern expressed over the Federal reliance on a private organization with such an obvious conflict of interest." *CY 2027 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies*, 91 Fed. Reg. 43,842, 43,952-53 (Jul. 16, 2026).

5. The AMA has no right to withhold *CPT* from the public and charge hefty fees for access. The AMA has no valid copyright in *CPT*. Federal and state law expressly incorporate *CPT* by reference, and copyright precedent has long recognized that "no one can own the law." *Georgia v. Public.Resource.Org, Inc.*, 590 U.S. 255, 265 (2020) (*PRO*). And even if the AMA's copyright were valid, the public is still entitled to access to *CPT* under well-established principles of fair use and copyright misuse.

6. PRA therefore brings this declaratory judgment action to clarify that it can make *CPT* freely available to the public at large. In particular, PRA has purchased a 2026 print edition of *CPT*, which—if it prevails in this suit—it intends to scan and post on its website for the public at large to access without charge. But at present, PRA cannot take these next steps without risking a ruinous copyright infringement lawsuit brought by the AMA. PRA thus respectfully requests that this Court grant it the declaratory relief necessary to allow it to pursue its mission of transparency and open public access to healthcare information.

PARTIES

7. PRA is a nonprofit 501(c)(3) organization whose core mission is to bring transparency and accountability to the healthcare system to promote a functional, competitive healthcare marketplace. PRA is currently incorporated under Massachusetts law, and its principal place of business is located in Massachusetts, although PRA is in the process of moving its incorporation and operations to Florida.

8. Defendant AMA is a 501(c)(6) trade association for physicians and medical students. Upon information and belief, Defendant AMA is incorporated under Illinois law, and its principal place of business is located at 330 North Wabash Avenue, Chicago, IL 60611.

9. The AMA is not a charity. It exists to promote the interests of its members, including through heavy lobbying activity. The AMA reported over \$24 million in lobbying and political expenditures in 2024. AMA Form 990, Sched. C, at 3 (2024), perma.cc/QJ8L-8BZ6. It reported total revenue of over \$546 million and total net assets of over \$1.1 billion. *Id.*, Form 990 at 1.

JURISDICTION AND VENUE

10. This Court has subject-matter jurisdiction under 28 U.S.C. §1331 because this case “arise[s] under” federal copyright law and the Declaratory Judgment Act, 28 U.S.C. §2201.

11. Venue is proper under 28 U.S.C. §1391 because the AMA is headquartered in Chicago.

FACTS

A. *CPT* has been Incorporated into Law for Over Four Decades.

12. *CPT* “is a set of codes, descriptions, and guidelines intended to describe procedures and services performed by physicians and other qualified health care professionals, or entities.” *CPT 2026: Professional Edition*, at xiii (2025) (*CPT 2026*). Each procedure or service is assigned a five-digit code and description. For instance, the code 01730 is assigned the description “Anesthesia for all closed procedures on humerus and elbow.” In addition, guidelines define key terms and provide additional guidance for how to code procedures. The codes are principally meant to be used in billing.

13. The AMA published the first edition of *CPT* in 1966. It has since produced three more “editions,” with the fourth edition (*CPT-4*) first published in 1977. The AMA publishes a “revision” to *CPT-4* every year, meaning that anyone seeking to use the *CPT* must purchase a new edition every year. Between “August 31 and early September,” the AMA publishes the revised code set as an electronic data file. *CPT 2026* at xiii. The codes become available as a physical book “several weeks later.” *Id.* The new codes generally have an “effective date” of January 1 of the following year. *Id.* Changes to *CPT* are made by a body called the CPT Editorial Panel. At present, the AMA Board of Trustees selects the Panel’s members.

14. The AMA asserts and has registered a copyright in every edition of *CPT* and in every annual revision of *CPT-4*. *See, e.g., 2026 Revision Copyright Registration* (Ex.A).

15. For over 40 years, federal and state law has adopted *CPT*, requiring its use in most healthcare billing transactions. Federal and state law incorporate *CPT* in three main ways: (1) CMS has adopted it as part of its coding system for Medicare and Medicaid; (2) the Department of Health and Human Services (HHS) has adopted it as part of its HIPAA standards for electronic billing; and (3) state and other federal regulations have incorporated *CPT* by reference in statutes and regulations for reimbursement claims, reporting requirements, and other purposes.

16. ***Medicare and Medicaid.*** Over 144 million Americans—nearly 40% of the population—receives healthcare through Medicare and Medicaid. The Medicare and Medicaid programs have annual expenditures over \$2 trillion. For over four decades, CMS has required the use of *CPT* in Medicare and Medicaid reimbursement claims.

17. In 1977, Congress directed the Health Care Financing Administration (HCFA)—CMS’s name before 2001—to establish a uniform procedure coding system for the coding of all physicians’ services in Medicare and Medicaid claim forms. *See* 42 U.S.C. §1395w-4(c)(5). In response to this mandate, HCFA worked with the AMA to develop the HCFA Common Procedure Coding System (HCPCS).¹ *See Medicaid Management Information System Proposed System Requirements*, 48 Fed. Reg. 16,750, 16,753 (Apr. 19, 1983). HCPCS consists of two “levels” of codes. Level I are the *CPT-4* codes adopted in their entirety. *Id.* Level II are codes developed directly by HCFA (and now CMS) “for some nonphysician services.” *Id.*

18. As part of developing HCPCS, HCFA entered into a license agreement with the AMA in 1983. *See* 1983 License Agreement (Ex.B). Under that agreement, “HCFA shall adopt and use CPT-4 in connection with HCPCS” and will not “use any other system of procedure nomenclature in HCPCS for reporting physicians’ services.” *Id.* §1. HCFA shall also “publicly endorse the use of CPT-4” and “where permitted by HCFA’s statutory authority and budgetary constraints, require the use of CPT-4 based HCPCS in programs administered by HCFA.” *Id.* §2. In exchange, the AMA conferred on HCFA “a non-exclusive, royalty free, and irrevocable license” to “the most current publicly available CPT-4” to the extent it is used in federal programs. *Id.* §3(a). The Agreement further specifies that “HCPCS shall be prepared in format(s) approved in writing by the AMA which include appropriate notice(s) to indicate that CPT-4 is copyrighted material of the AMA.” *Id.* §3(c).

¹ Following the redesignation of HCFA as CMS in 2001, HCPCS now stands for Healthcare Common Procedure Coding System. *See Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities—Update*, 66 Fed. Reg. 39,562, 39,562 (July 31, 2001).

19. The Agreement also recognizes that the AMA and HCFA have a “joint interest in maintaining CPT-4,” and the Agreement provides that the “AMA shall continue to convene the Editorial Panel which is responsible for maintaining CPT-4.” *Id.* §8(a). Changes made by the Panel must take effect within 30 to 180 days, unless HCFA determines that, due to “administrative considerations,” there is “good cause” for further delay. *Id.* §8(b). And, at the time the agreement was first signed, HCFA was given the right to nominate at least one of the 10 voting members of the panel. *Id.* §8(c). The HCFA (and then CMS) representative remained a voting member into at least 2018. *See Behind the Scenes: The Making of CPT* (Oct. 1, 2018), perma.cc/GHG2-EDKN. Government nominees from the CMS, CDC, and FDA subsequently became non-voting liaisons, *The purpose of the CPT coding system & the CPT Editorial Panel*, AMA (Apr. 24, 2026) (“*CPT Purpose*”), perma.cc/WZ2V-WGA7. In the AMA’s own words, “[t]hese individuals, while not voting, still have significant input into the Panel review process and are able to submit comments like all other Panel participants.” *Id.*

20. Finally, the Agreement provides that every year it will be renewed automatically, unless terminated by either party after 90 days’ notice. 1983 License Agreement §10. The parties can modify the Agreement at any time by written agreement. *Id.* §11.

21. Following the adoption of the 1983 License Agreement, HCFA began to require the use of *CPT* for both Medicare and Medicaid claims. In 1983, HCFA began to require HCPCS—and thus *CPT*—for Medicare claims. *Medicaid Management Information System Proposed System Requirements*, 48 Fed. Reg. at 16,753; *see also System Requirements*, 50 Fed. Reg. 4,800, 4,805 (Feb. 1, 1985). Two years later, HCFA issued a notice requiring the use of HCPCS in Medicaid reimbursement claims. *Medicaid Management Information System Requirements for Physician and Supplier Services*, 50 Fed. Reg. 40,895, 40,897–98 (Oct. 7, 1985). These requirements remain in place today. *See* 42 C.F.R. §433.112(b)(2); CMS, *State Medicaid Manual* §11300 (rev. 18); *CPT Purpose*.

22. On information and belief, the 1983 License Agreement, with immaterial amendments, remains in effect today. *See* CMS, Pub. No. 100-04, *Medicare Claims Processing Manual* ch. 23, §20.1 (2020), perma.cc/A83T-5JP2. In 1997, the Ninth Circuit held that the AMA’s copyright in *CPT* was unenforceable because the License Agreement’s requirement that HCFA not “use a competing coding system” amounted to copyright misuse. *Prac. Mgmt.*, 121 F.3d at 520-21. In response, the AMA purported to “renounc[e] its rights” under this provision of the Agreement. Brief for United States 5 n.6, *AMA v. Prac. Mgmt. Info. Corp.*, 524 U.S. 952 (1998) (No. 97-1254). But the existing “agreement” between the AMA and CMS still requires CMS to “adopt and use CPT-4 in connection with HCPCS for the purpose of reporting services under Medicare and Medicaid.” *Medicare Claims Processing Manual* ch. 23, §20.1. So the AMA’s purported renunciation likely has no practical effect with respect to AMA’s efforts to defend and enforce its claimed copyrights in *CPT*.

23. CMS is tasked under federal regulations with establishing and updating the HCPCS Level II codes. 42 C.F.R. §414.40. These alpha-numeric codes are used to “identify products, supplies, and services not included in the CPT codes, such as ambulance services or durable medical equipment.” CMS, *Healthcare Common Procedure Coding System (HCPCS)* (Apr. 17, 2026), perma.cc/CV9W-9VU6. CMS publishes the official versions of these alpha-numeric codes for free public download on a quarterly basis. *E.g.*, *HCPCS Quarterly Update*, CMS (Jun. 17, 2026), perma.cc/GN4L-5RJQ.

24. *CPT* codes are also incorporated into the Medicare reimbursement formula for physicians. An essential component of that formula is “the relative value for the service” provided. 42 U.S.C. §1395w-4(b)(6)(A). HCPCS codes (and thus *CPT* codes) are used to define each “service,” and CMS assigns a relative value to each HCPCS code. *See* 42 C.F.R. §414.24.

25. The use of *CPT* codes in the Medicare reimbursement formula has great significance for the healthcare industry. By themselves, Medicare expenditures exceed \$1.1 trillion per year, making up a large share of healthcare spending in their own right. In addition, private insurers frequently set

rates as “a percentage of the amount paid by Medicare for that service.” Cong. Budget Office, *The Prices That Commercial Health Insurers and Medicare Pay for Hospitals’ and Physicians’ Services* 3 (2022), perma.cc/VDQ5-RQTW.

26. **HIPAA.** Today, the vast majority of healthcare billing takes place electronically, and the vast majority of electronic healthcare billing is subject to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. No. 104-191, 110 Stat 1936. *See* 42 U.S.C. §1320d-4; 45 C.F.R. §162.923(a). HHS regulations implementing HIPAA adopt *CPT*, making compliance with *CPT*’s classification scheme legally mandatory for the vast majority of billing for physician services.

27. HIPAA requires the Secretary of HHS to adopt standards for electronic health transactions that incorporate “code sets” to identify information about the transactions at issue. 42 U.S.C. §1320d-2(c). The Secretary did so in 2000. *Standards for Electronic Transactions*, 65 Fed. Reg. 50,312 (Aug. 17, 2000). As part of those standards, the Secretary “adopt[ed] ... as the standard medical data code sets” “*Current Procedural Terminology, Fourth Edition (CPT-4)*, as maintained and distributed by the American Medical Association, for physician services and other health care services.” 45 C.F.R. §162.1002(a)(5), (b)(1), (c)(1). Consequently, “for all financial and administrative health care transactions sent electronically, the *CPT* code set will need to be used.” *CPT 2026*, at vi.

28. Failure to use the *CPT* codes where required is punishable by civil penalties of up to \$50,000 per violation. *See* 42 U.S.C. §§1320d-4, 1320d-5; 45 C.F.R. §§160.402(a), 162.1000(a).

29. **Other Federal and State Requirements.** At least 45 States likewise require by law the use of *CPT* codes via reimbursement regulations, reporting requirements, and other provisions.² Of

² *See* 11 Ark. Code R. §25-125(a)(2); Conn. Agencies Regs. §31-280-3; 16 Del. Admin. Code MED §1.20; 19 Del. Admin. Code §1341-4.0; D.C. Mun. Regs. tit. 7, §126.3; Ga. Comp. R. & Regs. 120-2-8.08(3)(i), 120-2-10.03(7), 144-4.08(2); Haw. Code R. §§12-15 Ex.A, 17-1737-51.1(f); Ind. Code §12-15-13-7.2; Iowa Admin. Code r. 441-79.1(249A); 907 Ky. Admin. Regs. 1:038; La. Stat. §46:460.71; 90-351-5 Me. Code R. §1; Md. Code Regs. 14.09.08.05; Mass. Gen. Laws ch. 118E, §62; 23-200 Miss. Code R. §1.13; Mo. Code Regs. tit. 11, §30-12.010(6); Neb. Work. Comp. Ct. R. 26(B)(2)(b); N.H. Code Admin. R. He-W 568.10(b), 577.07(a); N.M. Code R. §11.4.7.8; N.Y. Comp. Codes R. & Regs. tit. 12, §329-1.3; N.C. Gen. Stat. §131E-214.13(d); N.D.

those, at least 15 expressly incorporate *CPT* by reference.³ New Jersey’s Medicaid regulations, for instance, provide that “CPT codes are incorporated herein by reference, as amended and supplemented.” N.J. Admin. Code §10:61-3.1(a). This express incorporation makes *CPT* part of the very text of state law.

30. Similarly, federal Department of Labor regulations require the use of *CPT* codes in workers’ compensation claims for federal employees. *See* 20 C.F.R. §§10.801, 30.701, 725.708, 725.715.

B. The AMA Zealously Guards *CPT* as Its Purported Private Property.

31. Despite *CPT*’s explicit incorporation into federal and state law, the AMA aggressively claims the right to control the public’s ability to access, use, share, and discuss its contents. According to the AMA, “[a]ny entity using CPT content anywhere worldwide must have a license authorizing the use of CPT code set from the AMA or an authorized distributor.” *CPT Licensing Frequently Asked Questions (FAQs)*, AMA (July 14, 2026), perma.cc/33Q8-VK4S (*CPT FAQs*).

32. The AMA asserts a copyright in every annual revision of *CPT* and vigorously asserts its purported intellectual property rights. *See CPT 2026*, at iv-v. The current revision is available as a physical codebook and as a variety of digital products created by the AMA. The codebook specifies that “[t]his publication is for personal use only.” *Id.* at v; *see also CPT FAQs* (“*CPT Professional Edition*” is “for reference only”). AMA maintains that, “to use the CPT codes in an electronic product” (such as billing software), or “cop[y]” or “transmi[t]” them, one must obtain a license. *CPT Licensing FAQs*;

Admin. Code 92-01-02-45.1; Ohio Rev. Code §3901.381; Okla. Admin. Code §§317:30-5-432(a), -614; 34 Pa. Code §126.1; S.D. Admin. R. 20:06:27:03, 67:16:02:16.01; 28 Tex. Admin. Code §134.210; 13-4 Vt. Code R. §§2:40.0021(G), .0022(D); Va. Code §65.2-605; Wash. Admin. Code §§182-550-1350, 296-20-010; W. Va. Code R. §§85-20-9.3, -9.4; Wis. Stat. §632.798; Wis. Admin. Code DWD §80.72; *infra* n.3.

³ *See* Alaska Admin. Code tit. 7, §160.900(a)(1); Cal. Code Regs. tit. 8, §9789.31(h); tit. 22, §51050; 7 Colo. Code Regs. §§1101-3:18-2(B), :18-3(A)(2); Fla. Admin. Code r. 69L-7.020(2); Idaho Admin. Code r. 17.01.01.002(03); Ill. Admin. Code tit. 77, §840.20(b)(2)(G); Mich. Admin. Code r. 418.10107(a); Minn. R. 5221.0405(B); Mont. Admin. R. 37.86.101(4), .2002(2); Nev. Admin. Code §428.070(3); N.J. Admin. Code §10:61-3.1(a); Or. Admin. R. 436-009-0004(2); Tenn. Comp. R. & Regs. 0800-02-17-.01(2)(i); Utah Admin. Code R612-300-4(A); Wyo. Admin. Code tit. 053.0021, ch. 9, §1(c)(ii).

see also *CPT 2026*, at v (“No part of this publication may be reproduced, stored in a retrieval system, transmitted, or distributed in any form or by any means, without the prior written permission of the AMA.”); *id.* at iv (similar warning).

33. The Amazon page for the 2026 revision of *CPT-4* warns that “[t]he AMA ... takes the copyright protection of its content very seriously and is committed to providing the most effective anti-piracy efforts for its authors and readers.” *CPT Professional 2026*, Amazon, perma.cc/P9MF-FV9F (accessed July 28, 2026).

34. The AMA’s standard license agreement for end users (e.g., medical practices that want to use the codes in billing software) charges an up-front annual fee of \$82.50, as well as an additional annual fee of \$18.50 per user. *Internal End User Agreement: Royalty Rates for 2026 and 2027 Annual Releases of Specified Content*, AMA, perma.cc/9DK6-T8Z3 (archived Aug. 11, 2026). Group health plans must also pay \$0.24 per member. *Id.*

35. In 2025, the AMA reported \$296.4 million in revenue from “Books and Digital Content.” AMA, *Physicians’ Powerful Ally in Patient Care: 2025 Annual Report* 25 (Ex.C). After expenses, this category netted \$267.5 million in profit. *Id.* Upon information and belief, licenses and sales of *CPT* represent the overwhelming share of this revenue.

36. Multiple public officials have criticized how the AMA has used this government-sanctioned monopoly over the *CPT* billing codes. In October 2025, Senator Bill Cassidy of Louisiana sent a public letter to the AMA arguing that it has “abused [its] government-backed monopoly by charging exorbitant fees to anyone using the CPT code set, including doctors, hospitals, health plans, and health IT vendors. These fees inevitably are passed on by CPT users to patients in the form of higher health care costs.” *Cassidy Letter 2*. The letter also sought information about the revenue that the AMA derived from the sale and licensing of *CPT*, the association’s administrative costs for producing *CPT*, and how the association determines pricing for *CPT*. *Id.* at 2-3.

37. More recently, Congresswoman Diana Harshbarger has questioned whether a recent decision to revisit codes used for reimbursing peripheral nerve stimulation therapy was driven by pressure from “manufacturers of competing technologies that possess a direct commercial interest in the outcome of any reinterpretation of these codes.” Matthew Foldi, *Rep. Diana Harshbarger wants increased AMA transparency on CPT billing codes*, Wash. Reporter (Jul. 17, 2026) perma.cc/AV63-QAJ4.

38. CMS also recently sought public comment on the impact of the AMA’s monopoly in CPT on American healthcare. As part of its July 16, 2026 *Calendar Year 2027 Payment Policies* proposed rule, CMS issued a call for public comment “on a number of areas regarding the influence of the CPT® coding system and AMA process on physician payment policy.” *CY 2027 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies*, 91 Fed. Reg. at 43,952. The CMS’s call for comments noted the “longstanding concern expressed over the Federal reliance on a private organization with such an obvious conflict of interest as providing information on the time and resource requirements to conduct physician services when this information may influence their own payment.” *Id.* It sought comments regarding “the harms or challenges associated with AMA’s monopoly over CPT-4 licenses for health care entities.” *Id.* at 43,952-53. CMS also sought comments on what “alternatives exist to CPT-4 for CMS to consider as part of the national coding standard for physician services” and what “objective alternatives exist, or could be developed, to maintain a more objective process to the current AMA[,] CPT[,] and RUC committee processes.” *Id.* at 43,953.

39. Digital products make up an increasing and dominant share of the AMA’s publication revenue. The AMA has reported that, in 2024, “[r]oyalties and digital content sales drove a \$15.9 million revenue increase, as the market for electronic use of digital coding products continues to expand.” AMA, *Why We Fight: 2024 Annual Report* 18, perma.cc/S88R-E4K8. During the same period, the AMA disclosed that “[c]oding book sales declined \$1.7 million in 2024 continuing the move from print products to digital.” *Id.*

C. PRA's Standing to Challenge AMA's Copyright.

40. Consistent with its mission to bring transparency and accountability to the healthcare system, PRA strongly believes that *CPT* should be publicly available because it constitutes an important part of federal healthcare law and, indeed, has been *incorporated* into federal and state law. As a core part of federal healthcare law that determines how patients are billed for medical procedures, the *CPT* codes and descriptors should be freely and publicly available to help patients, payors, researchers, policymakers, and others understand how healthcare dollars are being spent.

41. Healthcare is a massive and growing multitrillion-dollar segment of the U.S. economy. But despite healthcare's importance, the way healthcare services are priced and billed is opaque and difficult to understand. PRA believes strongly that arming healthcare consumers and payors—patients, employees, employers, unions, and state and local governments—with more information about billing and pricing will enable them to pursue the best quality care at the lowest possible price and substantially reduce their costs of care and coverage.

42. In line with that mission, PRA hosts several hospital price tools on its website, allowing members of the public to look up the prices hospitals in different parts of the country charge for procedures, drugs, and other services. *See* PRA, patientrightsadvocate.org (last visited July 28, 2026) (“Hospital Price Tools”). PRA also regularly publishes reports on healthcare pricing. *See, e.g.*, PRA, *Analysis of Prescription Drug Prices in Hospitals* (2026), perma.cc/B2R3-2V3Z; PRA, *Seventh Semi-Annual Hospital Price Transparency Report* (Nov. 2024), perma.cc/QH7U-RWT3. *See generally* Reports, PRA, perma.cc/3PXG-RT9R (last visited July 28, 2026). In preparing this research and these tools, PRA relies heavily on hospitals' disclosures under the federal Price Transparency Rule. *Price Transparency Requirements for Hospitals*, 84 Fed. Reg. 65,524 (Nov. 27, 2019). PRA strongly supported that rule while it was being developed and later helped defend it in court. *See* Brief of PatientRightsAdvocate.org *et al.* as amici curiae, *AHA v. Azar*, 468 F. Supp. 3d 372 (D.D.C. 2020) (No. 1:19-cv-319); Brief of

PatientRightsAdvocate.org *et al.* as amici curiae, *AHA v. Azar*, 983 F.3d 528 (D.C. Cir. 2020) (No. 20-5193), 2020 WL 4922250.

43. Since 2025, PRA has been advocating to make a copy of the *UB-04 Data Specifications Manual* freely available on its website. Like *CPT*, the *UB-04 Manual* is a critical reference work incorporated into federal and state law whose use is required in the vast majority of medical billing for procedures carried out in hospitals. But the American Hospital Association (AHA) claims a copyright in the *UB-04 Manual*, which it aggressively enforces, preventing the public from accessing the *UB-04 Manual* and understanding the role it plays in healthcare pricing. PRA has sought to make the *UB-04 Manual* freely available to the public and, in doing so, has been sued by AHA in a currently pending case in this District that raises many of the same legal issues as this case. *AHA v. PRA*, No. 1:25-cv-15137 (N.D. Ill. filed Dec. 12, 2025).

44. PRA is ready, willing, and able to make *CPT* freely available on its website as soon as a court confirms its right to do so. To that end, PRA and its agents have purchased the print edition of the 2026 revision of *CPT*—*CPT 2026: Professional Edition*—from a third-party vendor and is ready, willing, and able to make this document publicly available once a court has declared that doing so would not infringe any enforceable copyrights. If this Court rules in PRA's favor, PRA would scan that document and make it freely available on its website in a searchable and user-friendly form.

45. PRA and its agents will purchase the 2027 revision of *CPT* as soon as it becomes available from third-party vendors. PRA and its agents will do the same for the 2028 revision and all future annual revisions of *CPT*.

46. Until this Court has declared its rights, PRA has not and will not use the *CPT 2026: Professional Edition* it purchased to take any step inconsistent with the AMA's asserted copyright. PRA has not scanned or copied this work, displayed it, republished it, or created any derivative work with it.

47. When PRA purchased *CPT 2026: Professional Edition*, it did not enter into any license agreement with the AMA that purports to require PRA to acknowledge the validity of any copyrights or refrain from challenging them. PRA did not even purchase *CPT 2026: Professional Edition* directly from the AMA.

48. PRA reasonably apprehends that the AMA would bring a copyright infringement lawsuit and seek significant damages if PRA attempted to make *CPT* freely available to the public. This reasonable fear is based on the AMA's extensive efforts to defend and profit from its putative copyright in *CPT*.

49. The AMA has been zealous in enforcing its purported copyright. *See supra* ¶¶31-34. It has formulated a public, nationwide policy making clear that the AMA “expect[s]” an organization “to obtain [an] appropriate license” if it “uses, references or displays CPT content.” *CPT FAQs*. The AMA has thereby imposed a strict licensing regime on the entire healthcare industry. This includes the federal government, whose license agreement strictly limits the extent to which the government can make use of *CPT* or reproduce its content, requires the government to publicize users’ need to obtain a license, and requires the AMA to sign off on new editions of HCPCS before it can be issued. *See* 1983 License Agreement §2; *Medicare Claims Processing Manual* ch. 23 §20.7; *American Medical Association Terms and Conditions: Current Procedural Terminology (CPT)* 4, CMS, perma.cc/VH66-FNU6 (archived July 28, 2026).

50. The AMA has also vigorously defended its asserted copyright privileges in court. In *Practice Management v. AMA*, it sought to enjoin the opposing party from distributing *CPT* without its authorization, *see* 121 F.3d at 518, and it fought to defend its right to do so all the way to the Supreme Court, *see* 524 U.S. 952.

51. More recently, the AMA submitted an *amicus* brief in *ASTM v. UpCodes, Inc.*, 172 F.4th 253 (3d Cir. 2026) (*ASTM III*), a case in which a standards-setting organization sought to enjoin a

company from posting its standards that had been incorporated into law for free online. *See* AMA Br., *ASTM v. UpCodes, Inc.*, 172 F.4th 253 (3d Cir. 2026) (No. 24-2965), 2025 WL 418687. The AMA submitted this brief to protect its interest in “the enforceability of AMA’s copyright in CPT.” *Id.* at 4. It argued at length that, despite *CPT*’s incorporation into law, the AMA’s copyright in the work remains valid, and posting *CPT* online is not fair use. *Id.* at 4–5. And it insisted that, without the ability to prevent copying and sharing of *CPT*, the AMA would not have sufficient incentive to continue producing it. *Id.* at 18-20. This brief makes clear that the AMA does not believe PRA has the right to post *CPT* online, would not permit PRA to do so, and would consider PRA’s decision to do so a serious threat calling for action.

52. PRA’s previous efforts to negotiate with powerful trade associations in the healthcare industry in order to make important materials public has led to litigation against it. In its effort to make the *UB-04 Manual* freely available, PRA sent a letter to AHA, asking it to confirm PRA’s right to do so. *See* Doc.1-4, *AHA v. PRA*, No. 1:25-cv-15137 (N.D. Ill. filed Dec. 12, 2025). AHA (which has a representative on the *CPT* Editorial Panel) never responded to the letter. Instead, it preemptively sued PRA for copyright infringement. The suit seeks damages and attorney’s fees from PRA, even though PRA has not copied or published the *UB-04 Manual* or begun creating any derivative work. *See* Compl., Doc.1, at 26, *AHA v. PRA*, No. 1:25-cv-15137 (N.D. Ill. filed Dec. 12, 2025).

53. PRA thus brings this declaratory judgment action to clarify its right to post *CPT* online without having to risk ruinous monetary damages in a copyright infringement lawsuit if PRA acts before a court clarifies its rights.

CLAIMS FOR RELIEF

54. Scanning the physical copy of *CPT* and making it publicly available for free on PRA’s website online would not constitute copyright infringement. This is so because (1) *CPT* is not copy-rightable, (2) posting *CPT* online is fair use, and (3) the AMA has engaged in copyright misuse.

COUNT I
Non-copyrightability

55. Plaintiff incorporates and restates all its prior allegations.

56. *CPT* is not copyrightable for three independent reasons: because the AMA exercises delegated lawmaking authority in issuing it, because it is incorporated into law, and because the federal government has jointly authored it in part.

57. The AMA publishes *CPT* while exercising delegated lawmaking authority. *CPT* therefore falls within the public domain.

a. Under “the government edicts doctrine, officials empowered to speak with the force of law cannot be the authors of—and therefore cannot copyright—the works they create in the course of their official duties.” *PRO*, 590 U.S. at 259.

b. The AMA is empowered to speak with the force of law when it issues *CPT*. *CPT* forms part of CMS’s “uniform procedure coding system” for Medicare and Medicaid. 42 U.S.C. §1395w-4(c)(5). Under the AMA’s license agreement with CMS, the agency must adopt *CPT*, including whatever revisions the AMA might make, wherever it has statutory authority to do so. *See* 1983 License Agreement §2; *Medicare Claims Processing Manual* ch. 23, §20.1. And CMS has done so by making *CPT* obligatory for Medicare and Medicaid claims. By requiring the government to adopt the AMA’s codes, this contract gives the AMA authority to speak with the force of law and thus places it under the government edicts doctrine.

c. In addition, HIPAA regulations delegate to the AMA authority to alter their requirements. Ordinarily, when a federal agency incorporates a private standard by reference, it must adopt a specific edition of that standard. 1 C.F.R. §51.1(f). If the agency later wants to adopt a newer edition, it must conduct a new rulemaking. *See id.* The HIPAA regulations, by contrast, adopt *CPT* as revised by the AMA on an ongoing basis. 45 C.F.R. §162.1002(a)(5). Whatever changes the AMA makes to *CPT* become mandatory under the HIPAA regulations

on whatever date the AMA specifies. §162.1011. HHS thus has given the AMA the extraordinary power to alter federal law prospectively and unilaterally.

58. *CPT* also is “not protected under the Copyright Act” because it has been “incorporated by reference into” a “regulation.” *Canadian Standards Ass’n v. P.S. Knight Co.*, 112 F.4th 298, 304–05 (5th Cir. 2024).

a. Federal HIPAA standards directly “adop[t]” *CPT*. 45 C.F.R. §162.1002(a)(5), (b)(1), (c)(1). CMS has adopted *CPT* as part of its “uniform procedure coding system” for Medicare and Medicaid. 42 U.S.C. §1395w-4(c)(5). And at least 15 States explicitly incorporate *CPT* by reference. *Supra* n.3.

b. “Incorporation by reference is a form of legislative shorthand”; its “effect ... is the same as if the referenced material were set out verbatim in the referencing” provision. *Artistic Ent. v. City of Warner Robins*, 331 F.3d 1196, 1206 (11th Cir. 2003). These incorporations by reference therefore make *CPT* part of the text of federal and state regulations.

c. Having been incorporated into law, *CPT* is an uncopyrightable work of federal and state regulators. As part of the text of binding regulations, *CPT* is the “work” of government officials with “authority to make ... law.” *PRO*, 590 U.S. at 266. A work so “incorporated” is “not protected under the Copyright Act.” *Canadian Standards*, 112 F.4th at 305; *accord BOCA v. Code Tech., Inc.*, 628 F.2d 730, 734 (1st Cir. 1980).

d. Because it is incorporated into the law, *CPT* is a work of federal and state regulators “regardless of who actually draft[ed]” its specific language. *Veeck v. S. Bldg. Code Cong. Int’l, Inc.*, 293 F.3d 791, 799 (5th Cir. 2002) (en banc) (quoting *BOCA*, 628 F.2d at 734). “[A]n incorporated provision ‘exists not as any part of the referenced material itself, but rather as a duplicate or clone of the referenced material that has been created within the adopting legislation.’” *Bd. of Trs. of Bakery Drivers Loc. 550 v. Pension Benefit Guar. Corp.*, 136 F.4th 26, 30

(2d Cir. 2025). Thus, “as *law*,” *CPT* is a distinct work in “the public domain.” *Veck*, 293 F.3d at 793. By adopting the text of *CPT* through the rulemaking process, federal and state regulators have “consciously” made it their own. *Id.* at 799; *accord BOCA*, 628 F.2d at 734. Moreover, HHS revises *CPT* every year for the purpose of incorporating it into law, and the AMA solicited both CMS and HHS to incorporate *CPT* into law.

e. Even apart from the issue of authorship, the government edicts doctrine forecloses any attempt to copyright *CPT*. The core “principle” of the government edicts doctrine is that “no one can own the law.” *PRO*, 590 U.S. at 265. *CPT* has been incorporated into federal and state regulations, which are “the law” under any conceivable definition. *Canadian Standards*, 112 F.4th at 304. Thus, no one can “own” *CPT* or impose a tax on members of the public who seek to access the law.

f. In addition, having been incorporated into law, *CPT* is uncopyrightable under the merger doctrine. When an idea or fact “can be expressed in only limited ways,” the author’s “expression ‘merges’ into the idea” or fact “and cannot receive copyright protection.” *Design Basics, LLC v. Signature Constr.*, 994 F.3d 879, 889 (7th Cir. 2021). The law can be expressed only one way—through its “text.” *Corner Post, Inc. v. Fed. Rsm.*, 603 U.S. 799, 815 (2024). Thus, *CPT*, as part of the law, cannot be copyrighted. *Veck*, 293 F.3d at 801.

g. If any doubt remains, constitutional avoidance militates against affirming the validity of the AMA’s copyrights. *See ASTM v. Public.Resource.Org, Inc. (ASTM I)*, 896 F.3d 437, 447 (D.C. Cir. 2018). Permitting a private party to hold a copyright on the law would violate the Free Speech Clause of the First Amendment and the Due Process Clause of the Fifth Amendment. *See id.* at 447; *id.* at 458-59 (Katsas, J., concurring).

59. Separately, *CPT* is not copyrightable in part because it was jointly authored with the federal government.

a. “In a joint work, the joint authors hold undivided interests in a work, despite any differences in each author’s contribution.” *Erickson v. Trinity Theatre, Inc.*, 13 F.3d 1061, 1068 (7th Cir. 1994) (citing 17 U.S.C. §201). But copyright protection is “not available for any work of the United States Government.” 17 U.S.C. §105(a). So any work jointly authored with the federal government is not copyrightable.

b. From 1983 until at least 2018, if not later, CMS had the right to nominate a voting representative to the *CPT* Editorial Panel. As a voting panel member, CMS’s representative had significant input on changes to *CPT* and the same degree of control over *CPT*’s content as every other member. On information and belief, while CMS had a voting representative on the *CPT* Editorial Panel, it proposed specific codes and descriptions that were adopted into *CPT*. CMS’s representative thus qualified as a joint author of *CPT*, making *CPT* an uncopyrightable government work. *See Herbert v. United States*, 36 Fed. Cl. 299, 309 (1996).

c. CMS’s representative is no longer a *voting* member of the *CPT* Editorial Panel. But, on information and belief, a substantial portion of *CPT* remains unchanged from the time when CMS’s representative was a voting member. At a minimum, any portions of the *CPT* that were drafted jointly with federal officials are not copyrightable. *See Waldman Pub. Corp. v. Landoll, Inc.*, 43 F.3d 775, 782 (2d Cir. 1994) (“In the case of a derivative work based on an underlying work that is in the public domain, only the material added to the underlying work is protected by copyright.”).

d. Government nominees from the CMS, CDC, and FDA continue to serve as non-voting liaisons to the *CPT* Editorial Panel. *CPT Purpose*, perma.cc/WZ2V-WGA7. In the AMA’s own words, “[t]hese individuals, while not voting, still have significant input into the Panel review process and are able to submit comments like all other Panel participants.” *Id.* On information and belief, they continue to propose revisions to *CPT*’s text that have been

adopted by the full Panel. *See CPT 2026*, at vi (thanking the CMS, CDC, and FDA representatives for their “contributions”).

COUNT II

Fair Use

60. Plaintiff incorporates and restates all its prior allegations.

61. Even if the AMA holds valid copyrights, releasing *CPT* to the public is fair use. As courts have uniformly recognized, the “non-commercial dissemination” of “technical standards for an industry,” “as incorporated by reference into law, constitutes fair use.” *ASTM v. Public.Resource.Org, Inc.*, 82 F.4th 1262, 1265 (D.C. Cir. 2023) (*ASTM II*); *accord ASTM III*, 172 F.4th at 271; *Facility Guidelines Inst. v. UpCodes, Inc.*, 677 F. Supp. 3d 955, 973 (E.D. Mo. 2023); *NFPA v. UpCodes, Inc.*, 2021 WL 4913276, *7 (C.D. Cal. Aug. 9, 2021); *Int’l Code Council v. UpCodes, Inc.*, 2020 WL 2750636, *28 (S.D.N.Y. May 27, 2020); *see also Prac. Mgmt. Info. Corp. v. AMA*, 121 F.3d 516, 519 (9th Cir. 1997); *CCC Info. Servs. v. Maclean Hunter Mkt. Reps.*, 44 F.3d 61, 74 n.30 (2d Cir. 1994).

62. The “fair use of a copyrighted work ... is not an infringement of copyright.” 17 U.S.C. §107. This doctrine “permits courts to avoid rigid application of the copyright statute when, on occasion, it would stifle the very creativity which that law is designed to foster.” *Google v. Oracle*, 593 U.S. 1, 18 (2021). Four factors guide the fair-use inquiry. 17 U.S.C. §107. Taken together, they establish that PRA’s public dissemination of *CPT* would be fair use.

63. *First*, “the purpose and character of the use”—“including whether such use is of a commercial nature or is for nonprofit educational purposes”—favors fair use. 17 U.S.C. §107(1).

a. PRA is a nonprofit organization dedicated to transparency in healthcare that intends to post *CPT* online “for free,” so its “use is for nonprofit, educational purposes.” *ASTM II*, 82 F.4th at 1267. This aim “tips the scales in favor of fair use.” *Google*, 593 U.S. at 32.

b. PRA's use also has "a purpose ... different from the original," which further "weighs in favor of fair use." *Andy Warhol Found. for the Visual Arts v. Goldsmith*, 598 U.S. 508, 529 (2023). The AMA produces *CPT* to "enable physicians, providers, payers, regulators, vendors and health care technology organizations to document, communicate and understand the care provided to patients," and it licenses the *CPT* codes and descriptors to make money. AMA, *CPT* (last accessed Jul. 17, 2026) perma.cc/4JRF-94PA. By contrast, PRA's goal is not to sell a competing billing standard or profit from its use of *CPT* but to ensure—consistent with its mission—that the public is able to freely access and understand the billing classifications and procedures required by law. For purposes of fair use, this "distinction" in purpose between "producing standards" and "provid[ing] the public with ... free" access to "the law" is "fundamental." *ASTM II*, 82 F.4th at 1268.

64. *Second*, "the nature of the copyrighted work," 17 U.S.C. §107(2), "weighs heavily in favor of fair use," *ASTM II*, 82 F.4th at 1268.

a. Works that serve a "utilitarian" rather than "artistic" function receive lesser copyright "protection." *Google*, 593 U.S. at 20. As a standard "incorporated into law," *CPT* falls "at best, at the outer edge of copyright's protective purposes." *ASTM II*, 82 F.4th at 1268.

b. *CPT* is even less like an ordinary private work than the typical incorporated standard. *CPT* is not merely a collection of best practices that happened to be incorporated into law after publication. To the contrary, CMS is contractually obligated to adopt *CPT* for Medicare and Medicaid, and HIPAA regulations give the AMA the authority to update federal law on a prospective, unilateral basis. *Supra* ¶57. A document maintained for the purpose of updating the federal regulations that govern electronic healthcare transactions has *de minimis* expressive or artistic value and can receive no more than the weakest copyright protection.

65. *Third*, “the amount and substantiality of the portion used in relation to the copyrighted work as a whole,” 17 U.S.C. §107(3), also “strongly supports fair use,” *ASTM II*, 82 F.4th at 1269. “[T]here is no per se rule against copying in the name of fair use an entire copyrighted work if necessary.” *Chi. Bd. of Educ. v. Substance, Inc.*, 354 F.3d 624, 629 (7th Cir. 2003). Here the federal government and many States have given “legal effect to [the] entire” *CPT*, so “its entire reproduction is reasonable in relation to the purpose of the copying, which is to provide the public” with “free” access to “the law.” *ASTM II*, 82 F.4th at 1269.

66. *Fourth*, “the effect of the use upon the potential market for or value of the copyrighted work,” §107(4), supports fair use—or at least “does not significantly tip the balance one way or the other,” *ASTM II*, 82 F.4th at 1272.

a. Any monetary losses the AMA may suffer from PRA posting *CPT* online are not “cognizable under the Copyright Act.” *Google*, 593 U.S. at 35. *CPT* is “valuable” only because state and federal law requires providers and payers to use it, not “because of its expressive qualities.” *Id.* at 38-39. If tomorrow the federal and state governments required a completely different system of billing procedures, demand for *CPT* would collapse. Its value thus derives from its status as an authoritative statement of *the law*, not because of any inherent expressive or artistic values.

b. Regardless, upon information and belief, the AMA currently receives vastly more in revenue from *CPT* than it costs to produce it.

c. Even if PRA’s proposed publication caused AMA to lose revenue, “self-interest” would continue to incentivize AMA to contribute to *CPT*. *Veck*, 293 F.3d at 806. “[I]t is difficult to imagine an area of creative endeavor in which the copyright incentive is needed less” than the production of model standards. *Id.* “Trade organizations have powerful reasons stemming from industry standardization, quality control, and self-regulation to produce these

model codes; it is unlikely that, without copyright, they will cease producing them.” *Id.* That is especially true here, because *CPT* defines the process for how physicians—the AMA’s members—*get paid*. It is self-evident that medical providers and their industry associations have ample incentive to develop guidelines that will help them get paid more efficiently.

d. The federal government and the States rely heavily on *CPT*, making its use mandatory for Medicare, Medicaid, electronic billing, and a variety of other purposes. If the AMA ever lacked the financial means to continue producing *CPT*, these governments would have a strong incentive to step in and financially support its continued production.

e. The fourth fair use factor also requires “tak[ing] into account the public benefits the copying will likely produce.” *Google*, 593 U.S. at 35. Here, “the substantial public benefits of free and easy access to the law” outweigh any cognizable harm the AMA is likely to suffer from PRA’s proposed use. *ASTM II*, 82 F.4th at 1271.

f. At minimum, the fourth fair use factor cannot overcome the weight of “the first three factors,” which “strongly favor fair use.” *Id.* at 1272.

67. If any doubt remains, constitutional avoidance requires a finding of fair use, *ASTM I*, 896 F.3d at 447, particularly because the fair-use defense is meant to safeguard “First Amendment values,” *Harper & Row Publishers v. Nation Enters.*, 471 U.S. 539, 555 (1985). The public cannot be denied open access to *CPT*, which is pervasively incorporated into federal and state law.

COUNT III Copyright Misuse

68. Finally, the doctrine of copyright misuse forecloses the AMA from enforcing its copyright against PRA. Copyright misuse is a defense against infringement. *See Lasercomb Am., Inc. v. Reynolds*, 911 F.2d 970, 976 (4th Cir. 1990). Here, the AMA’s license agreement with CMS constitutes copyright misuse from which the AMA has not purged itself.

69. In *Practice Management*, the Ninth Circuit held that “the AMA misused its copyright by licensing the CPT to HCFA in exchange for HCFA’s agreement not to use a competing coding system.” 121 F.3d at 520; *see* 1983 License Agreement §1 (“HCFA agrees not to use any other system of procedure nomenclature in HCPCS for reporting physicians’ services.”). Under this holding, the AMA’s copyright is not enforceable until the AMA “has purged itself of the misuse.” *Lasercomb*, 911 F.2d at 979 n.22; *see Prac. Mgmt.*, 121 F.3d at 520 n.9. This requires the AMA to show that “the improper practice has been abandoned and that the consequences of the misuse of the [copyright] have been dissipated.” *Morton Salt Co. v. G. S. Suppiger Co.*, 314 U.S. 488, 493 (1942).

70. The AMA attempted to purge this misuse by “renounc[ing] its rights under the exclusivity clause.” *See* Brief for U.S. 5 n.6, *Prac. Mgmt.*, 524 U.S. 952 (No. 97-1254). But this attempted purge was insufficient for at least two reasons:

a. Even without the exclusivity provision, on information and belief the license agreement still effectively “requires [CMS] to use the AMA’s copyrighted coding system and prohibits [CMS] from using any other.” *Prac. Mgmt.*, 121 F.3d at 520. Apart from the exclusivity provision, the 1983 License Agreement required that “HCFA shall adopt and use CPT-4 in connection with HCPCS.” §1. On information and belief, this provision remains in effect today. *See Medicare Claims Processing Manual* ch. 23, §20.1 (“CMS shall adopt and use CPT-4 in connection with HCPCS for the purpose of reporting services under Medicare and Medicaid.”). Since *CPT* is a comprehensive system for coding medical procedures that CMS is *required* to adopt, CMS is not free to adopt any other system of codes for Medicare and Medicaid reimbursement.

b. Even if CMS is free to use any system of codes today, “the consequences” of the AMA’s prior misuse have not “dissipated.” *Morton Salt*, 314 U.S. at 493. The AMA used the exclusivity provision to become the required system of codes for Medicare and Medicaid.

When it renounced the exclusivity provision, the AMA did not lose the advantage of being the existing required system. That ill-gained advantage “cannot be readily purged by a change in contract provisions because of sunk-cost investments made by physicians and others in using the AMA standard to comply with HCFA regulations.” Pamela Samuelson, *Questioning Copyrights in Standards*, 48 B.C. L. Rev. 193, 200 n.43 (2007).

PRAYER FOR RELIEF

This Court should enter judgment in Plaintiff’s favor and against Defendant and provide the following relief:

- A. A declaration that PRA’s proposed use of *CPT* is not copyright infringement.
- B. A declaration that the AMA’s asserted copyrights in *CPT* are invalid.
- C. A declaration that PRA’s proposed use of *CPT* is fair use.
- D. A declaration that the AMA’s asserted copyrights in *CPT* are unenforceable due to copyright misuse.
- E. Any other further equitable relief needed based on PRA’s declaratory judgment or decree.
- F. Reasonable costs and expenses of this action, including attorneys’ fees.
- G. All other relief to which PRA is entitled.

Dated: August 13, 2026

Respectfully submitted,

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Exhibit A

Registration Number

TX 9-584-177

Effective Date of Registration:

November 25, 2025

Registration Decision Date:

April 14, 2026

Title

Title of Work: CPT 2026 Professional Edition

Completion/Publication

Year of Completion: 2025

Date of 1st Publication: September 01, 2025

Nation of 1st Publication: United States

International Standard Number: ISBN 978-1-64016-322-5

Author

- Author:** American Medical Association
- Author Created:** text, New and revised text and compilation of data and text
- Work made for hire:** Yes
- Citizen of:** United States
- Domiciled in:** United States

Copyright Claimant

Copyright Claimant: American Medical Association
330 N. Wabash Avenue, Suite 39300, Chicago, IL, 60611, United States

Limitation of copyright claim

Material excluded from this claim: text, Previous edition

Previous registration and year: TX 9-391-694, 2024
TX 9-450-868, 2025

New material included in claim: text, New and revised text and compilation of data and text

Certification

Name: Yolanda Davis

Date: November 20, 2025

Exhibit B

American Medical Association

Physicians dedicated to the health of America



Betty Jane Anderson, JD 515 North State Street 312 464-4650
Special Counsel Chicago, Illinois 60610 312 464-5846 Fax
Health Law Division

7/28/98

This is the 1983 agreement. Several amendments have since been executed none of which alter the original terms in regard to the use of CPT codes for reporting Medicare and Medicaid covered services by physicians.

AGREEMENT

The Department of Health and Human Services
Health Care Financing Administration
and
American Medical Association



AGREEMENT

The Department of Health and Human Services
Health Care Financing Administration
and
American Medical Association

This Agreement is entered into February 1, 1983, between the Department of Health and Human Services, Health Care Financing Administration (hereinafter for convenience referred to as "HCFA") and the American Medical Association (hereinafter for convenience referred to as "AMA").

WHEREAS, the AMA has developed, published and updated a system of nomenclature and codes for describing medical procedures performed by physicians, which is commonly known as physicians' Current Procedural Terminology, now in its fourth edition (CPT-4); and

WHEREAS, HCFA has responsibility for administering various health care reimbursement, oversight and other programs in which procedures performed by physicians are routinely reported to HCFA, its agents and other entities participating in programs administered by HCFA; and

WHEREAS, HCFA has developed a new system of nomenclature called HCFA Common Procedure Coding System (HCPCS) for these purposes; and

WHEREAS, HCFA has concluded that CPT-4 is suitable for uses in HCPCS; and

WHEREAS, AMA is willing to permit HCFA, its agents and other entities participating in programs administered by HCFA, and the health care field in general to use CPT-4 codes and terminology as part of HCPCS;

NOW, THEREFORE, in consideration of the foregoing and the mutual covenants and agreements contained herein, the parties agree as follows:

1. HCFA shall adopt and use CPT-4 in connection with HCPCS, for the purpose of reporting physicians' services under Medicare and Medicaid. HCFA agrees not to use any other system of procedure nomenclature in HCPCS for reporting physicians' services. HCFA retains sole responsibility for determining which codes represent covered services and the amounts to be paid for those services.

2. HCFA shall: (a) publicly endorse the use of CPT-4 based HCPCS for the purpose set forth in paragraph 1; (b) where permitted by HCFA's statutory authority and budgetary constraints, require the use of CPT-4 based HCPCS in programs administered by HCFA by its agents and other entities participating in those programs; and (c) encourage the voluntary use of CPT-4 based HCPCS by others.

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3. (a) HCFA shall have a non-exclusive, royalty free, and irrevocable license to use, copy, publish and distribute the most current publicly available CPT-4 to the extent that such is used as part of HCPCS in its programs as specified in this Agreement. HCFA's agents and other entities will be authorized to use copies of HCPCS provided by HCFA incorporating CPT-4 codes and nomenclature in formats approved in writing by the AMA only for purposes directly related to participating in HCFA programs (provided, however, that such agents and other entities at all times will clearly separate CPT-4 from non-CPT-4 material and said copies contain the AMA's copyright notices in such content and location(s) as specified by the AMA in its sole discretion) except where AMA agrees to allow HCFA agents and other entities participating in programs administered by HCFA to use CPT-4 in converting their private business coding systems simultaneously with their similar conversion for purposes of Medicare and/or Medicaid.

(b) AMA may allow said HCFA agents and other entities to use CPT-4 in converting their private business coding systems simultaneously with their similar conversion for purposes of Medicare and/or Medicaid subject to the AMA's policies and appropriate requirements concerning preservation of the AMA's copyright in CPT-4. HCFA agrees to include a statement in HCPCS that participants will be authorized to use the copies of CPT-4 material in HCPCS only for purposes directly related to participating in HCFA programs and permission for any other use must be obtained from the AMA.

(c) HCPCS shall be prepared in format(s) approved in writing by the AMA which include appropriate notice(s) to indicate that CPT-4 is copyrighted material of the AMA. All CPT-4 material in the HCPCS must be clearly separated from the non-CPT-4 material and the propriety, adequacy, content and placement of AMA's copyright notice(s) in the HCPCS is subject to the mutual agreement of HCFA and AMA. Further, all copies, displays and printed versions of HCPCS shall contain the following disclaimer on a page not later than the third page of HCPCS or at such other location(s) as specified by the AMA:

Physician's Current Procedural Terminology, Fourth Edition, Copyright 1977, 1980, 1981 and 1982 by the American Medical Association ("CPT-4") is a listing of descriptive terms and numeric identifying codes and modifiers for reporting medical services and procedures performed by physicians. This Health Care Financing Administration Common Procedure Coding System ("HCPCS") includes CPT-4 descriptive terms and numeric identifying codes and modifiers for reporting medical services and procedures and other materials contained in CPT-4 which are copyrighted by the American Medical Association.

For purposes of paragraphs 3(a) and 3(c) hereof, AMA shall be deemed to approve HCPCS format(s) provided said format(s) are provided to the AMA in accordance with paragraph 13 hereof and the AMA does not notify HCFA of any objections to said format(s) within thirty (30) days of the AMA's

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4. Both AMA and HCFA will encourage health insurance organizations to adopt CPT-4 for the reporting of physicians' services in order to achieve the widest possible acceptance of the system and uniformity of physicians' services reporting consistent therewith. Therefore, AMA will expeditiously review requests for CPT-4 usage where any HCFA agents or other entities participating in programs administered by HCFA request to convert their private claims processing to HCPCS with CPT-4 as its base and will grant a non-exclusive, royalty-free license to use, copy, publish, and distribute CPT-4 to such HCFA agents or other entities in order to encourage the above stated aims, unless a good cause is extant, and will provide such HCFA agents or other entities its CPT-4 books or tapes at those prices customarily charged to other persons.

5. AMA recognizes that HCFA and other users of CPT-4 may not provide reimbursement under their programs for certain medical procedures identified in CPT-4. Accordingly, HCFA and other health insurance organizations may independently establish policies and procedures governing the manner in which the codes are to be used within their operations. These policies and procedures include, but are not limited to, those related to coverage and reimbursement. To carry out these policies and procedures, HCFA and health insurance organizations may issue instructions governing the use of CPT-4 codes in the claims process, and may specify CPT-4 codes that are not to be used. The parties acknowledge that where certain statutory or regulatory requirements of Medicare or Medicaid cannot be accommodated, HCFA may, subject to provisions of paragraph 8 of this Agreement, develop and use an appropriate HCPCS code to meet such requirements after providing notice to AMA. All other additions of new nomenclature or codes, deletions of existing nomenclature or codes, or other modifications to CPT-4 shall be made pursuant to paragraph 8.

6. HCFA shall be solely responsible, at its expense, for any material it prints, distributes, or prepares pursuant to this Agreement as well as all other related activities HCFA may perform under this Agreement. In connection with the preparation thereof, AMA will provide to HCFA, at no expense to HCFA, such consultation services and other background materials in the area of medical procedure terminology as HCFA may reasonably request.

7. AMA may continue to print, publish, sell, and otherwise disseminate CPT-4.

8. Maintenance of CPT-4 Editorial Panel

(a) AMA and HCFA acknowledge their joint interest in maintaining CPT-4 as a complete compilation of procedure nomenclature and codes which will be capable of fully describing all medical procedures performed by physicians in the United States. The parties also acknowledge their joint interest in improving the efficiency and effectiveness of procedure nomenclature and coding systems. To these ends, and during the term of this Agreement, AMA shall continue to convene the Editorial Panel which is responsible for maintaining CPT-4.

-4-

(b) The Editorial Panel has the sole responsibility and authority to revise, update or modify CPT-4. All such modifications shall be published and effective not sooner than thirty (30) days nor later than one hundred eighty (180) days after adoption by the Editorial Panel, except that HCFA may delay for a reasonable period of time the implementation of any modification to CPT-4 if necessary due to budgetary constraints or other reasonable administrative considerations constituting good cause for the delay.

(c) The Editorial Panel shall consist of ten (10) members, with seven (7) members nominated by AMA and one by HCFA. The Health Insurance Association of America and the Blue Cross and Blue Shield Associations each shall also be invited to nominate one member. Should either the Health Insurance Association of America or the Blue Cross and Blue Shield Associations decline to nominate a member, HCFA shall be permitted to nominate (a) replacement member(s). Any person nominated to the Editorial Panel shall be a physician knowledgeable in the areas of medical procedure nomenclature and coding and committed to maintaining CPT-4 in accordance with the highest professional standards and shall be subject to the approval of the AMA Board of Trustees, although said physician need not be an AMA member. All panel members must receive notification of proposed meetings to consider revisions, updates or modifications to CPT-4 with such notice postmarked at least thirty (30) calendar days before the date of the meeting. Any action or recommendation of the Editorial Panel shall be effective upon the majority vote of members present in which a quorum of the members is present. Six (6) members of the Editorial Panel shall constitute a quorum. Expenses and compensation of each panel member shall be paid by the organization nominating that panel member. Necessary staffing shall be provided by AMA at AMA's sole expense. Other expenses not otherwise provided for above shall be borne by the parties proportionately with their representation on the Editorial Panel.

9. During the term hereof, this Agreement shall be applicable to the current edition of CPT-4, as well as any subsequent editions, updates, revisions, and other modifications.

10. This Agreement shall be effective from the date of execution through September 30, 1983. Thereafter it shall be automatically renewed on a year to year basis except that it may be terminated by either party at any time by giving ninety (90) days written notice thereof to the other party. If AMA terminates this Agreement, HCFA shall have a right to continue using CPT-4 incorporated in HCPCS at the time of AMA's termination. If AMA abandons its rights and/or interest in CPT-4, HCFA shall have the right to continue using CPT-4 without restriction and to make such modifications to CPT-4 as HCFA deems to be necessary.

-5-

11. This Agreement may be modified at any time by written agreement of the parties thereto.

12. Neither party may assign its rights or obligations under this Agreement without prior written consent of the other. This Agreement shall be binding upon the successors and assigns of the parties.

13. All notices, requests for approval, and other communications in connection with paragraphs 3(a), 3(c), 10, and 11 of this Agreement shall be delivered in person or by certified mail to the persons at the addresses set forth below, or to such other person(s) or address(es) which may be subsequently designated in writing by the respective parties and shall be considered received under the terms of this Agreement when actually received by the party.

TO AMA:

Deputy Executive Vice President
Public Scientific and Health
Service Policy
American Medical Association
535 North Dearborn Street
Chicago, Illinois 60610

With a copy to the AMA Office of
the General Counsel at the same
address.

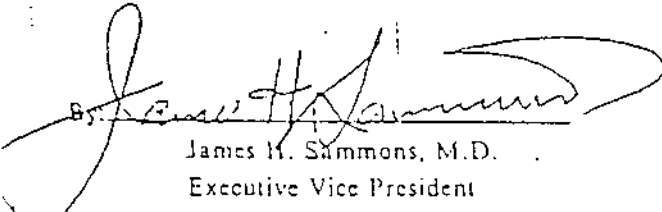
TO HCFA:

Deputy Administrator
Department of Health and Human Services
Health Care Financing Administration
6325 Security Boulevard
Baltimore, Maryland 21207

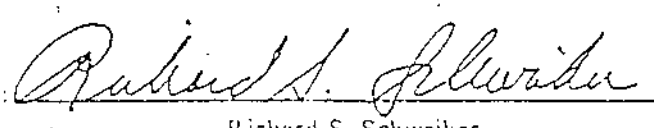
IN WITNESS WHEREOF, the parties hereby execute this Agreement this
1st day of February, 1983.

AMERICAN MEDICAL ASSOCIATION

DEPARTMENT OF HEALTH AND HUMAN SERVICES

By: 

James H. Simmons, M.D.
Executive Vice President

By: 

Richard S. Schweiker
Secretary

Exhibit C



PHYSICIANS' POWERFUL ALLY

IN PATIENT CARE



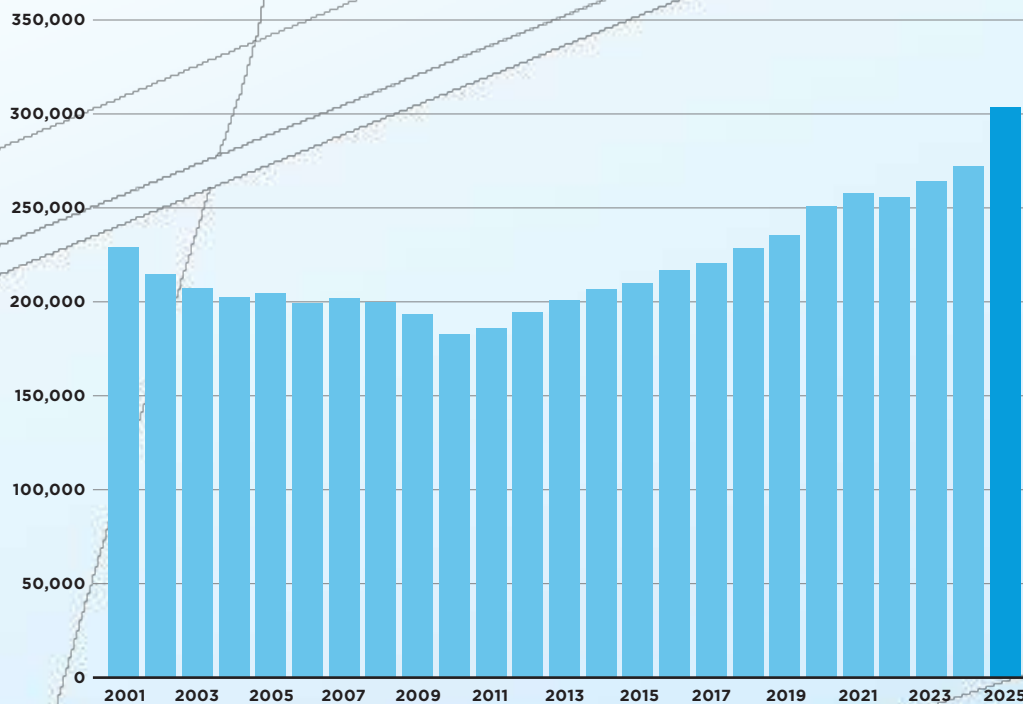
2025 ANNUAL REPORT

FINANCIAL HIGHLIGHTS

(Dollars in millions)	2025	2024
Revenues	\$ 536.4	\$ 513.2
Cost of products sold, selling and general and administrative expenses	463.8	458.0
Net operating results	68.7	51.1
Non-operating items	109.8	74.1
Changes in defined benefit postretirement plans, other than periodic expense, net of tax	(11.4)	2.0
Change in association equity	167.1	127.2
Change in association equity - donor restricted	(0.1)	0.1
Change in total association equity	\$ 167.0	\$ 127.3
Association equity at year-end	\$ 1,317.7	\$ 1,150.7
Employees at year-end	1,316	1,331

AMA MEMBERSHIP

(Dues-paying members)



LETTER TO STAKEHOLDERS

In a period of disruption and change across health care, it is increasingly clear that physician leadership is vital to the future of medicine.

Patients are navigating a system under strain. Physicians are facing mounting administrative burdens, workforce pressures, and an erosion of trust in science and medical expertise. And decisions that shape care—how it is delivered, paid for, regulated and transformed by technology—are being made every day. At this moment, physicians cannot afford to be observers of change. We must be its architects.

In 2025, with high-profile challenges to clinical guidelines, public health decisions and research priorities, the American Medical Association (AMA) stood firm in the belief that evidence must guide care. That commitment is foundational not only to the profession, but also to the trust patients place in their physicians.

As the nation's largest and most trusted physician organization, the AMA brought together leaders across states, specialties and practice settings to confront some of the most pressing challenges in health care. We pushed back against threats to medical research, defended clinical autonomy, protected patient privacy and worked to remove barriers that often prevent patients from accessing high-quality care. At the same time, we advanced a new strategic vision for the organization centered on three imperatives: modernizing physician education and training, strengthening the physician workforce, and ensuring that clinical expertise leads the transformation of digital health.

That work was grounded in a simple but powerful belief that the future of medicine is not something physicians can wait for. It must be shaped—deliberately and collaboratively—by those who understand care best.

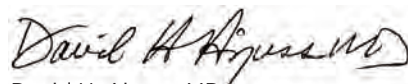
This ethos led to the AMA's creation of two physician-led initiatives in 2025, one focused on improving health outcomes locally and the other designed to embed physician expertise in the expansive world of health technology. The AMA's new Community Health Impact Lab grants are a \$1 million investment to fund 20 physician-led initiatives to address health needs in the communities they serve. The AMA's new Center for Digital Health and AI was created to give physicians a platform to help establish ethical guardrails, shape policy and support workflow integration so that AI and other digital tools enhance care rather than complicate it. In public health and technology, physicians should not be reacting to change. They must lead.

In advocacy, the AMA partnered with dozens of state and specialty medical societies to defeat nearly 100 bills that would have placed patients at risk by expanding scope of practice by non-physicians beyond their appropriate training. We continued to press for Medicare payment reforms that reflect the true cost of delivering care. We advanced prior authorization reforms and made physician well-being a priority across the country.

In education, the AMA announced a \$12 million investment in a new precision education grant program, designed to create personalized, data-driven learning experiences that better prepare physicians for modern clinical practice. From the moment students consider medicine to the day physicians retire, lifelong learning must evolve alongside the realities of care.

AMA's advocacy and mission activities were fueled by another strong year of financial performance and the reach of our voice online. AMA membership eclipsed 300,000 for the first time since the AMA began modern membership tracking, and the number of people reading, watching and listening to our content grew by 3% to more than 31 million.

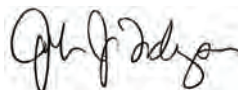
At this consequential moment, medicine needs physicians to lead—together. By speaking with a unified voice, grounding decisions in clinical expertise, and embracing innovation with purpose, physicians can shape a future for medicine that better serves patients and strengthens our profession for generations to come.



David H. Aizuss, MD
Chair, Board of Trustees



Scott Ferguson, MD
Finance Committee Chair, Board of Trustees



John Whyte, MD, MPH
CEO and Executive Vice President



DRIVING DIGITAL HEALTH

WITH CLINICAL EXPERTISE



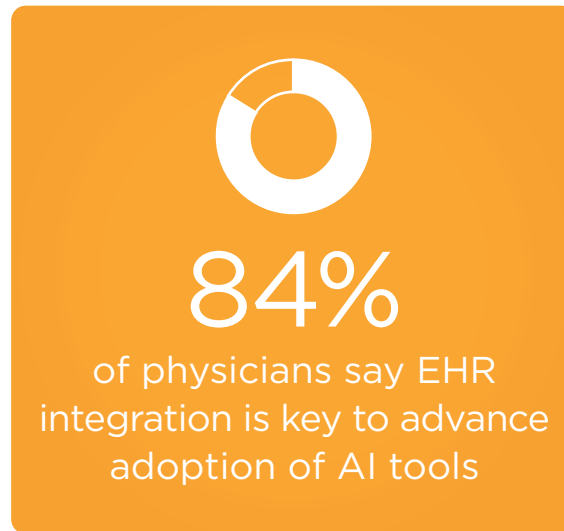
The rapid changes in digital health and augmented intelligence (AI) over the last few years accelerated even more in 2025.

As a growing number of physicians and health systems adopt AI tools, they're experiencing, first-hand, the potential for this technology to transform how they care for patients.

And yet, we've only scratched the surface of what's possible with AI and digital health. Going forward, it's going to be more important than ever that physicians be at the center of shaping, guiding and implementing these transformative technologies.

With the launch of the AMA Center for Digital Health and AI in 2025, we're taking the lead in this space. The new center is focusing on:

- **Policy and regulatory leadership:** Working with regulators, policymakers and technology leaders to shape benchmarks for safe and effective use of AI in medicine and digital health tools.
- **Clinical workflow integration:** Creating opportunities for doctors to shape AI and digital tools so they work within clinical workflows and enhance the patient and clinician experience.
- **Education and training:** Equipping physicians and health systems with the knowledge and tools to integrate AI efficiently and effectively into practice.



- **Collaboration:** Building partnerships across the tech, research, government and health care sectors to drive innovation aligned with patient needs.

Physicians are excited about the possibilities of AI, but they're also aware of how it still needs to evolve and the issues that must be addressed. Their voice must guide the development of AI in health care to ensure this technology supports physicians, improves patient care and changes medicine for the better.




2 out of 3
physicians use
AI-enabled tools
in some form



AMPLIFYING PHYSICIAN VOICES

AND SHAPING POLICY



In 2025, the AMA worked to elevate the voices of physicians in Washington, D.C., and across the country—because physicians play a leading role in shaping the future of health care.

At the national level, the AMA continued its critical work to push for Medicare payment reform, fix prior authorization, promote physician-led care and more by:

- **Generating more than 100 million in earned media and ad impressions** and driving more than 100,000 emails last year alone from physicians and patients to their legislators about Medicare payment reform through our Fix Medicare Now grassroots campaign.

- Facilitating a commitment from AHIP and the Blue Cross Blue Shield Association to **lessen the burden of prior authorization** in 60 of their member plans.
- **Opposing legislation** that would expand pharmacists' scope of practice with respect to testing and treating patients for influenza, COVID-19, RSV and strep throat.

In partnership with state and specialty societies, AMA advocacy protected patients by:

- **Blocking more than 95 bills** that would have inappropriately expanded the scope of practice for physician assistants, pharmacists, optometrists and more.
- **Supporting the passage of more than 20 state laws** that reduce care delays caused by prior authorization.



620,000
contacts to Congress
in total through
FixMedicareNow.org



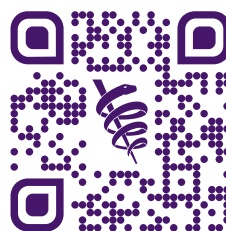
95+

scope of practice bills
defeated nationwide

- **Increasing advocacy efforts with the Dr. Lorna Breen Heroes' Foundation**

to verify that more than 40 state medical boards and more than 1,800 health systems (and others) removed stigmatizing mental health and substance use questions from their licensing and credentialing applications.

Whenever and wherever policymakers were discussing issues that impact patients and physicians, the AMA was there. For a comprehensive look at our accomplishments across the country, check out our 2025 State Advocacy Impact Report.



STANDING UP FOR SCIENCE

AND ELEVATING EXPERTS



In a year where public health was marked by near-constant change, the need for physician leadership was greater than ever—and the AMA answered the call.

We were a steady voice amidst uncertainty and doubt. We defended science and maintained that evidence should guide care decisions and public health policy. We did that by:

- **Amplifying expert voices** and opposing efforts to destabilize the nation's public health infrastructure.
- **Elevating science** and science-based policy through statements and social media—all backed by action.

The AMA will always ensure that the voice of physicians is heard loud and clear and stand resolute in our defense of science-based medicine.



“With measles outbreaks occurring in multiple states and spring break travel approaching, the AMA urges everyone who isn’t already vaccinated to get themselves and their families vaccinated against measles now.”

—Bruce A. Scott, MD
Immediate Past President, AMA



“In the wake of CDC budget cuts and the termination of hundreds of employees earlier this year, the AMA is deeply concerned that this turmoil leaves us highly susceptible to public health threats.”

—Bobby Mukkamala, MD
President, AMA



TURNING PHYSICIANS INTO CATALYSTS FOR CHANGE

Administrative burdens like prior authorization aren't the only barriers physicians must overcome when treating patients.

For example, health disparities like food deserts or a lack of safe housing within communities can have as much impact on patients' health as anything that happens in the exam room.

That's why the AMA launched its first Community Health Impact Lab micro grants in 2025—as a way to invest in physicians who have ideas to address barriers they see in their communities with local, creative and measurable solutions.

LEADING CONVERSATIONS ON THE FUTURE OF CARE

For physicians to be architects of change, they need to be more than involved in conversations about the future of care. They need to be driving them.

The AMA's original reports, research, trusted analysis and resources help physicians stay informed and prepared to do exactly that.

In 2025, the AMA published a wide range of content that shared new insights on some of the biggest trends in health care and solutions to some of today's most pressing problems.

This research and other reports, like our annual survey on prior authorization and our update on the overdose epidemic, cement the AMA as the definitive voice of medicine and an authoritative resource for policymakers, journalists and academic institutions.



- **The AMA Community Health Impact Lab** is offering up to 20 grants of \$50,000 each.
- Grants will help fund **physician-led, community-centered projects** that improve health outcomes among patient populations that often face obstacles to healthy living.

This initiative brings together the unique insights physicians have about the health challenges in their communities with the support they need to be a catalyst for change.

Recipients of the micro grants were notified in April of 2026. They will have 12 months to turn their ideas into action, with the AMA providing advice and coaching along the way.



20

physician-led initiatives
supported



\$1 million

in micro grants
awarded

MANAGEMENT'S DISCUSSION AND ANALYSIS

MANAGEMENT'S DISCUSSION AND ANALYSIS

Introduction

The objective of this section is to help American Medical Association (AMA) members and other readers of our financial statements understand management's views on the AMA's financial condition and results of operations. This discussion should be read in conjunction with the audited consolidated financial statements and notes to the consolidated financial statements.

Improving the health of the nation is at the core of the AMA's work. As the physicians' powerful ally in patient care, the AMA delivers on this mission by representing physicians with a unified voice in courts and legislative bodies across the nation, removing the largest governmental and private sector obstacles that interfere with optimal patient care, and driving the future of medicine to tackle the biggest challenges in health care and training the leaders of tomorrow. AMA's strategic focus is centered on advocacy, membership, financial performance, and operational excellence. Our advocacy; support for optimal health outcomes; putting physicians at the center of shaping, guiding and implementing technologies transforming medicine; growing our national and social media presence as well as several other new initiatives will ensure that our AMA achieves success.

2025 was a transformative year with a mid-year change in leadership driving the start of a transition toward our new priorities. At the same time, AMA continued efforts to re-build health care so that it works better for physicians and all those they serve: 1) reforming Medicare payment to promote thriving physician practices and innovation; 2) fixing prior authorization to reduce the burden on practices and minimize care delays for patients; 3) promoting physician-led care as health care teams working together—with physicians in the lead—is critical to having the best and safest outcomes for patients; 4) reducing physician burnout and addressing the stigma around mental health; and 5) working to ensure physician voices are integrated into the creation and refinement of all medical technology to make technology an asset to physicians, not a burden.

For example, through research, advocacy and education, the AMA continued to defend the practice of medicine against scope of practice expansions that threaten patient safety. AMA efforts helped deliver concrete results in protecting patients from inappropriate scope of practice expansions, providing grants for key state fights, and directly assisted in the defeat of almost 100 problematic bills. The AMA's Fix Medicare Now campaign delivered strong results with over 100 million earned media and ad impressions and more than 600 thousand contacts to Congress.

The results for both 2021 and 2022 included in this report were dramatically impacted by the COVID-19 pandemic. Early in 2020, the AMA, like all other organizations, recognized that there was substantial uncertainty about the effects and risk of COVID-19 on our funding, financial condition, and results of operations. As a result, AMA took steps to ensure that programmatic activities and employment levels would be protected during a sustained pandemic, knowing the potential for economic uncertainty. AMA lifted a freeze on hiring in the spring of 2021, but the level of open positions remained high through 2022 as the job market was very tight. Vacancies and limited travel for most of the three years garnered substantial savings that were temporary in nature resulting in unusually high operating income for AMA. Results began to normalize in 2023, although better than expected revenue growth and a slower ramp up than expected in operating expenses continue to drive a higher level of net operating income through 2025 than experienced in the past.

The AMA is committed to its responsibility of ensuring that the organization focuses its finite resources on its core mission activities while improving the quality and breadth of products and services for physicians and medical students. Our physicians' and medical students' voices are central to AMA's overall success.

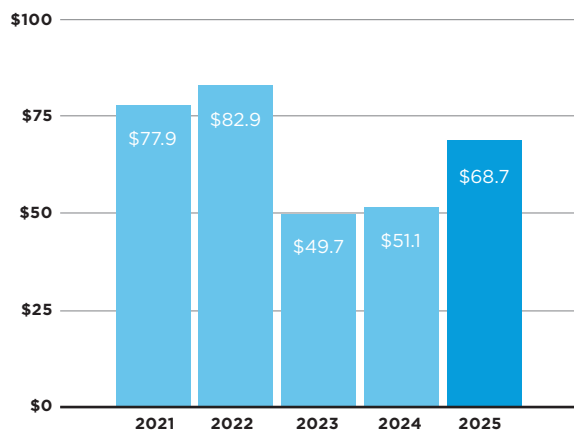
The following pages discuss the 2025 consolidated financial results as compared to 2024. Additional detailed discussion of operating unit results is included in the section titled "Group Operating Results."

Consolidated financial results

Results from operations

Net operating results

(In millions)



As noted above, the hiring freezes and remote work during the pandemic and an unusually tight labor market that adversely impacted hiring and limited travel and in-person meetings through 2022 were major factors in spending levels running substantially less than budgets. Spending levels began to normalize in 2023 although open positions remained higher than previously experienced.

In both 2024 and 2025, revenue growth more than offset a continued increase toward normalized spending levels, resulting in continued unusually strong operating results when compared to historical levels.

Revenues

In 2025, total revenue increased \$23.2 million over the prior year. Continued growth in AMA's royalties and investment income as well as improved coding book sales, membership dues and advertising revenue were partially offset by declines in print subscriptions and insurance commission revenue.

Consolidated investment income, which is dividend and interest income, net of management fees, increased in 2025, mainly due to a larger invested asset base. Market gains or losses are not included in investment income and are reported as non-operating results.

The number of AMA dues paying members increased by 11.5 percent in 2025, the 14th year of growth in the past 15 years. During that 15-year period, AMA dues paying membership increased by over 121,000. Dues revenue increased 1.5 percent in 2025 as much of the growth was in lower dues paying categories such as group memberships and sponsored memberships.

Most other revenue categories were largely unchanged for the year.

Cost of products sold and selling expenses

All variable expenses related to production, distribution and sale of periodicals, books, coding products, and licensed products are included in the cost of products sold and selling expense categories. Examples include paper, sales commissions, promotional activities, distribution costs, and third-party editorial costs.

In 2025, cost of products sold and selling expenses decreased \$6.3 million from the prior year. Most of the decrease was due to reclassifying certain editorial costs to outside professional services, coupled with additional savings from eliminating distribution of print journals to a controlled population of physicians who were included in measuring journal readership scores, a key indicator for print ad placement.

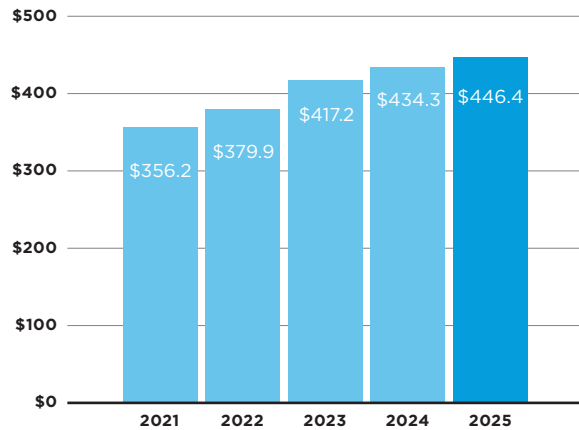
Contribution to general and administrative expenses

Cost of products sold and selling expenses are deducted from revenues to determine the amount of money available for the general and administrative expenses of the organization. Contribution to general and administrative expenses measures the gross margin derived from revenue-producing activities.

The contribution to general and administrative expenses increased \$29.5 million to \$519 million in 2025, a combination of the \$23.2 million revenue improvement coupled with the reduction in cost of products sold noted above.

General and administrative expenses

(in millions)



General and administrative expenses rose \$12.1 million in 2025, or 2.8 percent, when compared to 2024. This was substantially less than the \$44.9 million increase budgeted for 2025, with approximately \$33 million of under budget spending in almost all categories of spending, with the largest variances in marketing and promotion and outside professional services.

Compensation and benefits increased \$8.4 million in 2025, up 3 percent. Compensation, including temporary help, was \$9.1 million higher in 2025, a 4.8 percent increase which was a function of annual merit increases and filling open positions. Fringe benefit costs increased \$2.7 million in total primarily due to higher medical and payroll tax expenses. Incentive compensation decreased \$3.2 million as certain key performance indicators were rated lower than the prior year.

Occupancy costs were down \$2.3 million, driven by a reduction in rent expense. In late 2023, AMA negotiated an extension of the current headquarters lease in return for future contraction options and lease incentives. Most of the reduction in occupancy was related to rent abatement from the renegotiation and a reduction in real estate taxes due to a change in valuation of the building.

Travel and meeting costs increased by \$2.5 million in 2025 due to holding several large biennial meetings such as the International Congress on Peer Review and Scientific Publication and the ChangeMedEd® National Conference, as well as inflationary cost pressures.

Technology costs were largely unchanged. As more technology moves to the cloud, costs associated with the technology platforms will be reflected in operating expense instead of capitalized as an asset and depreciated. This model has the benefit of reducing the need for in-house development expertise but also exposes AMA to more price risk from vendors.

Marketing and promotion costs decreased \$2.5 million in 2025, as Advocacy had expanded its grassroots and media campaign activity on Medicare payment reform in 2024, but returned campaign spending back to previous levels in 2025.

Outside professional services increased \$1.9 million in 2025, as a substantial decline in the use of outside consulting in the Core Mission Activities and Health2047 was offset by a reclassification of certain editorial costs from cost of products sold.

Other operating expenses increased \$3.8 million in 2025 due primarily to recognizing a \$4.5 million loss related to divesting most of Health2047's investment in an affiliate.

Operating results before income taxes

The AMA reported \$72.6 million in pre-tax operating income in 2025 compared to \$55.2 million in 2024. The current year results include over \$23 million in revenue growth that was only partially offset by higher spending, the latter a continuation toward budgeted expense levels.

Income taxes

Taxes decreased \$0.2 million in 2025 when compared to 2024, reflecting lower taxable income in one of the for-profit subsidiaries.

Net operating results

Net operating income was \$68.7 million in 2025 compared to \$51.1 million in 2024, as revenue growth was only partially offset by higher spending.

Non-operating items

The AMA reported a \$113.8 million gain in the fair value of its portfolio during 2025. Additional portfolio performance information is discussed in the group operating results section.

As a result of an accounting standard for postretirement benefit plans, non-operating results include \$6.1 million in postretirement plan interest expense in 2025 and \$5.7 million of plan interest expense and recognized actuarial losses in 2024. In 2025, AMA also recognized a \$2 million gain on the liquidation of a Health2047 spin out company.

Revenue in excess of expenses

Revenues exceeded expenses by \$178.5 million in 2025, a combination of \$68.7 million in operating income, a \$113.8 million gain in fair value in the portfolio and \$4 million in other non-operating expenses. In 2024, revenues exceeded expenses by \$125.2 million, a combination of \$51.1 million in operating income, a \$79.7 million gain in fair value in the portfolio and \$5.6 million in other non-operating expenses.

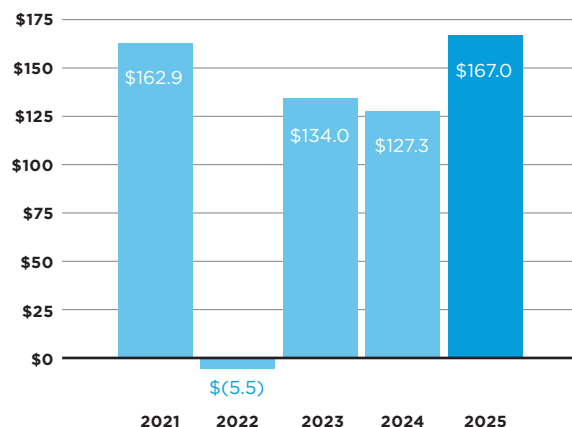
Accounting standards require organizations to recognize deferred actuarial losses and prior service credits or charges for defined benefit postretirement plans as a charge or credit to equity.

In 2025, AMA recorded an \$11.4 million charge to equity reflecting an actuarial loss for the postretirement health care plan, net of income tax. A change increasing the initial health care cost trend in 2025 and adverse claims cost experience were the major drivers of the actuarial loss in 2025.

In 2024, AMA recorded a \$2 million credit to equity reflecting an actuarial gain for the postretirement health care plan, net of a reclassification of actuarial gains to operating expense and income tax. The gain resulted primarily from a change in interest rates from 5 percent to 5.7 percent which reduced the present value of projected liabilities, offset by higher claims cost experience.

Change in total association equity

(in millions)



The AMA reported a \$167 million increase in association equity in 2025. This reflects the amount by which revenues exceeded expenses, less the charge to equity for changes in defined benefit postretirement plans discussed above, as well as a slight decrease in donor-restricted equity.

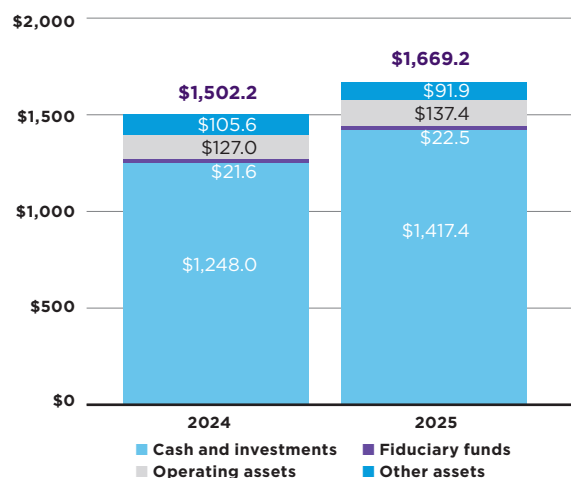
The AMA reported a \$127.3 million increase in association equity in 2024. This reflects the amount by which revenues exceeded expenses, plus the credit to equity for changes in defined benefit postretirement plans discussed above, as well as a slight increase in donor-restricted equity.

Financial position and cash flows

The AMA's assets include cash, cash equivalents, and investments; operating assets such as accounts receivable, inventory and prepaid expenses; fixed capital such as equipment, information technology hardware and software; and other assets. AMA assets are supported by association equity, operating liabilities, and deferred revenue.

Assets

(in millions)



The AMA's total assets increased \$167 million in 2025. This includes a \$169.4 million increase in cash and investments resulting from \$58.7 million in free cash flow plus a \$113.8 million gain in the fair value of investment securities less \$3.1 million for investments in affiliates.

Fiduciary funds are premium payments from insurance customers not yet remitted to the carriers and funds held by the AMA for third parties for future use as approved by the third parties. This approximates the offsetting liability titled insurance premiums and other fiduciary funds payable.

Operating assets increased \$10.4 million in 2025, primarily due to increases in accounts receivable and prepaid software licensing expenses. Changes in operating assets from year to year are largely due to timing of cash flows.

Other assets include operating lease right-of-use assets, property and equipment, investment in affiliates and investments in mutual funds maintained in separate accounts designated for various non-qualified benefit plans that are not available for operations. The right-of-use assets declined by \$9.2 million, which included \$4.8 million in amortization of the asset and a \$4.9 million reduction related to the early termination of the existing Washington D.C. office lease in anticipation of a 2026 move to a new space, offset by a \$0.5 million increase for a new satellite office lease.

Property and equipment net book value decreased as new capital spending was exceeded by annual depreciation and amortization of existing capital assets.

Operating liabilities increased \$1.4 million in 2025, led by an increase in the postretirement health care liability. This was largely offset by a \$3.8 million decrease in accrued expenses and a \$10.9 million reduction in the lease liability from cash payments exceeding rent expense and a reduction in liability due to terminating the existing Washington D.C. office lease. The new lease in D.C. will not begin until 2026.

Deferred revenue represents funds received during the year that will not be recognized as income until the following year or thereafter. These amounts vary, as well as accounts payable and accrued expenses, depending on the timing of cash receipts and payments.

Cash flows

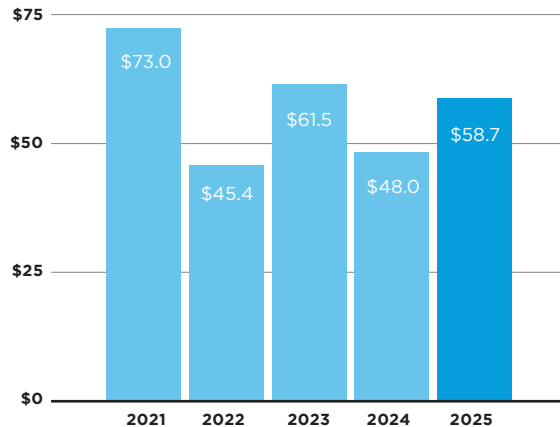
Cash, cash equivalents and donor-restricted cash increased \$6.8 million and \$3.5 million in 2025 and 2024, respectively. This comparison may cause

misleading conclusions, as the change in cash and cash equivalents includes reductions for amounts invested in marketable securities, as well as cash inflows from non-operating activities.

Free cash flow measures the AMA's ability to fund operations, capital expenses and major programmatic initiatives from funds generated from operations. This measure excludes non-operating gains and losses.

Free cash

(in millions)

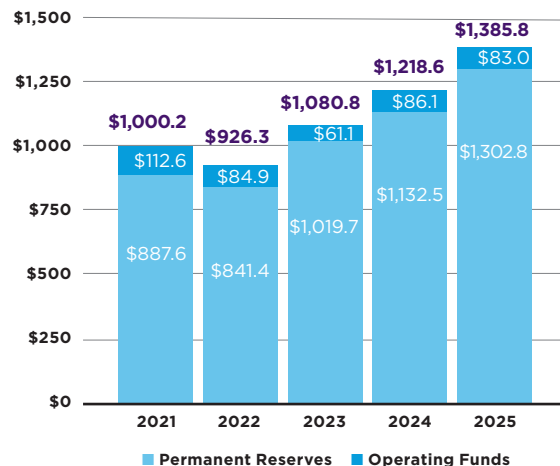


Free cash in 2025 totaled \$58.7 million, \$10.7 million greater than 2024, a result of higher cash operating income offset by changes in operating assets and liabilities.

Reserve portfolio

Reserves and operating funds

(in millions)



The reserve and operating fund portfolios above do not include cash and investments in the for-profit subsidiaries and reflect only the not-for-profit entity's cash and investment portfolio values.

As of year-end 2025, the reserve portfolio's value was \$1,302.8 million compared to \$1,132.5 million in 2024, a \$170.3 million increase. That increase was mainly the result of a \$112.8 million gain in the fair value of the reserve portfolio plus a \$56 million transfer of 2024 excess operating funds to reserves. Operating funds totaled \$83 million in 2025, down \$3.1 million from 2024.

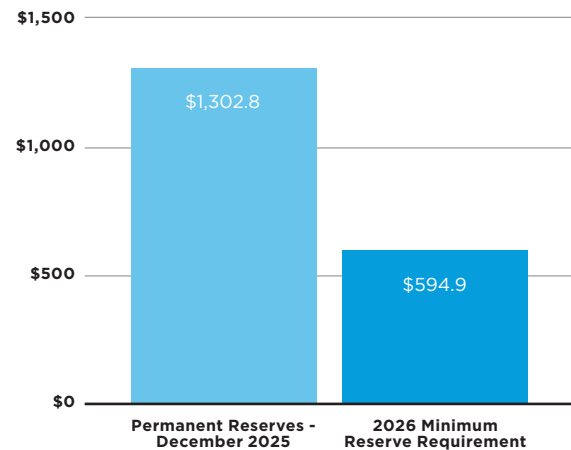
The AMA has established a required minimum reserve investment portfolio level that is adequate to cover 100 percent of annual general and administrative expenses (excluding grant expenses) plus an amount sufficient to pay long-term postretirement and lease liabilities (net of the right-of-use asset value). Operating funds, coupled with operating assets, are to be maintained at a level that allows payment of all operating liabilities.

AMA's reserves provide the backbone for the organization's long-term viability and independence, currently operating as a quasi-endowment fund, with a goal of achieving levels that could generate adequate funding to ensure the long-term future of the organization. Building these reserves to function as an endowment fund will provide considerable protection against future loss of revenue and maintain AMA's independence over the long term.

Reserve portfolio funds also provide the AMA with the ability to fund major strategic spending initiatives not within the operating budget. Spending from reserve funds is limited to dollar- or time-limited initiatives and capped at the amount by which reserves exceed the minimum requirement. Reserves may not be used for ongoing operating expenses. The Board of Trustees must authorize any use of reserves.

Permanent reserves and minimum reserve requirement

(in millions)



Group operating results

The AMA is organized into various operating groups: Membership; Publishing, Health Solutions & Insurance; Core Mission Activities; Administration and Operations; Affiliated Organizations; Unallocated Overhead; and Health2047 (including subsidiary). Revenues and expenses directly attributed to those units are included in the group operating results.

A financial summary of group operating results is presented at the end of this section. The prior year financial results have been updated to be consistent with the current year reported results for each group.

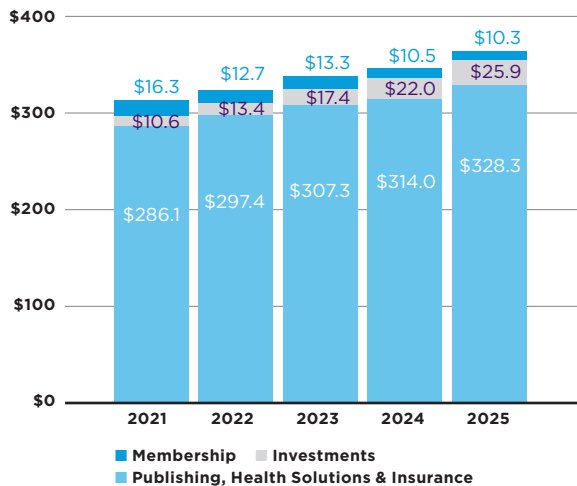
Contribution margin (net expenses)

Contribution margin equals individual group revenues minus cost of products sold, selling expenses, and direct general and administrative expenses such as compensation, occupancy, travel and meetings, technology costs, and professional services.

Net expenses equals total spending, net of any revenue produced by the group, such as grants or other fee income. Total contribution margin and net expenses equals consolidated operating results before income taxes. The charts on the following pages separate groups with contribution margin from groups with net expenses.

Contribution margin

(in millions)



The contribution margin generated by Membership; Publishing, Health Solutions & Insurance; as well as Investments, provides the funding for all mission-related activities of the AMA as well as funding for all administration and support operations required to run the organization.

Membership

The Membership group's net membership dues revenue includes the gross dues revenue collected, reduced by any commissions paid to state societies, and equals the membership dues revenue reported on the statement of activities.

In 2025, AMA again reported an increase in the number of dues-paying members, up 11.5 percent from 2024. In 14 of the last 15 years, AMA has reported increases in the number of dues-paying members, a major accomplishment. Membership continues to focus on broad use of digital tools to engage physicians and retain them as lifelong members, group membership marketing, and expanding AMA's reach to physicians through important programmatic mission-based activities.

Dues revenue was \$33 million, a \$0.5 million increase from 2024. Although the number of post-training physician members increased substantially, most of the growth was in lower dues paying categories. Membership expenses are up \$0.7 million from staffing expenses related to merit and open positions as well as higher membership solicitation costs. As a result, Membership's contribution margin decreased \$0.2 million in 2025.

Publishing, Health Solutions & Insurance

Publications in the JAMA Network® include the *Journal of the American Medical Association* (JAMA®) and the JAMA Network specialty journals. In the last 11 years, the JAMA Network has launched four new journals: *JAMA Oncology* in 2015 and *JAMA Cardiology* in 2016, which are hybrid journals offering open access options for research articles; *JAMA Network Open* in 2018, a fully open access journal; and *JAMA Health Forum* in 2021, a peer-reviewed, open-access, online journal focused on health policy, health care systems, and global and public health.

Publishing revenues are derived from advertising, subscriptions, site licensing, reprints, electronic licensing, open access fees, and royalties. Publishing revenues increased \$2.5 million in 2025, largely a function of a \$1.4 million increase in open access fees resulting from pricing changes and a \$1 million increase in advertising revenue and site licensing fees. Expenses in total rose \$2.2 million during 2025, as the cost of filling open positions and merit increases were only partially offset by reduced production costs related to eliminating print journals. The contribution margin improved by \$0.3 million to \$0.4 million.

Health Solutions includes two major lines: Database Products, and Books and Digital Content.

Database Products includes royalties from licensed data sales and credentialing products revenue. Revenues increased in 2025, up \$0.4 million when compared to 2024. Growth in credentialing revenues, including revenues from a new credentialing product, VeriCre™, drove the revenue improvement. VeriCre is a credentials wallet that streamlines credentialing by pre-filling physician applications with authoritative, verified AMA data, reducing administrative burden for physicians and medical staff professionals. Total expenses were up \$1.6 million, of which \$0.9 million relates to development of the new physician credentialing product. The remaining \$0.7 million cost increase was driven by filling open positions, and technology projects. The resulting contribution margin declined by \$1.2 million in 2025 to \$51.4 million.

AMA-published books and coding products, such as coding books and tools, workshops, and licensed data files, make up the Books and Digital Content unit. Royalties, coding book sales, and digital content sales drove a \$15.9 million revenue increase, as the market for electronic use of digital coding products continues to expand. A three percent price increase as well as phasing in previous pricing model changes were also factors. Expenses were down \$0.5 million, driven by a reduction in professional services for projects related to content and product strategy, market research, and project management. The contribution margin increased by \$16.4 million to \$267.5 million.

The AMA has two active for-profit subsidiaries, the AMA Insurance Agency (Agency) and Health2047. The latter is discussed separately at the end of this discussion and analysis.

The Agency's revenue declined by \$0.9 million in 2025, mainly due to lower interest income. A dividend from the Agency to AMA reduced the investible funds balance, with a resulting decline in investment income. The Agency, as broker, receives a commission on insurance policies sold, which declined slightly in 2025, flattening a trend of larger commission revenue declines in previous years. Expenses were down \$0.4 million mainly due to staff and occupancy reductions. The contribution margin decreased to \$13.3 million from \$13.8 million in the prior year.

Other business operations net expenses were up \$0.7 million in 2025 due to staffing and professional service expense increases.

In total, Publishing, Health Solutions & Insurance contribution margin was \$328.3 million, up \$14.3 million from 2024.

Investments (AMA-only)

AMA-only investment income includes dividend and interest earnings on the AMA's portfolio. Investment income in AMA's for-profit subsidiaries is included as part of the group results for Publishing, Health Solutions & Insurance and Health2047.

Investments' revenue was \$26.7 million in 2025, a \$3.8 million increase over the prior year. Dividend and interest income continued to improve in 2025, impacted in large part by an increased level of investible funds. The contribution margin increased by \$3.9 million as expenses dropped slightly.

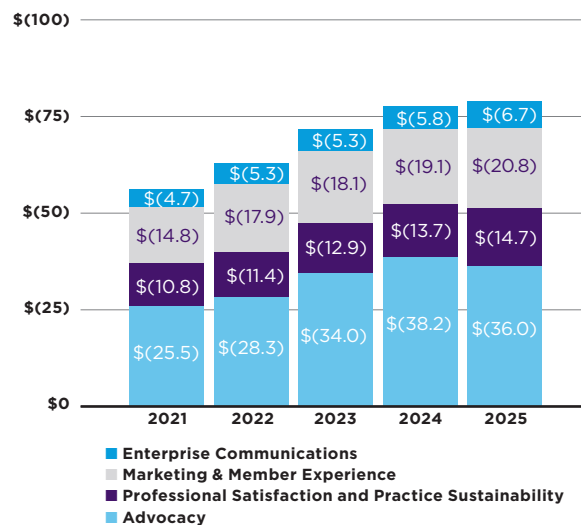
The net gain or loss on the market value of investments is not included in operating results but reported as a non-operating item. This amount is in addition to the investment income discussed above.

In 2025, AMA reported a net gain of \$113.8 million. The total investment return, including investment income, on the reserve portfolios was 11.5 percent compared to a 15.7 percent gain in the composite benchmark index. A combination of factors caused the below benchmark performance including poor performance by a small cap manager that has been replaced and overall private equity market performance that substantially lagged the public market indices in the past year.

Net expenses

Core Mission Activities

(In millions)



Core Mission Activities include direct costs associated with the groups for Advocacy; Professional Satisfaction and Practice Sustainability (PS2); Marketing & Member Experience (MMX); Enterprise Communications, Medical Education (Med Ed); the AMA Ed Hub™; the Center for Optimal Health Outcomes (COHO), previously the Center for Health Equity; Health, Science & Ethics; and Improving Health Outcomes (IHO). The Integrated Health Model Initiative, focused on technology innovation, was closed in 2023. IHO activities have been folded into COHO, fully effective in 2026, to take advantage of synergies between the units. See the chart below for additional business unit results.

Advocacy includes federal and state level advocacy to enact laws and advance regulations on issues important to patients and physicians; economic, statistical and market research to support advocacy efforts; political education for physicians; grassroots advocacy; and maintaining relations with the federation of medicine. This ensures that AMA's critical voice is represented in federal and state courts around the country on a broad range of issues, working with state and federal policymakers to oppose legislation and laws that interfere with the practice of medicine and elevating the voice of physician leadership on critical issues of public health.

In 2025, the AMA worked to elevate the voices of physicians in Washington, D.C., and across the country—because physicians play a leading role in shaping the future of health care. At the national level, the AMA continued its critical work to push for Medicare payment reform, fix prior authorization, promote physician-led care and more.

AMA's Fix Medicare Now grassroots campaign and sustained advocacy led to more than 600,000 physicians and patients contacting legislators about Medicare payment reform. While AMA sought a permanent payment increase, the One Big Beautiful Bill Act included a 2.5 percent increase for 2026.

AMA secured a commitment from American's Health Insurance Plans (AHIP) and the Blue Cross Blue Shield Association to lessen the burden of prior authorization in 60 of their member plans and in partnership with state specialty societies supported passage of more than 20 state laws that reduce care delays caused by prior authorization.

AMA efforts in protecting patients from inappropriate scope of practice expansions, included opposing legislation that would expand pharmacists' scope of practice with respect to testing and treating patients for influenza, COVID-19, RSV and strep throat and, with constituent societies, blocked nearly 100 bills that would have inappropriately expanded the scope of practice for physician assistants, pharmacists, optometrists and more. The AMA had a major win when the National Council of Insurance Legislators adopted model legislation based in large part on AMA's state model bill.

In 2025, Advocacy net spending decreased \$2.2 million, due to the absence of a prior year increase

in media and professional service costs for the Medicare reform campaign. As noted in AMA's annual budget, the use of these campaign funds would be dependent on the environment. The focus in 2026 is to expand AMA's advocacy efforts such as expanding the Scope of Practice grants to \$1 million and increasing spending on a public-facing Medicare payment reform campaign.

PS2 includes three major streams of work: professional satisfaction/practice transformation, practice sustainability, and digital health, all designed to improve the day-to-day practice and professional experience of physicians and remove obstacles to care. The goals of this group are to promote successful models in both the public and private sectors. This includes expanding research of credible practice science, creating tools and other solutions to help guide physicians, care teams and health system leaders on developing and implementing strategies to optimize practice efficiencies, reduce burnout and improve professional well-being; ensuring the physician perspective is represented in the design, implementation and evaluation of new health care technologies; and shaping the evolution of payment models for sustainability and satisfaction. The work of the digital health unit will transfer to the newly created Center for Digital Health and AI in 2026.

In 2025, the PS2 resources such as the Joy in Medicine™ Health System Recognition Program, the Organizational Biopsy®, STEPS Forward®, webinars, podcasts, coaching and learning collaboratives increased the impact of PS2 efforts with physicians as measured by the number of physicians served and the assessment of high value reflected in post-engagement surveys.

The AMA Joy in Medicine Health System Recognition Program received a record number of applications in 2025 and recognized 109 health systems who met the evidence-based criteria, representing their commitment to organizational well-being. The Organizational Biopsy team partnered with 151 health care organizations to conduct well-being assessments in 2025. AMA STEPS Forward expanded its library and grew webinar attendees and podcast downloads substantially in 2025. AMA also co-sponsored the 2025 American Conference on Physician Health™ with the Mayo Clinic and Stanford Medicine, with a record number of attendees presenting a record high number of abstracts. In 2025, net expenses

increased \$1 million, driven almost entirely by staffing increases.

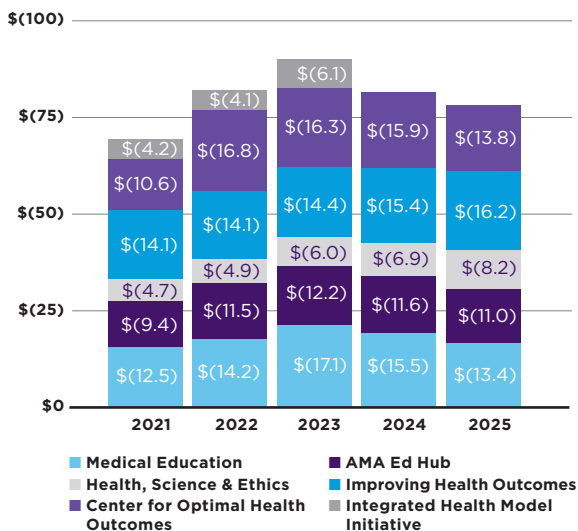
MMX extends the reach and impact of AMA's mission and advocacy initiatives, builds and executes programs to grow and retain members and strengthens the AMA brand. MMX continues to take on increased oversight for managing the quality, timing and relevance of the experience physicians have at each point of interaction through AMA's digital publishing, health system engagement, and member programs. MMX creates or packages AMA's content into digital formats and distributes AMA resources and thought leadership to intended audiences through owned and paid channels, raising awareness of AMA initiatives, resources and accomplishments and elevating the voice of AMA and physicians. Key results in 2025 included the continuation of the "Why We Fight" campaign focused on reforming Medicare payment, fighting scope creep, fixing prior authorization, reducing physician burnout, and making technology work for physicians. MMX also focused on working collaboratively with key business units (PS2, IHO, COHO, Med Ed, Ed Hub) to expand delivery of mission value to existing and potential new health system partners and developing a pragmatic and growth-oriented marketing program for AMA's health equity work. AMA's audience of readers, watchers and listeners totaled over 31 million in 2025.

Net expenses increased \$1.7 million in 2025, with increased spending on compensation and marketing and promotion to support delivery of AMA's message.

Ongoing responsibilities of the Enterprise Communications area include amplifying the work of individual operating units among their core audiences while providing consistency and alignment with the AMA narrative. Enterprise Communications distinctly communicates AMA's leading voice in science and evidence to embed equity, innovation, and advocacy across the AMA's strategic work throughout health care, driving thought leadership on priority issues in health care and digital health; securing speaking opportunities at marquee, high visibility events; publishing op-eds; and enhancing AMA visibility with national and social media opportunities. Net expenses were up \$0.9 million in 2025, largely due to increased staffing costs and leveraging outside agency expertise to drive efficient and effective impact across all external channels.

Core Mission Activities (continued)

(in millions)



While the Accelerating Change in Medical Education (ACE) undergraduate medical school grants successfully concluded in 2018 and the five-year Reimagining Residency grants, designed to improve the transition from undergraduate to graduate medical education and to maintain and reinforce the positive changes initiated by the undergraduate consortium work, ended in 2024, AMA has continued to catalyze innovation in medical education through its ChangeMedEd® initiative. Building upon the learning and momentum gained from the two previous programs, the American Medical Association's efforts and focus have entered an important new phase, forming groundwork teams, issuing innovation grants and identifying select innovation sites to tackle the AMA's new priorities in competency-based medical education, precision education and workforce development.

This initiative has inspired a community of innovation in medical education that works collaboratively to create a workforce better prepared to meet the needs of patients and communities, driving change to reduce barriers to lifelong learning, advance health equity and improve patient outcomes. One of the key outcomes of the ACE consortium was the development of Health Systems Science, a foundational platform and framework for the study and understanding of how care is delivered, how health professionals work together to deliver that care, and how the health system can improve patient care and health care delivery.

In 2025, Med Ed expanded its efforts on precision education, a system that can leverage technology and data to improve education personalization and learning efficiency across the continuum, in support of students, residents, fellows, physicians, and ultimately the needs of patients. Innovation Grants were awarded to 13 sites applying precision education approaches in medical school, residency and continuing professional development. The AMA Transforming Lifelong Learning Through Precision Education (Precision Ed) portfolio, launched in 2025, will cultivate and promote democratization of the precision education ecosystem to offer individualized learning that aligns physician education with the needs of patients both now and in the future. The recipients of a four-year, \$12 million Precision Education grant program were announced, and 11 teams were identified to receive these grants and join the ChangeMedEd Consortium. Med Ed is also responsible for defining or influencing standards for undergraduate, graduate and continuing medical education and providing support for the Council on Medical Education. Over 600 attendees took part in the flagship biennial conference, ChangeMedEd 2025, featuring 30 “blue sky” ideas on the application of AI in medical education.

Net expenses decreased \$2.1 million in 2025, reflecting the end of the Reimagining Residency grant program in mid-2024. The Precision Ed grants will begin in 2026.

The AMA Ed Hub, formally launched in 2018, is a multi-sided platform providing physicians and other health care providers content and educational services that support lifelong professional development. The Ed Hub has unified the AMA education portfolio and integrated an increasing number of external content providers, launched new content sets, and established internal development plans enterprise wide, including the Health Equity Education Center and the UME Curricular Enrichment Program. The Ed Hub also gives physicians and other health professionals a streamlined way to earn, track and report continuing medical education activities spanning clinical, practice transformation and professionalism topics. In 2025, the AMA Ed Hub offered more than 9,000 education activities from AMA and over 80 partner organizations. A new Physician Education Program™ was developed in

2025 for physician members, curating member-only educational bundles. Net expenses were down \$0.6 million in 2025 due largely to a reduced level of technology development and professional services as the Ed Hub platform has reached a stable state.

The Center for Health Equity (CHE) was created in response to a Board sponsored 2018 taskforce that identified a continuing and urgent need for the AMA to play a leading and public role in eliminating health care disparities and promoting health equity through all segments of our society. In late 2025, certain activities in IHO were sunsetted and others merged with CHE in this newly constituted business unit, renamed the Center for Optimal Health Outcomes (COHO), that will fully support the original goal to achieve optimal health for all by eliminating health inequities and improve health outcomes, particularly for marginalized and underrepresented communities.

During 2025, CHE graduated the third cohort of the Medical Justice and Advocacy Fellowship with fellows presenting their capstone projects at the AMA Interim Meeting; convened the first hybrid meeting of the AMA’s Disability Advisory Group and published the first educational module on improving disability inclusion in medicine and health care; and engaged with new policy audiences utilizing the Release the Pressure campaign as an entry point for discussions with lawmakers, engaging for the first time with the Congressional Black Caucus Foundation Annual Legislative Conference. CHE also continued its educational work and continued as an anchor partner in the West Side United Collaborative focusing on improving housing, job creation and local purchasing on Chicago’s West Side.

Additionally, CHE and IHO began the transition to the new combined operating unit launching an innovative grant program for physician led community health projects, the Community Health Impact Lab (CHIL) micro grants. COHO (previously CHE) reported a \$2.1 million net expense decline in 2025, due mainly to reduced use of outside professional services and a small decline in compensation due to open positions.

Health, Science & Ethics is involved in developing AMA policies on scientific, public health and ethical issues for the House of Delegates; providing leadership, subject matter expertise and scientifically sound content and evidence that underpins and informs both current and future AMA initiatives in areas such as infectious disease, drug policy and opioid prescribing; overseeing maintenance of the AMA Code of Medical Ethics and publication of the *AMA Journal of Ethics*®, AMA's online ethics journal, which was wound down in 2025; and managing the United States Adopted Names (USAN) program, responsible for selecting generic names for drugs by establishing logical nomenclature classifications based on pharmacological or chemical relationships (reported separately in group operating results).

In 2025, this group collaborated with Health AI Partnership and the Duke Institute for Health Innovation to develop physician education on the ethical use of AI, including publishing an ethics AI toolkit on the AMA Ed Hub; launched a new online portal to streamline and improve the application process for generic drug names; supported the Firearm Injury Prevention Task Force; and in collaboration with the Ad Council and a coalition of health care leaders, launched a new digital resource hub to empower physicians and other health care professionals to engage in conversations about firearm injury prevention. Net expenses increased \$1.3 million in 2025, with increased staffing costs, a substantial marketing outlay to support flu vaccines and a write-off of technology assets related to closing the *AMA Journal of Ethics*.

As noted above, IHO was downsized substantially in late 2025, with certain activities sunsetted and others merged with the Center for Health Equity in the newly constituted business unit, COHO. IHO over the past several years developed empirically validated tools such as its AMA MAP™ Solutions (for hypertension control) and dashboards that, in conjunction with its well-established partnerships with the American Heart Association (AHA), Centers for Disease Control and Prevention (CDC), and the Ad Council, have created opportunities to focus on community health, in conjunction with the previously named Center for Health Equity.

The main focus during most of 2025 was on hypertension outcome goals using cloud-based MAP BP (a three-step program that works to diagnose and manage patients with hypertension) dashboards at health care organizations (HCOs), providing a visual representation of their performance on five key blood pressure metrics, including stratification by ethnicity, race and gender. The AMA and AHA recognized nearly 2,400 organizations that committed to improving blood pressure control rates by submitting data to the 2025 Target: BP Award Achievement. Over 38 million patients were served by 2,393 total eligible participating health care organizations across 49 U.S. states and territories. To advance the national Million Hearts® campaign, the AMA, in partnership with the CDC and AllianceChicago, engaged five Health Center Controlled Networks and 19 community health centers with an aim to prevent heart attacks and strokes in over 900,000 adult patients, with a focus on minority, rural and medically under-resourced communities.

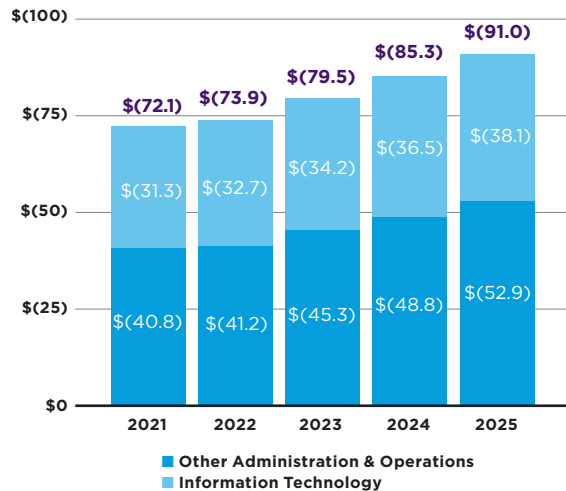
In 2025, net expenses increased by \$0.8 million, largely due to costs related to downsizing certain activities.

Governance

Governance includes the Board of Trustees and Officer Services (BOT), the House of Delegates (HOD) and Sections & International units. The Board of Trustees unit includes costs related to governance activities as well as expenses associated with support of the Core Mission Activities. The HOD, Sections & International unit includes costs associated with annual and interim meetings, groups, sections and other HOD activities, as well as costs associated with AMA's involvement in the World Medical Association. In 2025, Governance net spending was up \$1.2 million, driven by costs for the new Emergency Assistance Program that provides grants to federation societies to fund certain delegate travel costs and higher overall travel and meeting costs for the BOT, HOD and Sections.

Administration and Operations

(in millions)



These units provide administrative and operational support for Publishing & Health Solutions, Membership, and Core Mission Activities, as well as other operating groups. Net expenses were up 6.7 percent in 2025, an increase of \$5.7 million, due primarily to compensation costs from staff additions, filling open positions and merit increases; increased technology costs and outside legal fees.

Affiliated Organizations

Affiliated Organizations represent either grant or in-kind service support provided by the AMA to other foundations and societies. In some cases, the AMA is reimbursed for services provided. No net expenses were reported in 2025.

Unallocated Overhead

The net expenses in this area include costs not allocated back to operating units such as corporate insurance and actuarial services, employee incentive compensation, valuation allowances or other reserves. In 2025, these expenses total \$28.1 million, down \$7.5 million from 2024. Lower incentive and other compensation savings were the main factors in the decline, as well as savings from rent abatement obtained in the headquarters lease renegotiation.

Health2047 and Subsidiary

AMA owns a business formation and commercialization enterprise designed to enhance AMA's ability to define, create, develop, and launch, with partners, a portfolio of products and technologies that will have a profound impact on

many aspects of the U.S. health care system and population health, with a central goal of helping physicians in practice. The AMA Board of Trustees approved the use of reserves to establish this subsidiary with plans to use third-party resources to assist in funding spinoffs with commercial potential in future years. These liquidity events generally occur somewhere between eight and twelve years after the initial spinoff.

Health2047's mission is to advance the AMA's core mission by developing early-stage companies that will attract third party investment as they mature to successful financial exits. Health2047 operates with two critical venture industry expectations: one that only a minority of early-stage start-up companies will reach maturity and consequently that it is important to aggressively manage investments and second that the industry expected timeframe for successful exit is between eight and twelve years.

To date thirteen spinout companies have been launched, nine of which continue to operate and are attracting outside interest and investment. Given the relative youth of Health2047, none of these spinout companies have yet achieved a final financial exit. The nine spinout companies reflect a wide range of physician centric solutions including Medicare Advantage for underserved populations, effective data extraction for health care enterprises, obesity phenotyping for precision medicine, cybersecurity situational awareness for health care, evidence-based point of care insight, a digital learning platform for medical and health professional schools, clinical-grade cognitive rehabilitation using AI-powered tools, and augmented intelligence applied to medical images.

Net expenses increased by \$2.9 million in 2025, including the impact of a \$4.5 million loss on the divestment of ownership in one company, partially offset by reduced use of consultants. In addition, Health2047 liquidated its investment in a subsidiary during 2025, recognizing a \$2 million non-operating gain.

The summary of group operating results is included on the following page.

American Medical Association group operating results

(in millions)	Revenues		Margin (Net expenses)	
	2025	2024	2025	2024
Membership	\$ 33.0	\$ 32.5	\$ 10.3	\$ 10.5
Publishing, Health Solutions & Insurance				
Publishing	64.2	61.7	0.4	0.1
Books and Digital Content	296.4	280.5	267.5	251.1
Database Products	68.6	68.2	51.4	52.6
Insurance Agency/Affinity Products	33.5	34.4	13.3	13.8
Other business operations	-	-	(4.3)	(3.6)
	462.7	444.8	328.3	314.0
Investments (AMA-only)	26.7	22.9	25.9	22.0
Core Mission Activities				
Advocacy	1.2	0.9	(36.0)	(38.2)
Professional Satisfaction and Practice Sustainability	0.7	-	(14.7)	(13.7)
Marketing and Member Experience	0.8	0.9	(20.8)	(19.1)
Enterprise Communications	-	-	(6.7)	(5.8)
Medical Education	0.4	0.2	(13.4)	(15.5)
AMA Ed Hub	0.4	0.4	(11.0)	(11.6)
Health, Science & Ethics	-	-	(8.2)	(6.9)
Center for Optimal Health Outcomes (Center for Health Equity)	0.1	0.7	(13.8)	(15.9)
Improving Health Outcomes	-	-	(16.2)	(15.4)
United States Adopted Names Program	5.1	4.7	4.2	3.8
Grants	3.5	2.9	0.2	0.2
	12.2	10.7	(136.4)	(138.1)
Governance				
Board of Trustees and Officer Services	-	-	(7.6)	(7.8)
House of Delegates, Sections, & International	0.1	0.1	(12.5)	(11.1)
	0.1	0.1	(20.1)	(18.9)
Administration and Operations				
Information Technology	-	-	(38.1)	(36.5)
Senior Executive Management	-	-	(9.4)	(7.4)
General Counsel	-	-	(8.2)	(6.6)
Finance & Risk Management	-	-	(10.3)	(9.8)
Human Resources	-	-	(9.3)	(8.9)
Corporate Services	-	-	(6.6)	(6.2)
Customer Service	-	-	(3.9)	(3.7)
Strategic Insights and Planning	-	-	(5.2)	(6.2)
	-	-	(91.0)	(85.3)
Affiliated Organizations	0.2	0.1	-	-
Unallocated Overhead	1.5	2.1	(28.1)	(35.6)
Health2047 & Subsidiary	-	-	(16.3)	(13.4)
Consolidated revenue and income before tax	\$ 536.4	\$ 513.2	72.6	55.2
Income taxes			(3.9)	(4.1)
Consolidated net operating income			\$ 68.7	\$ 51.1

CONSOLIDATED FINANCIAL STATEMENTS

AMERICAN MEDICAL ASSOCIATION AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF ACTIVITIES

Years Ended December 31

(in millions)	2025	2024
Revenues		
Membership dues	\$ 33.0	\$ 32.5
Advertising	8.2	7.8
Journal print subscription revenues	1.9	2.2
Journal online revenues	32.8	32.2
Other publishing revenues	20.2	18.8
Books, newsletters and online product sales	23.7	22.1
Royalties and credentialing products	340.9	326.0
Insurance commissions	29.0	29.7
Investment income (Note 4)	28.7	25.7
Equity in losses of affiliates (Note 2)	(0.4)	(0.5)
Grants and other income	18.4	16.7
Total revenues	536.4	513.2
Expenses		
Cost of products sold and selling expenses	17.4	23.7
Contribution to general and administrative expenses	519.0	489.5
General and administrative expenses		
Compensation and benefits	287.8	279.4
Occupancy	17.5	19.8
Travel and meetings	22.9	20.4
Technology costs	34.7	34.4
Marketing and promotion	21.6	24.1
Professional services	37.1	35.2
Other operating expenses	24.8	21.0
Total general and administrative expenses	446.4	434.3
Operating results before income taxes	72.6	55.2
Income taxes (Note 10)	3.9	4.1
Net operating results	68.7	51.1
Non-operating items		
Net gain on investments (Note 4)	113.8	79.7
Defined benefit postretirement plan non-service periodic expense (Note 9)	(6.1)	(5.7)
Other non-operating income	2.1	0.1
Total non-operating items	109.8	74.1
Revenues in excess of expenses	178.5	125.2
Changes in defined benefit postretirement plans, other than periodic expense, net of tax (Notes 9 and 10)	(11.4)	2.0
Change in association equity	167.1	127.2
Change in donor restricted association equity		
Restricted contributions	0.7	0.7
Net assets released from restriction	(0.8)	(0.6)
Change in association equity - donor restricted	(0.1)	0.1
Change in total association equity	167.0	127.3
Total association equity at beginning of year	1,150.7	1,023.4
Total association equity at end of year	\$ 1,317.7	\$ 1,150.7

See accompanying notes to the consolidated financial statements.

AMERICAN MEDICAL ASSOCIATION AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF FINANCIAL POSITION

As of December 31

(in millions)	2025		2024	
Assets				
Cash, cash equivalents and donor-restricted cash	\$	46.4	\$	39.6
Fiduciary funds (Note 2)		22.5		21.6
Investments in affiliates (Note 2)		17.8		19.4
Accounts receivable and other receivables, net of an allowance for doubtful accounts of \$0.1 in 2025 and 2024		118.5		110.2
Inventories		1.5		1.7
Prepaid expenses and deposits		13.2		11.6
Deferred income taxes (Note 10)		4.2		3.5
Investments (Note 4)		1,371.0		1,208.4
Property and equipment, net (Note 7)		20.5		24.7
Operating lease right-of-use assets (Note 11)		41.0		50.2
Other assets (Note 6)		12.6		11.3
	\$	1,669.2	\$	1,502.2
Liabilities, deferred revenue and association equity				
Liabilities				
Accounts payable, accrued expenses and other liabilities	\$	16.3	\$	18.8
Accrued payroll and employee benefits (Note 8)		62.6		63.9
Accrued postretirement health care benefits (Note 9)		124.0		108.8
Insurance premiums and other fiduciary funds payable (Note 2)		22.4		21.5
Operating lease liability (Note 11)		56.5		67.4
		281.8		280.4
Deferred revenue				
Membership dues		11.0		11.5
Subscriptions, licensing, insurance commissions and royalties		55.9		56.6
Grants and other		2.8		3.0
		69.7		71.1
Association equity		1,317.7		1,150.6
Donor-restricted association equity		-		0.1
Total association equity		1,317.7		1,150.7
	\$	1,669.2	\$	1,502.2

See accompanying notes to the consolidated financial statements.

AMERICAN MEDICAL ASSOCIATION AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF CASH FLOWS

Years Ended December 31

(in millions)	2025	2024
Cash flows from operating activities		
Change in total association equity	\$ 167.0	\$ 127.3
Adjustments to reconcile change in association equity to net cash provided by operating activities		
Depreciation and amortization	9.4	10.0
Postretirement health care expense	6.4	6.2
Noncash operating lease expense	9.1	8.9
Net gain on investments	(113.8)	(79.7)
Equity in losses of affiliates	0.4	0.5
Noncash charge (credit) for changes in defined benefit plans other than periodic expense net of tax	11.4	(2.0)
Noncash loss upon liquidation of affiliate and subsidiary	2.4	-
Loss on disposal of property and equipment	0.4	-
Bad debt expense	-	0.1
Other	-	(0.3)
Changes in assets and liabilities		
Accounts receivable and other receivables	(8.3)	(5.8)
Inventories	0.2	0.4
Prepaid expenses and deposits	(1.6)	(1.1)
Accounts payable, accrued liabilities and income taxes	(12.3)	(2.0)
Accrued postretirement benefit costs	(3.2)	(3.0)
Deferred revenue	(1.4)	(5.1)
Net cash provided by operating activities	66.1	54.4
Cash flows from investing activities		
Purchase of property and equipment	(7.4)	(6.4)
Investment in affiliates	(3.1)	(4.2)
Purchase of investments	(1,343.4)	(1,228.6)
Proceeds from sale of investments	1,294.6	1,188.3
Net cash used in investing activities	(59.3)	(50.9)
Net change in cash, cash equivalents and donor restricted cash	6.8	3.5
Cash, cash equivalents and donor restricted cash at beginning of year	39.6	36.1
Cash, cash equivalents and donor restricted cash at end of year	\$ 46.4	\$ 39.6
Noncash operating activities		
Right-of-use assets obtained for lease obligation	\$ 0.5	\$ 3.1
Noncash investing activities		
Accounts payable for property and equipment additions	\$ 0.5	\$ 2.3

See accompanying notes to the consolidated financial statements.

AMERICAN MEDICAL ASSOCIATION AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

For the Years Ended December 31, 2025 and 2024
(Columnar amounts in millions)

1. Nature of operations

The American Medical Association (AMA) is a national professional association of physicians with approximately 322 thousand members. The AMA serves the medical community and the public through standard setting and implementation in the areas of science, medical education, improving health outcomes, health equity, delivery and payment systems, ethics, representation and advocacy, policy development, and image and identity building. The AMA provides information and services to hundreds of thousands of physicians and includes journal and book publishing, physician credentialing, database licensing, insurance and other professional services for physicians.

The AMA classifies all operating results as revenues and expenses in the consolidated statements of activities. Non-operating items include net realized and unrealized gains and losses on investments, defined benefit postretirement plan non-service expense and other non-recurring income or expense.

Donor-restricted association equity includes contributions restricted for use for a scope of practice program which are not available for general use by AMA.

2. Significant accounting policies

Consolidation policy

The accompanying consolidated financial statements include the accounts of the AMA and its subsidiaries, AMA Services, Inc., American Medical Assurance Company (AMACO) and Health2047 Inc. (collectively, the AMA).

AMACO, a reinsurer for physician medical professional liability coverage, ceased accepting new and renewal business in 1986 and began running off claims under existing contracts. Since 1986, AMACO pursued the commutation of various treaties and the final treaties were commuted in 2024, with all related exposures eliminated. AMACO obtained approval from the Illinois Insurance Commissioner for a plan of dissolution

and implemented that plan in 2024, with no material impact on the consolidated financial results.

AMA, through its wholly owned subsidiary, Health2047 Inc. (Health2047), has investments in nine companies or limited partnerships as of December 31, 2025.

Health2047 controlled and consolidated the results of one company, First Mile Care, Inc., that was liquidated in 2025 resulting in recognizing a \$2 million gain that is included in other non-operating income.

The equity method of accounting is used to account for investments in companies or limited partnerships in which the AMA has significant influence but not overall control. The investments are initially recorded at the original amounts paid for common and convertible preferred stock and subsequently adjusted for the AMA's share of undistributed earnings and losses from the underlying entities from the dates of formation. Each investment will be increased or reduced by any future additional contributions and distributions received, respectively. The cost method of accounting is used to account for investments in companies in which the AMA has neither significant influence nor overall control and where the fair value is not readily determinable.

The results of one company, Heal Security, Inc. (formed in February 2021) are accounted for under the equity method. At December 31, 2025, AMA ownership interest is 33.3% in Heal Security, Inc. and the book value of the investment, net of convertible debt, is \$0.7 million.

In addition, at December 31, 2025, AMA has an ownership interest in eight companies or limited partnerships. The investments in these entities are accounted for using the cost method, as AMA holds less than a 20% ownership and does not exercise significant influence over the entities. This includes ownership interests of 2.7% in Zing Health Enterprises, LP (formed in May 2020), 16.3% in Medcurio Inc. (formed in February 2020), 19.2% in Phenomix Sciences, Inc. (formed in August 2020), 13.6% in Evidium, Inc. (formerly Recovery Exploration Technologies, Inc., formed in August 2021), 5% in Sitebridge Research, Inc. (formed in January 2021), 5.7% in Scholar Rx, Inc. (acquired in December 2022), 5.3% in IntellixAI, Inc. (acquired in 2023), and 3.5% in Cognitive Health Solutions, Inc. (acquired in 2025). The book value of the eight investments carried at cost at December 31, 2025 is \$17.1 million. AMA divested the majority of its interest in SiteBridge Research, Inc. during 2025 and recognized a \$4.5 million loss that is included in other operating expenses.

Health2047 had investments in nine companies or limited partnerships as of December 31, 2024. Health2047 controlled and consolidated the results of one company, First Mile Care, Inc.

At December 31, 2024, AMA ownership interest was 33.3% in Heal Security, Inc. and the book value of the investment, net of convertible debt, was \$1 million.

In addition, at December 31, 2024, AMA had ownership interest of 2.9% in Zing Health Enterprises, LP, 16.4% in Medcurio Inc., 18.7% in Phenomix Sciences, Inc., 13.2% in Evidium, Inc., 18.4% in Sitebridge Research, Inc., 6% in Scholar Rx, Inc. and 5.4% in IntellixAI, Inc. The investments in these entities were accounted for using the cost method, as AMA held less than 20% ownership and did not exercise significant influence over the entities. The book value of the seven investments carried at cost at December 31, 2024 was \$18.4 million.

Use of estimates

Preparation of consolidated financial statements in conformity with accounting principles generally accepted (GAAP) in the United States of America requires management to make estimates and assumptions that affect reported amounts of assets, liabilities, revenues and expenses as reflected in the consolidated financial statements. Actual results could differ from estimates.

Cash equivalents

Cash equivalents consist of liquid investments with original maturities of three months or less and are recorded at cost, which approximates fair value.

Fiduciary funds

One of the AMA's subsidiaries, the AMA Insurance Agency, Inc., in its capacity as an insurance broker, collects premiums from the insured and, after deducting its commission, remits the premiums to the underwriter of the insurance coverage. Unremitted insurance premiums are invested on a short-term basis and are held in a fiduciary capacity. The AMA also collects and holds contributions on behalf of a separate unincorporated entity with \$2.4 million held at December 31, 2025 and December 31, 2024.

Inventories

Inventories, consisting primarily of books and paper for publications, are valued at the lower of cost or net realizable value.

Property and equipment

Property and equipment are carried at cost, less accumulated depreciation and amortization. Depreciation and amortization are computed using the straight-line method over the estimated useful lives of the assets. Furniture and office equipment, hardware and software are depreciated or amortized over three to 10 years. Leasehold improvements are depreciated over the shorter of the estimated useful lives or the remaining lease term.

Revenue recognition

Revenue is recognized upon transfer of control of promised products or services to customers in an amount that reflects the consideration that AMA expects to receive in exchange for those products or services. AMA enters into contracts that generally include only one product or service and as such, are distinct and accounted for as separate performance obligations. Revenue is recognized net of allowances for returns and any taxes collected from customers, which are subsequently remitted to governmental authorities.

Membership dues are deferred and recognized as revenue in equal monthly amounts during the applicable membership year, which is a calendar year.

Licensing and subscriptions to scientific journals, site licenses, newsletters or other online products are recognized as revenue ratably over the terms of the subscriptions or service period. Advertising revenue and direct publication costs are recognized in the period the related journal is issued. Book and product sales are recognized at the time the book or product is shipped or otherwise delivered to the customer. Royalties are recognized as revenue over the royalty term. Insurance brokerage commissions on individual policies are recognized as revenue on the date they become effective or are renewed, to the extent services under the policies are complete. Brokerage commissions or plan rebates on the group products are recognized as revenue ratably over the term of the contract as services are rendered.

Contract balances

AMA records a receivable when the performance obligation is satisfied and revenue is recognized. For agreements covering subscription or service periods, AMA generally records a receivable related to revenue recognized for the subscription, license or royalty period. For sales of books and products, AMA records a receivable at the time the product is shipped or otherwise delivered to the customer. These amounts are included in accounts receivable on the consolidated statements of financial position and the balance, net of allowance for doubtful accounts, was \$111.9 million and \$103.8 million as of December 31, 2025 and December 31, 2024, respectively.

The allowance for doubtful accounts reflects AMA's best estimate of probable losses inherent in the accounts receivable balance. The allowance is based on historical experience and other currently available evidence.

Payment terms and conditions vary by contract type, although terms generally include a requirement of payment within 30 to 60 days. Some annual licensing agreements carry longer payment terms. In instances where the timing of revenue recognition differs from the timing of invoicing, AMA has determined that these contracts generally do not include a significant financing component.

Prepaid dues by members are included as deferred membership dues revenue in the consolidated statements of financial position. Prepayments

by customers in advance of the subscription, royalty or insurance coverage period are recorded as deferred subscriptions, licensing, insurance commissions and royalty revenue in the consolidated statements of financial position.

Income taxes

The AMA is an exempt organization as defined by Section 501(c)(6) of the Internal Revenue Code and is subject to income taxes only on income determined to be unrelated business taxable income. The AMA's subsidiaries are taxable entities and are subject to income taxes. See Note 10.

Changes in presentation

In 2025, AMA realigned its business units to reflect the current operations of the organization. As a result, the presentation of the functional expenses for 2024 in Note 15 has been updated to be consistent with the current presentation.

As of December 31, 2025, AMA expanded the disclosure of initial health care cost trend rates. As a result, the presentation of the initial health care cost trend rates for 2024 in Note 9 has been updated to be consistent with the current presentation.

3. New accounting standards update

In December 2023, Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) No. 2023-09, *Improvements to Income Tax Disclosures*. This requires an entity to report the amount of income taxes paid disaggregated by federal, state, and foreign taxes as well as the amount of income taxes paid disaggregated by individual jurisdictions in which income taxes paid is equal to or greater than five percent of total income taxes paid. The new standard is effective for AMA for annual periods beginning after December 15, 2025. The adoption of the standard will expand certain footnote disclosures but will not have an impact on the AMA's consolidated financial statements.

In September 2025, FASB issued ASU No. 2025-06, *Targeted Improvements to the Accounting for Internal-Use Software*. This applies to internal use software and replaces the current criteria for capitalization of software development costs with a framework that includes two criteria relating to management authorizing a commitment of funds

and meeting a probable to complete threshold. The new standard is effective for AMA for annual periods beginning after December 15, 2027. The adoption of the standard will not have a material impact on the AMA's consolidated financial statements.

4. Investments

Investments include marketable securities and venture capital private equity investments that are carried at fair value.

In determining fair value, the AMA uses various valuation approaches. The FASB's Accounting Standards Codification (ASC) Topic 820, *Fair Value Measurements and Disclosures*, establishes a hierarchy for inputs used in measuring fair value that maximizes the use of observable inputs and minimizes the use of unobservable inputs by requiring that the most observable inputs be used when available. Observable inputs are inputs that market participants would use in pricing the asset based on market data obtained from sources independent of the organization. Unobservable inputs are inputs that would reflect an organization's assumptions about the assumptions market participants would use in pricing the asset developed based on the best information available in the circumstances. The hierarchy is broken down into three levels based on the observability of inputs as follows:

Level 1—Valuations based on quoted prices in active markets for identical assets that the organization has the ability to access. Since valuations are based on quoted prices that are readily and regularly available in an active market, valuation of these products does not entail a significant degree of judgment.

Level 2—Valuations based on one or more quoted prices in markets that are not active or for which all significant inputs are observable, either directly or indirectly.

Level 3—Valuations based on inputs that are unobservable and significant to the overall fair value measurement.

The availability of observable inputs can vary from instrument to instrument and is affected by a wide variety of factors, including, for example, the liquidity of markets and other characteristics particular to the transaction. To the extent that

valuation is based on models or inputs that are less observable or unobservable in the market, the determination of fair value requires more judgment.

The AMA uses prices and inputs that are current as of the measurement date, obtained through a third-party custodian from independent pricing services.

A description of the valuation techniques applied to the major categories of investments measured at fair value is outlined below.

Exchange-traded equity securities are valued based on quoted prices from the exchange. To the extent these securities are actively traded, valuation adjustments are not applied and they are categorized in Level 1 of the fair value hierarchy.

Mutual funds are open-ended Securities and Exchange Commission (SEC) registered investment funds with a daily net asset value (NAV). The mutual funds allow investors to sell their interests to the fund at the published daily NAV, with no restrictions on redemptions. These mutual funds are categorized in Level 1 of the fair value hierarchy.

The fair value of corporate debt securities is estimated using recently executed transactions, market price quotations (where observable) or bond spreads. If the spread data does not reference the issuer, then data that reference a comparable issuer are used. Corporate debt securities are generally categorized in Level 2 of the fair value hierarchy.

U.S. government agency securities consist of two categories of agency issued debt. Non-callable agency issued debt securities are generally valued using dealer quotes. Callable agency issued debt securities are valued by benchmarking model-derived prices to quoted market prices and trade data for identical or comparable securities. Agency issued debt securities are categorized in Level 2 of the fair value hierarchy.

U.S. government securities are valued using quoted prices provided by a vendor or broker-dealer. These securities are categorized in Level 2 of the fair value hierarchy, as it is difficult for the custodian to accurately assess at a security level whether a quoted trade on a bond represents an active market.

Foreign and U.S. state government securities are valued using quoted prices in active markets when available. To the extent quoted prices are not available, fair value is determined based on interest rate yield curves, cross-currency basis index spreads, and country credit spreads for structures similar to the bond in terms of issuer, maturity, and seniority. These investments are generally categorized in Level 2 of the fair value hierarchy.

Investments also include investments in a diversified closed end private equity fund with a focus on buyout and secondary market opportunities in the United States and the European Union, as well as an investment in a venture capital fund focused on companies developing promising health care technologies that can be commercialized into revolutionary products and services that improve the practice of medicine and the delivery and management of health care. The investments are not redeemable and distributions are received through liquidation of the underlying assets of the funds. It is estimated that the underlying assets will be liquidated over the next four to ten years. The fair value estimates of these investments are based on NAV as provided by the investment managers. Unfunded commitments as of December 31, 2025, and December 31, 2024 totaled \$77.5 million and \$76.1 million, respectively.

The AMA manages its investments in accordance with Board-approved investment policies that establish investment objectives of real inflation-adjusted growth over the investment time horizon, with diversification to provide a balance between long-term growth objectives and potential liquidity needs.

The following table presents information about the AMA's investments measured at fair value as of December 31. In accordance with ASC Subtopic 820-10, investments that are measured at fair value using the NAV per share (or its equivalent) practical expedient have not been classified in the fair value hierarchy. The fair value amounts presented in this table are intended to permit reconciliation of the fair value hierarchy to the amounts presented in the consolidated statements of financial position.

	2025	2024
Level 1 – Quoted prices in active market for identical securities		
Equity securities	\$ 694.2	\$ 588.1
Fixed-income mutual funds	20.6	13.8
	714.8	601.9
Level 2 – Significant other observable inputs		
Debt securities		
Corporate	152.1	139.2
U.S. government and federal agency	286.4	275.9
Foreign government	47.9	39.4
U.S. state government	0.2	0.1
	486.6	454.6
Other investments measured at NAV – Private equity and venture capital funds		
	169.6	151.9
Investments	\$ 1,371.0	\$ 1,208.4

Interest and dividends are included in investment income as operating revenue while realized and unrealized gains and losses are included as a component of non-operating items.

Investment income consists of:

	2025	2024
Investment dividend and interest income	\$ 33.5	\$ 30.1
Management fees	(4.8)	(4.4)
	\$ 28.7	\$ 25.7

Investment non-operating items include:

	2025	2024
Realized gains on investments, net	\$ 55.8	\$ 69.8
Unrealized gains on investments, net	58.0	9.9
	\$ 113.8	\$ 79.7

5. Derivative instruments

AMA uses exchange-traded U.S. Treasury note future contracts in order to efficiently manage duration of fixed income investments in the portfolio. These transactions do not qualify for hedge accounting. The fair value of the futures contracts is recognized as part of investments in the consolidated statements of financial position and changes in the fair value of these futures contracts are recognized as a component of net gain or loss on investments included in non-operating items in the consolidated statements of activities. The fair values as of December 31, 2025 and December 31, 2024 and changes in fair value during 2025 and 2024 were not material.

6. Other assets

Other assets include investments in mutual funds maintained in separate accounts designated for various non-qualified benefit plans that are not available for operations. Mutual funds are open-ended SEC registered investment funds with a daily NAV. The mutual funds allow investors to sell their interests to the fund at the published daily NAV, with no restrictions on redemptions. These mutual funds are categorized in Level 1 of the fair value hierarchy. The investments totaled \$12.6 million and \$11.3 million as of December 31, 2025 and December 31, 2024, respectively.

7. Property and equipment

Property and equipment at December 31 consists of:

	2025	2024
Leasehold improvements	\$ 36.3	\$ 36.1
Furniture and office equipment	17.7	17.6
Information technology		
Hardware	12.2	11.4
Software	97.4	100.9
	163.6	166.0
Accumulated depreciation and amortization	(143.1)	(141.3)
Property and equipment, net	\$ 20.5	\$ 24.7

8. Retirement savings plan

The AMA has a 401(k) retirement and savings plan, which allows eligible employees to contribute up to 75 percent of their compensation annually, subject to Internal Revenue Service (IRS) limits. The AMA matches 100 percent of the first three percent and 50 percent of the next two percent of employee contributions. The AMA may, at its discretion, make additional contributions for any year in an amount up to two percent of the compensation for each eligible employee. Compensation is subject to IRS limits and excludes bonuses and severance pay. AMA matching and discretionary contribution expense totaled \$10.3 million and \$9.8 million in 2025 and 2024, respectively.

9. Postretirement health care benefits

The AMA provides health care benefits to retired employees who were employed on or prior to December 31, 2010. After that date, no individual can become a participant in the plan. Generally, qualified employees become eligible for these benefits if they retire in accordance with the plan provisions and are participating in the AMA medical plan at the time of their retirement. The AMA shares the cost of the retiree health care payments with retirees, paying approximately 60 to 80 percent of the expected benefit payments. The AMA has the right to modify or terminate the postretirement benefit plan at any time. Other employers participate in this plan and liabilities are allocated between the AMA and the other employers.

The AMA has applied for and received the federal subsidy to sponsors of retiree health care benefit plans that provides a prescription drug benefit that is actuarially equivalent to Medicare Part D under the *Medicare Prescription Drug, Improvement and Modernization Act of 2003*. In accordance with ASC Topic 958-715, *Compensation-Retirement Benefits*, the AMA initially accounted for the subsidy as an actuarial experience gain to the accumulated postretirement benefit obligation.

The postretirement health care plan is unfunded. In accordance with ASC Topic 958-715, the AMA recognizes this liability in its consolidated statements of financial position.

The following reconciles the change in accumulated benefit obligation and the amounts included in the consolidated statements of financial position at December 31:

	2025	2024
Benefit obligation at beginning of year	\$ 108.8	\$ 107.8
Service cost	0.3	0.5
Interest cost	6.1	5.5
Benefits paid	(4.6)	(4.4)
Participant contributions	1.2	1.2
Federal subsidy	0.2	0.2
Actuarial loss (gain)	12.0	(2.0)
Accrued postretirement benefit costs	\$ 124.0	\$ 108.8

The postretirement health care plan accumulated actuarial losses not yet recognized as a component of periodic postretirement health care expense, but included as an accumulated charge to equity are \$18.4 million and \$6.4 million at December 31, 2025 and December 31, 2024, respectively.

Actuarial assumptions used in determining the accumulated benefit obligation at December 31 are:

	2025	2024
Discount rate	5.6%	5.7%
Initial health care cost trend		
Pre-Medicare	9.3%	8.4%
Medicare eligible	8.6%	8.6%
Ultimate health care cost trend	4.0%	4.0%
Year that the rate reaches the ultimate trend rate	2050	2048

The change in the initial health care cost trend in 2025 and claims cost experience were the major driver of the \$12 million actuarial loss in 2025. The change in the discount rate from 5.0% at the end of 2023 to 5.7% in 2024, offset by the impact of higher claims cost experience, was the major driver of the \$2 million actuarial gain in 2024.

AMA recognizes postretirement health care expense in its consolidated statements of activities. The service cost component is included as part of compensation and benefits expense and the other components of expense are recognized as a non-operating item:

	2025	2024
Service cost	\$ 0.3	\$ 0.5
Non-service costs		
Interest cost	6.1	5.5
Amortization of actuarial loss	-	0.2
Total non-service costs	6.1	5.7
	\$ 6.4	\$ 6.2

Postretirement health care-related changes, other than periodic expense, that have been included as a charge or credit to unrestricted equity consist of:

	2025	2024
Actuarial (loss) gain arising during period	\$ (12.0)	\$ 2.0
Reclassification adjustment for recognition of actuarial loss	-	0.2
Change in association equity	\$ (12.0)	\$ 2.2

Actuarial assumptions used in determining postretirement health care expense are the same assumptions noted in the table above for determining the accumulated benefit obligation, except as follows:

	2025	2024
Discount rate	5.7%	5.0%
Initial health care cost trend		
Pre-Medicare	7.9%	8.1%
Medicare eligible	8.1%	8.2%

The following postretirement health care benefit payments are expected to be paid by the AMA, net of contributions by retirees and federal subsidies:

2026	\$ 4.5
2027	5.0
2028	5.4
2029	5.8
2030	6.3
2031-2035	37.3

10. Income taxes

The provision for income taxes includes:

	2025	2024
Operating		
Current	\$ 4.0	\$ 4.8
Deferred	(6.5)	(5.2)
Valuation allowance	6.4	4.5
	3.9	4.1
Tax (benefit) expense related to credits or charges to equity		
Deferred	(0.6)	0.2
	\$ 3.3	\$ 4.3

As prescribed under ASC Topic 740, *Income Taxes*, the AMA determines its provision for income taxes using the asset and liability method. Under this method, deferred tax assets and liabilities are recognized for future tax effects of temporary differences between the consolidated financial statement carrying amounts of existing assets and liabilities and their respective tax basis.

The deferred tax benefit or expense from credits or charges to equity represents the estimated tax benefit from recording unrecognized actuarial losses and prior service credits for the postretirement health care plan, pursuant to ASC Topic 958-715.

Valuation allowances are provided to reduce deferred tax assets to an amount that is more likely than not to be realized. The AMA evaluates the likelihood of realizing its deferred tax assets by estimating sources of future taxable income and assessing whether or not it is likely that future taxable income will be adequate for the AMA to realize the deferred tax asset. The valuation allowance reflects the fact that deferred tax assets include future expected benefits largely related to net operating or capital losses where recoverability will not occur until future taxable income is generated, as well as retiree health care payments that may not be deductible due to a projected lack of taxable advertising income in future years. Increases or decreases in deferred tax assets, where future benefits are considered unlikely, will result in an equal and offsetting change in the valuation reserve. If the AMA were to make a determination in future years that these deferred tax assets would be realized, the related valuation allowance would be reduced and a benefit to earnings recorded.

Deferred income taxes recognized in the consolidated statements of financial position at December 31 include the following deferred tax assets and (liabilities):

	2025	2024
Net operating and capital loss carryforward	\$ 37.3	\$ 30.6
Benefit plans and compensation	6.7	6.0
Right-of-use assets	(1.4)	(1.9)
Lease liabilities	1.5	2.1
Other	0.3	0.5
	44.4	37.3
Valuation allowance	(40.2)	(33.8)
	\$ 4.2	\$ 3.5

Cash payments for income taxes were \$3.7 million and \$4.3 million in 2025 and 2024, respectively, net of refunds.

AMA's federal taxes are open to examination by taxing authorities from 2022 through 2025. AMA's state taxes are open to examination for various years depending on the jurisdiction.

11. Leases

AMA leases office space at a number of locations and the initial terms of the office leases range from four years to 15 years. Most office space leases have options to renew at then prevailing market rates, or, in one circumstance, early terminate or contract with appropriate notice and termination payments. As any renewal, termination, or contraction is at the sole discretion of AMA, and at this date is not certain, renewal and termination options are not included in the right-of-use asset (ROU asset) or lease liability. AMA also leases copiers and printers in several locations, with initial terms generally of four years.

The lease agreements do not contain variable lease payments, residual value guarantees or material restrictive covenants. All leases are classified as operating leases.

AMA leases do not provide an implicit interest rate and as such, AMA calculates the lease liability at lease commencement or remeasurement date as the present value of unpaid lease payments using an estimated incremental borrowing rate. The incremental borrowing rate represents the rate of interest that AMA estimates it would have to pay to borrow an amount equal to the lease payments on a collateralized basis over a similar term, based on information available at the time of commencement or remeasurement.

During 2025, AMA exercised an early termination option in the existing Washington, D.C. office. The ROU asset and lease liability were remeasured as of the modification date resulting in a \$4.9 million decrease in both the ROU asset and corresponding lease liability. AMA then entered into a new lease agreement at a different Washington, D.C. location scheduled to commence in 2026. In addition, AMA entered into a new satellite office space lease which resulted in a \$0.5 million increase in the ROU asset and corresponding lease liability.

During 2024, AMA entered into a new office space lease which resulted in a \$3.1 million increase in the ROU asset and corresponding lease liability.

Operating lease costs totaled \$9.1 million in 2025 and \$8.9 million in 2024. Cash paid for amounts included in the measurement of lease liabilities totaled \$9 million in 2025 and \$11.5 million in 2024.

The remaining weighted-average lease term is 9.1 years and 9.9 years as of December 31, 2025 and December 31, 2024, respectively. The weighted-average discount rate used for operating leases is 7.1% and 6.9% for 2025 and 2024, respectively.

The maturity of lease liabilities as of December 31, 2025:

2026	\$	4.0
2027		0.9
2028		4.5
2029		11.2
2030		10.7
2031 and beyond		53.7
Total lease payments		85.0
Less imputed interest		(28.5)
Present value of lease obligations	\$	56.5

12. Financial asset availability and liquidity

AMA has a formal reserve policy that defines the reserve investment portfolios as pools of liquid net assets that can be accessed to mitigate the impact of undesirable financial events or to pursue opportunities of strategic importance that may arise, as well as provide a source of capital appreciation. The policy establishes minimum required dollar levels required to be held in the portfolios (defined as an amount equal to one-year's general and administrative operating expenses plus long-term liabilities). The policy also covers the use of dividend and interest income, establishes criteria for use of the funds and outlines the handling of excess operating funds on an annual basis.

Dividend and interest income generated from the reserve portfolios are transferred to operating funds monthly and used to fund operations. The formal reserve policy contemplates use of reserve portfolio funds for board approved time- or dollar-limited strategic outlays, to the extent that the reserve portfolio balances exceed the minimum amount established by policy. All surplus funds generated from operations annually (defined as operating cash plus other current assets minus current liabilities and deferred revenue at year end) are transferred to the reserve portfolios after year-end. The reserve policy does not cover the for-profit subsidiaries' activities.

AMA invests cash in excess of projected weekly requirements in short-term investments and money market funds. AMA does not maintain any credit facilities as the reserve portfolios provide ample protection against any liquidity needs.

The following reflects AMA's financial assets as of December 31 reduced by amounts not available for general use that have been set aside for long-term investing in the reserve investment portfolios or funds subject to donor restrictions. AMA's financial assets include cash, cash equivalents and donor restricted cash, short-term investments and long-term investments in the reserve portfolios.

	2025	2024
Financial assets	\$ 1,417.4	\$ 1,248.0
Less assets unavailable for general expenditures:		
Restricted by donor with purpose restrictions	-	(0.1)
Restricted by governing body primarily for long-term investing or for governing body approved outlays	(1,302.8)	(1,132.5)
Financial assets available to meet cash needs for general expenditures within one year	\$ 114.6	\$ 115.4

In addition to financial assets available to meet general expenditures over the next 12 months, the AMA operates under a policy that requires an annual budget surplus, excluding time- or dollar-limited strategic expenditures approved by the board, and anticipates generating sufficient revenue to cover general ongoing expenditures on an annual basis.

13. Contingencies

In the opinion of management, there are no pending legal actions for which the ultimate liability will have a material effect on the equity of the AMA.

14. Subsequent events

ASC Topic 855, *Subsequent Events*, establishes general standards of accounting for and disclosure of events that occur after the consolidated balance sheet date but before consolidated financial statements are issued or are available to be issued. For the year ended December 31, 2025, the AMA has evaluated all subsequent events through February 13, 2026, which is the date the consolidated financial statements were available to be issued, and concluded no additional subsequent events have occurred that would require recognition or disclosure in these consolidated financial statements that have not already been accounted for.

15. Functional expenses

The costs of providing program and other activities have been summarized on a functional basis in the consolidated statements of activities. Certain costs have been allocated among the Membership; Publishing, Health Solutions and Insurance; Core Mission Activities and other supporting services.

The expenses that are allocated and the method of allocation include the following: fringe benefits based on percentage of compensation and occupancy based on square footage. All other expenses are direct expenses of each functional area.

	Membership	Publishing, Health Solutions and Insurance	Investments (AMA only)	Core Mission Activities	Governance, Administration and Operations	Health2047 and Subsidiary	Total
Cost of products sold and selling expense	\$ -	\$ 17.4	\$ -	\$ -	\$ -	\$ -	\$ 17.4
Compensation and benefits	7.9	77.3	-	91.7	103.5	7.4	287.8
Occupancy	0.6	5.1	-	6.6	4.2	1.0	17.5
Travel and meetings	0.2	4.2	-	9.1	8.9	0.5	22.9
Technology costs	1.1	12.9	-	6.9	13.7	0.1	34.7
Marketing and promotion	11.0	1.0	-	9.3	-	0.3	21.6
Professional services	0.4	11.2	0.2	17.0	6.0	2.3	37.1
Other operating expense	1.5	5.3	0.6	8.0	4.7	4.7	24.8
2025 total expense	\$ 22.7	\$ 134.4	\$ 0.8	\$ 148.6	\$ 141.0	\$ 16.3	\$ 463.8
Cost of products sold and selling expense	\$ -	\$ 23.7	\$ -	\$ -	\$ -	\$ -	\$ 23.7
Compensation and benefits	7.4	72.5	-	86.4	105.4	7.7	279.4
Occupancy	0.6	5.5	-	6.8	6.1	0.8	19.8
Travel and meetings	0.1	3.9	-	7.5	8.5	0.4	20.4
Technology costs	1.1	12.5	-	7.4	13.2	0.2	34.4
Marketing and promotion	11.5	0.9	-	11.5	-	0.2	24.1
Professional services	0.4	6.5	0.2	19.4	5.1	3.6	35.2
Other operating expense	0.9	5.3	0.7	9.8	3.8	0.5	21.0
2024 total expense	\$ 22.0	\$ 130.8	\$ 0.9	\$ 148.8	\$ 142.1	\$ 13.4	\$ 458.0

INDEPENDENT AUDITOR'S REPORT

The Board of Trustees of American Medical Association

Opinion

We have audited the consolidated financial statements of American Medical Association (the "AMA") and subsidiaries, which comprise the consolidated statements of financial position as of December 31, 2025 and 2024, and the related consolidated statements of activities and cash flows for the years then ended, and the related notes to the consolidated financial statements (collectively referred to as the "financial statements").

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of the AMA as of December 31, 2025 and 2024, and the results of its operations and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS). Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the AMA and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the AMA's ability to continue as a going concern for one year after the date that the financial statements are available to be issued.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of

expressing an opinion on the effectiveness of the AMA's internal control. Accordingly, no such opinion is expressed.

- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the AMA's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control-related matters that we identified during the audit.

Deloitte + Touche LLP

February 13, 2026

WRITTEN STATEMENT OF CERTIFICATION OF CHIEF EXECUTIVE OFFICER AND CHIEF FINANCIAL OFFICER

The undersigned hereby certify that the information contained in the consolidated financial statements of the American Medical Association for the years ended December 31, 2025 and 2024 fairly present, in all material respects, the financial condition and the results of operations of the American Medical Association.

John Whyte MD, MPH
Executive Vice President
and Chief Executive Officer

Denise M. Hagerty
Senior Vice President
and Chief Financial Officer

February 13, 2026

OFFICERS AND TRUSTEES



Standing committees

Executive Committee

Dr. Aizuss, Chair
Dr. Ajayi
Dr. Mukkamala
Dr. Underwood
Dr. Scott
Dr. Ding
Dr. Egbert
Dr. Suk

Audit Committee

Dr. Levin, Chair
Ms. Breig
Dr. Egbert
Dr. Ding
Dr. Ferguson
Dr. Huynh
Dr. Underwood

Awards and Nominations

Dr. Armstrong, Chair
Dr. Garretson
Dr. Jeffers
Mr. Magrath
Dr. Rege
Dr. Van Beek
Dr. Welsh



Compensation Committee

Dr. Suk, Chair
 Dr. Aizuss
 Dr. Underwood
 Dr. Ferguson
 Dr. Ajayi
 Dr. Scott
 Dr. Mukkamala

Governance and Self-Assessment Committee

Dr. Scott, Chair
 Dr. Aizuss
 Dr. Armstrong
 Dr. Ferguson
 Dr. Levin
 Dr. Suk

Finance Committee

Dr. Ferguson, Chair
 Dr. Ding
 Dr. Fryhofer
 Dr. Heine
 Dr. Jeffers
 Dr. Underwood
 Dr. Suk

*Note: Drs. Aizuss, Ajayi and Suk serve on all committees, except where otherwise noted, as ex-officio members without vote.
 Dr. Mukkamala serves on all committees as an ex-officio member with vote.*

CIVIL COVER SHEET

The JS 44 civil cover sheet and the information contained herein neither replace nor supplement the filing and service of pleadings or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. (SEE INSTRUCTIONS ON NEXT PAGE OF THIS FORM.)

I. (a) PLAINTIFFS

PatientRightsAdvocate.org, Inc.

(b) County of Residence of First Listed Plaintiff Middlesex (MA)

(EXCEPT IN U.S. PLAINTIFF CASES)

(c) Attorneys (Firm Name, Address, and Telephone Number)

Cameron T. Norris, Jeffrey M. Harris (Consovoy McCarthy PLLC, 1600 Wilson Boulevard, Ste. 700, Arlington, VA 22209, 703-243-9423)

DEFENDANTS

American Medical Association

County of Residence of First Listed Defendant _____

(IN U.S. PLAINTIFF CASES ONLY)

NOTE: IN LAND CONDEMNATION CASES, USE THE LOCATION OF THE TRACT OF LAND INVOLVED.

Attorneys (If Known)

II. BASIS OF JURISDICTION (Place an "X" in One Box Only)

- ☐ 1 U.S. Government Plaintiff
- ☒ 3 Federal Question (U.S. Government Not a Party)
- ☐ 2 U.S. Government Defendant
- ☐ 4 Diversity (Indicate Citizenship of Parties in Item III)

III. CITIZENSHIP OF PRINCIPAL PARTIES (Place an "X" in One Box for Plaintiff and One Box for Defendant)

- | | PTF | DEF | | PTF | DEF |
|---|----------------------------|----------------------------|---|----------------------------|----------------------------|
| Citizen of This State | ☐ 1 | ☐ 1 | Incorporated or Principal Place of Business In This State | ☐ 4 | ☐ 4 |
| Citizen of Another State | ☐ 2 | ☐ 2 | Incorporated and Principal Place of Business In Another State | ☐ 5 | ☐ 5 |
| Citizen or Subject of a Foreign Country | ☐ 3 | ☐ 3 | Foreign Nation | ☐ 6 | ☐ 6 |

IV. NATURE OF SUIT (Place an "X" in One Box Only)Click here for: [Nature of Suit Code Descriptions.](#)

CONTRACT	TORTS	FORFEITURE/PENALTY	BANKRUPTCY	OTHER STATUTES
☐ 110 Insurance ☐ 120 Marine ☐ 130 Miller Act ☐ 140 Negotiable Instrument ☐ 150 Recovery of Overpayment & Enforcement of Judgment ☐ 151 Medicare Act ☐ 152 Recovery of Defaulted Student Loans (Excludes Veterans) ☐ 153 Recovery of Overpayment of Veteran's Benefits ☐ 160 Stockholders' Suits ☐ 190 Other Contract ☐ 195 Contract Product Liability ☐ 196 Franchise	PERSONAL INJURY ☐ 310 Airplane ☐ 315 Airplane Product Liability ☐ 320 Assault, Libel & Slander ☐ 330 Federal Employers' Liability ☐ 340 Marine ☐ 345 Marine Product Liability ☐ 350 Motor Vehicle ☐ 355 Motor Vehicle Product Liability ☐ 360 Other Personal Injury ☐ 362 Personal Injury - Medical Malpractice PERSONAL INJURY ☐ 365 Personal Injury - Product Liability ☐ 367 Health Care/Pharmaceutical Personal Injury Product Liability ☐ 368 Asbestos Personal Injury Product Liability PERSONAL PROPERTY ☐ 370 Other Fraud ☐ 371 Truth in Lending ☐ 380 Other Personal Property Damage ☐ 385 Property Damage Product Liability	☐ 625 Drug Related Seizure of Property 21 USC 881 ☐ 690 Other LABOR ☐ 710 Fair Labor Standards Act ☐ 720 Labor/Management Relations ☐ 740 Railway Labor Act ☐ 751 Family and Medical Leave Act ☐ 790 Other Labor Litigation ☐ 791 Employee Retirement Income Security Act IMMIGRATION ☐ 462 Naturalization Application ☐ 465 Other Immigration Actions	☐ 422 Appeal 28 USC 158 ☐ 423 Withdrawal 28 USC 157 PROPERTY RIGHTS ☒ 820 Copyrights ☐ 830 Patent ☐ 835 Patent - Abbreviated New Drug Application ☐ 840 Trademark SOCIAL SECURITY ☐ 861 HIA (1395ff) ☐ 862 Black Lung (923) ☐ 863 DIWC/DIWW (405(g)) ☐ 864 SSID Title XVI ☐ 865 RSI (405(g)) FEDERAL TAX SUITS ☐ 870 Taxes (U.S. Plaintiff or Defendant) ☐ 871 IRS—Third Party 26 USC 7609	☐ 375 False Claims Act ☐ 376 Qui Tam (31 USC 3729(a)) ☐ 400 State Reapportionment ☐ 410 Antitrust ☐ 430 Banks and Banking ☐ 450 Commerce ☐ 460 Deportation ☐ 470 Racketeer Influenced and Corrupt Organizations ☐ 480 Consumer Credit ☐ 485 Telephone Consumer Protection Act ☐ 490 Cable/Sat TV ☐ 850 Securities/Commodities/Exchange ☐ 890 Other Statutory Actions ☐ 891 Agricultural Acts ☐ 893 Environmental Matters ☐ 895 Freedom of Information Act ☐ 896 Arbitration ☐ 899 Administrative Procedure Act/Review or Appeal of Agency Decision ☐ 950 Constitutionality of State Statutes
REAL PROPERTY ☐ 210 Land Condemnation ☐ 220 Foreclosure ☐ 230 Rent Lease & Ejectment ☐ 240 Torts to Land ☐ 245 Tort Product Liability ☐ 290 All Other Real Property	CIVIL RIGHTS ☐ 440 Other Civil Rights ☐ 441 Voting ☐ 442 Employment ☐ 443 Housing/Accommodations ☐ 445 Amer. w/Disabilities - Employment ☐ 446 Amer. w/Disabilities - Other ☐ 448 Education PRISONER PETITIONS Habeas Corpus: ☐ 463 Alien Detainee ☐ 510 Motions to Vacate Sentence ☐ 530 General ☐ 535 Death Penalty Other: ☐ 540 Mandamus & Other ☐ 550 Civil Rights ☐ 555 Prison Condition ☐ 560 Civil Detainee - Conditions of Confinement			

V. ORIGIN (Place an "X" in One Box Only)

- ☒ 1 Original Proceeding ☐ 2 Removed from State Court ☐ 3 Remanded from Appellate Court ☐ 4 Reinstated or Reopened ☐ 5 Transferred from Another District (specify) ☐ 6 Multidistrict Litigation - Transfer ☐ 8 Multidistrict Litigation - Direct File

VI. CAUSE OF ACTIONCite the U.S. Civil Statute under which you are filing (Do not cite jurisdictional statutes unless diversity):
17 U.S.C. § 501; 28 U.S.C. §2201

Brief description of cause:

Suit seeking declaration of copyright invalidity, copyright unenforceability, and noninfringement

VII. REQUESTED IN COMPLAINT:☐ CHECK IF THIS IS A CLASS ACTION UNDER RULE 23, F.R.Cv.P. DEMAND \$ _____

CHECK YES only if demanded in complaint:

JURY DEMAND: ☐ Yes ☒ No**VIII. RELATED CASE(S) IF ANY**

(See instructions):

JUDGE Martha M. PacoldDOCKET NUMBER 1:25-cv-15137

DATE

08/13/2026

SIGNATURE OF ATTORNEY OF RECORD

s/ Cameron T. Norris

FOR OFFICE USE ONLY

RECEIPT # _____

AMOUNT _____

APPLYING IFP _____

JUDGE _____

MAG. JUDGE _____

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INSTRUCTIONS FOR ATTORNEYS COMPLETING CIVIL COVER SHEET FORM JS 44

Authority For Civil Cover Sheet

The JS 44 civil cover sheet and the information contained herein neither replaces nor supplements the filings and service of pleading or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. Consequently, a civil cover sheet is submitted to the Clerk of Court for each civil complaint filed. The attorney filing a case should complete the form as follows:

- I.(a) Plaintiffs-Defendants.** Enter names (last, first, middle initial) of plaintiff and defendant. If the plaintiff or defendant is a government agency, use only the full name or standard abbreviations. If the plaintiff or defendant is an official within a government agency, identify first the agency and then the official, giving both name and title.
 - (b) County of Residence.** For each civil case filed, except U.S. plaintiff cases, enter the name of the county where the first listed plaintiff resides at the time of filing. In U.S. plaintiff cases, enter the name of the county in which the first listed defendant resides at the time of filing. (NOTE: In land condemnation cases, the county of residence of the "defendant" is the location of the tract of land involved.)
 - (c) Attorneys.** Enter the firm name, address, telephone number, and attorney of record. If there are several attorneys, list them on an attachment, noting in this section "(see attachment)".
- II. Jurisdiction.** The basis of jurisdiction is set forth under Rule 8(a), F.R.Cv.P., which requires that jurisdictions be shown in pleadings. Place an "X" in one of the boxes. If there is more than one basis of jurisdiction, precedence is given in the order shown below.
- United States plaintiff. (1) Jurisdiction based on 28 U.S.C. 1345 and 1348. Suits by agencies and officers of the United States are included here.
- United States defendant. (2) When the plaintiff is suing the United States, its officers or agencies, place an "X" in this box.
- Federal question. (3) This refers to suits under 28 U.S.C. 1331, where jurisdiction arises under the Constitution of the United States, an amendment to the Constitution, an act of Congress or a treaty of the United States. In cases where the U.S. is a party, the U.S. plaintiff or defendant code takes precedence, and box 1 or 2 should be marked.
- Diversity of citizenship. (4) This refers to suits under 28 U.S.C. 1332, where parties are citizens of different states. When Box 4 is checked, the citizenship of the different parties must be checked. (See Section III below; **NOTE: federal question actions take precedence over diversity cases.**)
- III. Residence (citizenship) of Principal Parties.** This section of the JS 44 is to be completed if diversity of citizenship was indicated above. Mark this section for each principal party.
- IV. Nature of Suit.** Place an "X" in the appropriate box. If there are multiple nature of suit codes associated with the case, pick the nature of suit code that is most applicable. Click here for: [Nature of Suit Code Descriptions](#).
- V. Origin.** Place an "X" in one of the seven boxes.
- Original Proceedings. (1) Cases which originate in the United States district courts.
- Removed from State Court. (2) Proceedings initiated in state courts may be removed to the district courts under Title 28 U.S.C., Section 1441. When the petition for removal is granted, check this box.
- Remanded from Appellate Court. (3) Check this box for cases remanded to the district court for further action. Use the date of remand as the filing date.
- Reinstated or Reopened. (4) Check this box for cases reinstated or reopened in the district court. Use the reopening date as the filing date.
- Transferred from Another District. (5) For cases transferred under Title 28 U.S.C. Section 1404(a). Do not use this for within district transfers or multidistrict litigation transfers.
- Multidistrict Litigation – Transfer. (6) Check this box when a multidistrict case is transferred into the district under authority of Title 28 U.S.C. Section 1407.
- Multidistrict Litigation – Direct File. (8) Check this box when a multidistrict case is filed in the same district as the Master MDL docket.
- PLEASE NOTE THAT THERE IS NOT AN ORIGIN CODE 7.** Origin Code 7 was used for historical records and is no longer relevant due to changes in statute.
- VI. Cause of Action.** Report the civil statute directly related to the cause of action and give a brief description of the cause. **Do not cite jurisdictional statutes unless diversity.** Example: U.S. Civil Statute: 47 USC 553 Brief Description: Unauthorized reception of cable service
- VII. Requested in Complaint.** Class Action. Place an "X" in this box if you are filing a class action under Rule 23, F.R.Cv.P.
- Demand. In this space enter the actual dollar amount being demanded or indicate other demand, such as a preliminary injunction.
- Jury Demand. Check the appropriate box to indicate whether or not a jury is being demanded.
- VIII. Related Cases.** This section of the JS 44 is used to reference related pending cases, if any. If there are related pending cases, insert the docket numbers and the corresponding judge names for such cases.

Date and Attorney Signature. Date and sign the civil cover sheet.