



TASK FORCE ON REORGANIZATION

**FINAL REPORT
JANUARY 7, 2026**

Task Force on Reorganization Final Report

January 7, 2026

Executive Summary

The Michigan State Medical Society (MSMS) faces significant structural, financial, and membership challenges that threaten its long-term viability. The Reorganization Task Force, appointed by the MSMS Board of Directors following resolutions adopted by the 2025 House of Delegates, was charged with developing recommendations to modernize governance, improve efficiency, and strengthen engagement across the organization.

After extensive review and deliberation, the Task Force unanimously recommends a series of comprehensive structural changes designed to position MSMS for the next decade of success. These recommendations are interdependent and intended to be adopted as a unified reform plan rather than individually.

1. Context and Financial Overview

Over the last 25 years, MSMS has experienced:

- 60% decrease in dues revenue
- 51% drop in active members
- 87% reduction in staff (from 154 to 20 employees)

While the 2025 budget was temporarily balanced by one-time grants, ongoing declines in membership and revenue continue. Without reform, MSMS faces an unsustainable future that could result in severe downsizing—potentially to an organization of just three staff members within a few years. The Task Force concluded that structural change is essential to preserve MSMS’s financial integrity, mission, and relevance.

2. Key Recommendations

A. House of Delegates

Recommendation: Replace the House of Delegates with an all MSMS member, online policy-making process.

- Expands participation to all members, rather than the 2% currently represented in the House of Delegates.
- Reduces direct costs (~\$60,000 for in-person meeting) and indirect staff time.
- Modernizes governance through continuous, year-round policy engagement using digital platforms.
- Retains democratic decision-making while improving efficiency and inclusivity.

B. Organizational Partnerships

Recommendation: Eliminate mandatory dual membership between MSMS and county medical societies (CMS).

- Aligns with legal counsel’s findings that the dual membership model poses significant liability risks for MSMS and the CMS.
- Addresses inequitable dues structures (CMS dues range from \$0 to \$415) and the resulting barriers to state membership.
- Reduces administrative complexity (over 2,300 dues combinations) and costs.
- Empowers counties to operate independently while continuing advocacy and collaboration with MSMS.
- Modernizes membership to reflect the realities of modern medical practice, supporting flexibility and affordability.

C. Leadership – Board of Directors

Recommendation: Reduce the size of the MSMS Board of Directors from 36 to 13 members, focusing on skill-based rather than representational governance.

- Reflects nonprofit best practices for associations under \$3 million in revenue.
- Promotes strategic decision-making grounded in financial, organizational, and physician leadership expertise.

D. Judicial Commission

Recommendation: Eliminate the Judicial Commission and peer review committees and transfer disciplinary authority to the Board of Directors.

- Reflects common practice among other state medical societies.
- Streamlines governance by referring complaints to appropriate professional licensing boards while retaining MSMS authority over membership status.

3. Alternate Outcomes

If the recommendations are not adopted and trends continue, MSMS will need to take immediate cost-cutting actions, including:

- Further staff reductions, including potential downsizing to a minimal staff of three employees.
- Elimination of education programs.
- Selling or closing subsidiary businesses - Physicians Insurance Agency (PIA), Professional Credentials and Verification Service (PCVS), Physicians Service Inc (PSI) and Physicians Holding Company (PHC).

Without structural reform, MSMS risks losing its operational capacity, advocacy influence, and long-term sustainability.

4. Conclusion

The Task Force urges the MSMS Board of Directors and House of Delegates to adopt this report in full. The proposed reforms—modern governance, flexible membership, financial

stabilization, and enhanced engagement—represent a realistic, forward-looking approach to rebuilding MSMS into a more efficient, inclusive, and resilient organization prepared for the next era of organized medicine in Michigan.

1. Task Force Charge

Based on three resolutions approved by the House of Delegates in May 2025, the Board of Directors appointed a Task Force on Reorganization to review the structure of the organization with precedence to membership engagement, financial impact and administration simplification. The Task Force was specifically asked to provide recommendations on three major structural areas within MSMS:

- House of Delegates
- Organizational Partnerships (County, Specialty and Physician Organization)
- Leadership (Board of Directors and Judicial Commission)

The Task Force met four times (August, September, October and January) with ambitious agendas, ideas, and recommendations for action. These discussion areas and recommendations were deliberately crafted in tandem to create a cohesive restructuring of MSMS leadership and governance, ensuring the organization is well-positioned for future financial stability and policy effectiveness. While this report contains several recommendations, the Task Force asks the Board of Directors and the House of Delegates to consider this document as a whole. Structural change, while difficult and complex, crosses many areas of the infrastructure. Reforming one without the other creates confusion and inconsistency. Consider the last reorganization efforts which changed the Board of Directors regions but not the House of Delegates. Of note, all recommendations in this report received full consensus from the entire Task Force.

House of Delegate Resolutions Under Review

47-25 - Study Medical Society Structures – APPROVED

RESOLVED: That MSMS study the organizational structures, Constitution and Bylaws, and business model of other state medical societies as potential options for improving the efficiency and productivity of our organization.

16-25 - County and State Medical Society Alliance – APPROVED

RESOLVED: That MSMS create a task force of physicians across the state, in both county and state society leadership, to do the following:

- Examine the history, finances, and bylaws of our county and state societies;
- Be bold and creative in offering a unified solution to solve this historical issue, and future-proof our organizations so we can focus on our mission together;
- Utilize MSMS legal counsel to aid in this effort by examining county medical society and state medical society bylaws and offering a clear plan on how to update county and state medical society bylaws to achieve the mutual goals; and

- Present recommendations to county and state medical societies prior to the 2026 House of Delegates, with any MSMS bylaws changes presented for a first vote at that time.

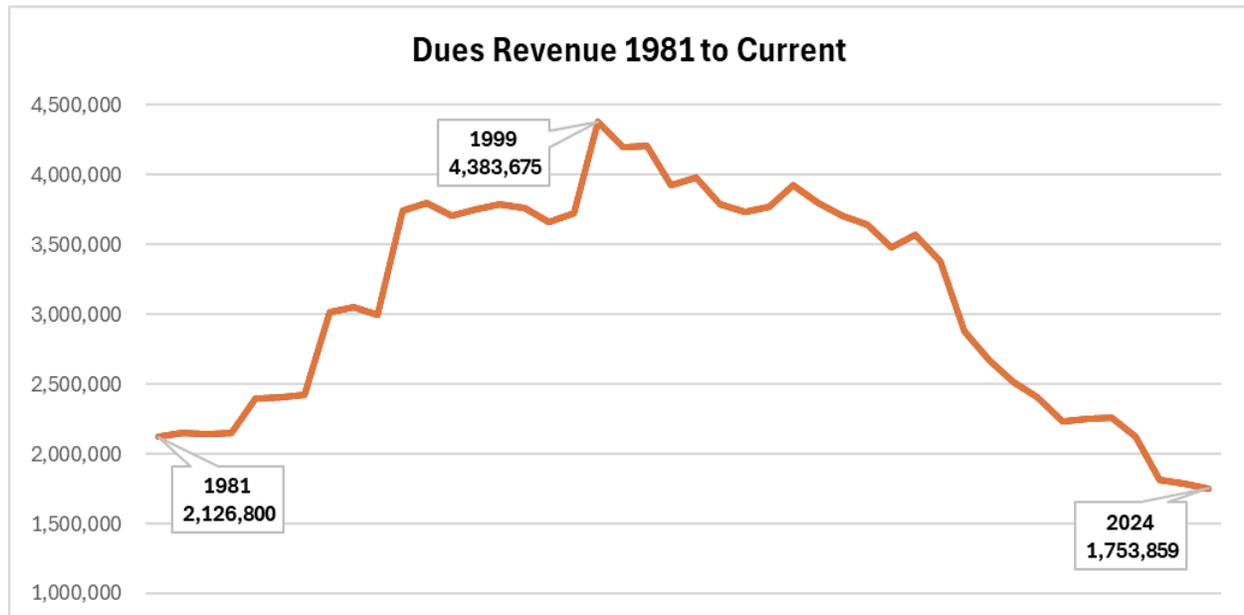
14-25 - Rotation of MSMS House of Delegates Meeting Location – REFERRED

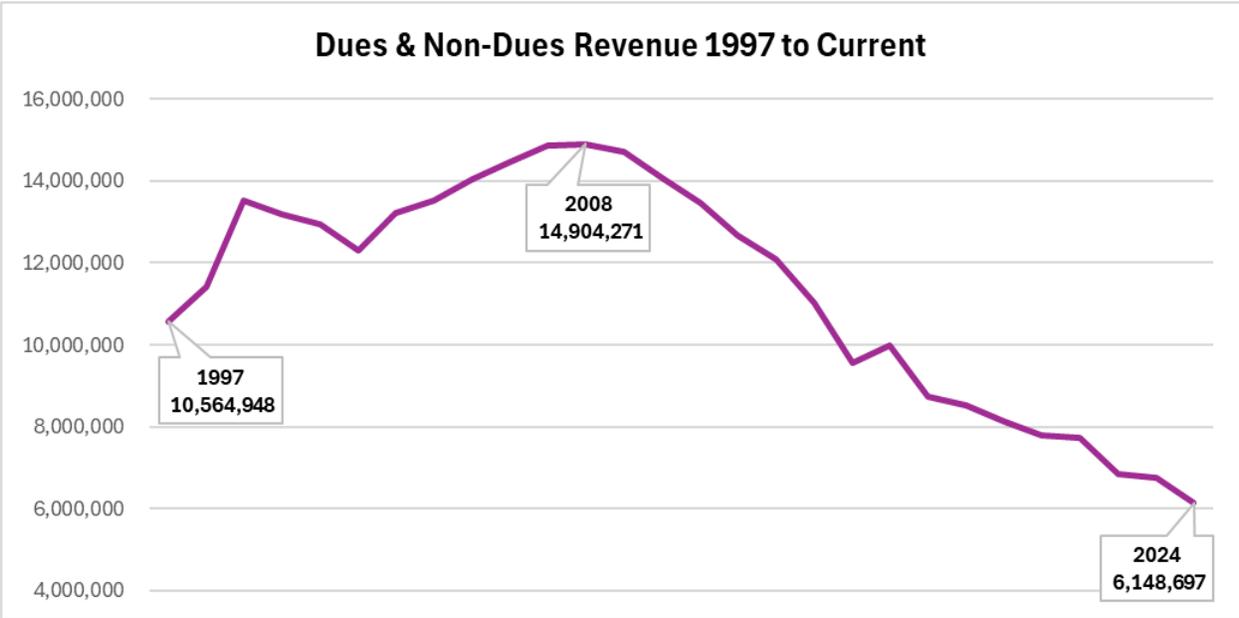
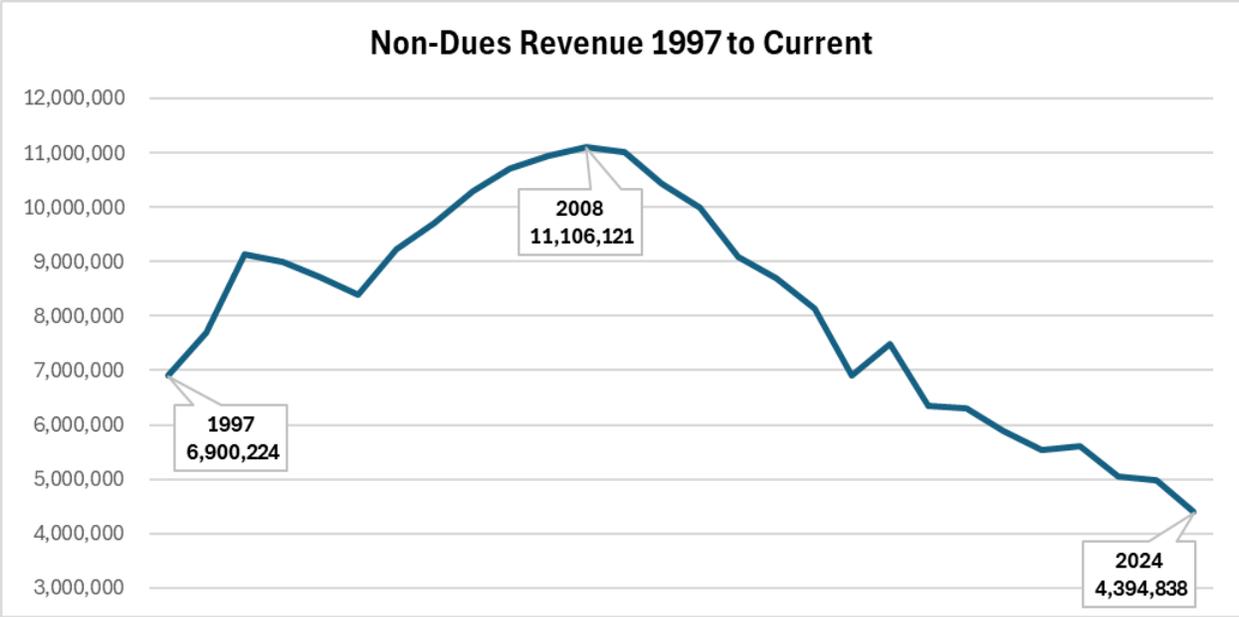
RESOLVED: That the MSMS House of Delegates shall return to the rotation of alternating meetings between an outstate venue and a southeast Michigan venue with the 2026 meeting to be held in the Detroit area.

2. Historical Analysis, Current Status, Projections of Financials

The 2025 budget includes \$600,000 of one-time grants. MSMS will exceed budget this year due to these grants, resulting in a year-over-year increase in revenue. However, MSMS experienced a 15 percent decline in dues revenue in 2025, the third largest year-over-year decrease in the past 25 years. An operating loss was likely if not for the one-time grants.

MSMS has experienced 25 years of declining dues revenue since 1999, which is a 60 percent reduction. Active members have dropped by 51 percent or 4,070 members since 1999; 7,967 in 1999; and 3,950 in 2025. MSMS has also experienced 16 years of declining non-dues revenue beginning in 2010 when the Affordable Care Act (ACA) was passed. Non-dues revenue declined by 60 percent since 2008 going from \$11.1 million to \$4.4 million. The ACA regulations eliminated MSMS’s unique insurance offerings and created health insurance marketplaces resulting in diminishing traditional commission-based insurance sales, which comprised 75 percent of non-dues revenue.





During these 25 years of declining revenue, MSMS had different four CEO's, all who needed to reduce expenses to maintain profitability. Many expenses were reduced including selling the building, closing unprofitable businesses, eliminating/reducing staff benefits and implementing other operational cost efficiencies. However, the single largest expense reduction was staff deductions. Since 1999, MSMS staff has been reduced from 154 to 20 (87% reduction). Of those 20, only nine are dedicated MSMS staff. Others work for a subsidiary company. There have been minimal impacts on services due to the staff restructurings (i.e. fewer staff doing more). For 2026, if not for the conversion of the House

of Delegates to virtual and reducing the American Medical Association Delegation travel reimbursements, MSMS would have budgeted a deficit.

MSMS is budgeting dues revenue to be reduced by another 7 percent in 2026, so membership and revenue are still trending down. This means additional expenses will need to be reduced to remain profitable moving forward. In addition, the staff reductions over the years (including the 45% reduction over the past 3 years) with little change to services has left current staff exhausted. Further staff reductions will necessitate the elimination or reduction of essential services including advocacy, as well as the sale of businesses, eventually leading to a state medical society staffed by three to five people. Since most other expense reductions and restructuring have been directed toward the internal operations of the organization, the next area of focus has been governance and pricing. Also, with a smaller staff, these new restructuring efforts will need to reduce both actual costs and staff administrative time.

In summary, MSMS has experienced 25 years of declining membership dues revenue, 16 years of declining active members, and 25 years of declining staff levels. MSMS must reduce costs to help balance the budget and reduce staff administration time to allow more time for membership and revenue growth. The next steps for MSMS must include real structural reforms. The Officers and the Board of Directors have a fiduciary duty to protect the financial integrity of MSMS. Structural reforms may be uncomfortable for Board members, but they are crucial to fulfilling that responsibility. By possessing the ability to amend the MSMS Constitution and Bylaws, the House of Delegates plays a vital role in enabling the Board of Directors to effectuate what it has determined is necessary to protect the financial integrity of MSMS, position it for continued existence and otherwise make changes that are in the best interest of MSMS.

3. House of Delegates

For any association, an engaged and active member is a member for life. The Task Force considered how MSMS can engage more members in our policy and advocacy efforts with the goals of creating policy with broader physician input and expanding advocacy reach, retaining current members and recruiting new members, and increasing dues revenue.

Through the current process, the House averages 100 delegates in-person for the general session. Over the years, delegates and members expressed several concerns about barriers to participation including the time and travel commitment, the often-tedious process of testimony and voting, and occasionally the unprofessional tone or conduct of delegates. This has created a system whereas mostly the same 100 delegate members determine policy and priorities for thousands of members. In terms of improved representation and structural sustainability, the Task Force was interested in other models of governance that would include more physicians, more members and more engagement.

When MSMS had 16,000 members it was necessary to have a “representative structure” like the House of Delegates due to the sheer size of the organization and need for designated delegates to stay informed about what was happening at the state level. Physicians serving as delegates usually in private practices or retired. Taking time off from private practice, for any reason, was a loss of income in addition to the inconvenience of travel. Now, we have significantly less members and at the same time advances in virtual communication have made it possible to communicate from virtually anywhere instantaneously. As a result, MSMS has the opportunity to move from a cumbersome representative model to a more engaging democratic model where each member’s voice is equally represented.

Another factor that deserves further research and dialogue is the direct and in-direct costs of the meeting. A one-day, in-person, centrally located House of Delegates costs MSMS approximately \$60,000. This does not include in-direct staff costs. In the last few years, MSMS has not had enough employees to cover all the required areas of the meeting. Out of necessity, the work of the House is mostly completed after hours by MSMS staff who shoulder many other responsibilities including revenue. Historically, there were dedicated staff whose entire jobs were preparing for and managing the House of Delegates. However, due to the many budget cuts over the years, those positions were eliminated, and the House was assigned and reassigned to the few remaining staff.

For these critical financial reasons, the Board of Directors voted to transition the House to a virtual format for 2026. This would keep the same Reference Committee process online with live testimony but also move the general session online with live testimony and voting. While this option addresses issues with the direct expenses, it does not fully litigate expanding involvement. In investigating other options, further opportunities exist for process efficiencies, in-direct staff costs and engagement with all members.

While many states have eliminated their House of Delegates completely, about a dozen have moved to an all-member online policy system. They report equal if not greater success in terms of member engagement and policy outcomes. Resolutions are collected year-round. A Policy Review Committee evaluates resolutions two to three times per year. Testimony is collected via an online written forum, like the one currently used. Then the Policy Committee’s recommendations are sent to all members for a vote. The Policy Committee would have authority to evaluate resolutions for purview per bylaws (medical policy vs financial/business decisions), prioritizing practice sustainability and practice of medicine, MSMS scope, and fiscal notes. As many of our state medical societies have already experienced, this system allows all members to have the opportunity to introduce and engage with policy initiatives, allows MSMS to make more timely policy decisions, eliminates all direct costs, creates efficiency and redistributes work throughout the year for the limited staff.

The inaugural Chair and Vice-Chair of the Policy Committee would be the current Speaker and Vice-Speaker of the House of Delegates. The Board of Directors would appoint 10 to

12 other Committee members with recommendations from counties, specialties, sections, physician organizations and individual members. This option allows for more immediate decisions, engages all members, and decreases direct and indirect costs.

With the shift away from an in-person House, the Task Force also conferred the importance of making delegates and members more aware of additional opportunities for engagement. As an example, MSMS meets with:

- County Presidents Meetings – 3/year, 30 attendees
- Special Society Presidents Meetings – 3/year, 40 attendees
- Physician Organization Council Meetings – 6/year, 100 attendees
- MSMS Committees and Boards (10) – at least 2/year, 20-30 attendees
- In-Person Education Conferences – 4/year, 200-250 attendees
- Live Virtual Education Programs – 24/year, 50 attendees
- State of MSMS Open Member Forums – 4/year, 100-150 attendees

House of Delegates Recommendation

The MSMS Task Force on Reorganization recommends replacing the House of Delegates with an all MSMS member, online policy making process.

House of Delegates Resources

A. State Medical Society Data

There is not one resource that tracks this information. Based on states voluntarily responding to an MSMS survey.

- Online option – Colorado, Minnesota, Iowa, Wisconsin, Wyoming
- Some type of hybrid – Illinois
- In-person – California, Indiana, Ohio

B. Recent Attendance Numbers

Delegate Attendance	
2025	105
2024	117
2023	126
2022	115
2021	virtual
2020	virtual
2019	125
2017	125

C. Membership Survey, May 2025 – 350 responses

QUESTION 1: What are the most important reasons you choose to be an MSMS member?

Reason	Count	Percent
Educational opportunities (CME, webinars, etc.)	203	63%
Advocacy at the state level	200	62%
Legal and regulatory updates	132	41%
Staying connected to organized medicine	120	37%
Professional networking	91	28%
Discounts or member-only benefits	51	16%
Practice management support	46	14%
AMA advocacy	44	14%
Physician wellness resources	41	13%
MSMS House of Delegates	38	12%
Other	9	3%

4. Organizational Partnerships

MSMS and the County Medical Societies have many long-term, successful partnerships with groups within the physician and health care community including Specialty Societies, Physician Organizations, Medical Schools, Primary Care, and Other Health Care Associations. Reasons vary but all involve common advocacy or activities with set goals or outcomes. These relationships are strictly voluntary and usually works on a per “topic” basis meaning they may be partners on some issues, and not on others. These are productive, collegial, beneficial relationships that work for all parties. MSMS and CMS have a unique partnership as it is as an additional connection via bylaws with joint membership and a financial relationship. This requirement does not exist for any other collaborations.

Throughout this reorganization process, the Task Force reviewed numerous issues surrounding the joint membership requirements. The first, and perhaps the most pressing matter is legal counsel’s concerns that MSMS is at legal risk for mandating members to also hold membership in a separate entity (that MSMS does not control and has no ability to exercise oversight of) – this also applies to the county with requiring MSMS membership. MSMS and the CMS have no oversight of each other's expenses, financial controls, dues, or tax filings.

MSMS chartering a CMS and maintaining that charter in and of itself often creates the misconception that the CMS is a division of MSMS rather than a separate entity. The requirement of membership in both MSMS and a component society adds to this misconception. For example, members may claim that the MSMS requirement of dual membership constitutes a representation by MSMS that component society dues are being collected, safeguarded and used for proper purposes with MSMS oversight, verification,

and management. A court may view this as a reasonable expectation of members, creditors and others claiming that the component society's relationship to MSMS was misrepresented to them. And further, they were fraudulently induced to pay dues to a defunct or failing component society.

In reviewing the 2025 dues data, MSMS charters 59 component societies. Thirteen are active and collect dues ranging from \$50 to \$415. Eleven are inactive with no discernible activities but still charge dues. According to the state of Michigan and IRS business filings, 2 counties have been dissolved by law and nine have no record. Thirty-five counties are mostly inactive and do not charge dues. With the decreases in membership, this has led to smaller county organizations, fewer physicians engaged in the leadership and overall less oversight. Based on requirements for CPA firms to perform independent financial audits, most of the counties would not qualify for as they do not have adequate staffing to meet standards for internal controls, segregation of duties or approval processes.

The only way to eliminate the risk of claims is to amend the Constitution and Bylaws to eliminate the chartering of component societies by MSMS and the requirement of dual membership in MSMS and a component society. This legal advice protects MSMS, which the MSMS Board has a fiduciary duty to act exclusively in the best interest of MSMS. But also protects County Medical Societies, as County Boards have the fiduciary duty to protect themselves.

Other equally meaningful barriers involve the cost of membership. Selling membership priced at \$495, plus the county dues ranging from \$100 to \$415 has become increasingly difficult. Current membership trends demonstrate this. The price of the dual membership has exceeded the perceived value. This extends from individual membership to groups, even with the quantity discounts. Joint membership requirements also create financial barriers, particularly for younger physicians or those in lower-paying specialties. Options for membership lower the cost of participation, making it easier for more physicians to engage in organized medicine. Additionally, there is significant variability in member benefits and cost across counties, which blurs return of investment for prospective members, individuals and groups. Even MSMS's initiation of free Continuing Medical Education has not made inroads because the dual costs of membership are still greater than the cost of the education. Staff have tracked several non-members a week choosing to purchase education rather than membership for these reasons. Over the past several years, the State and Counties have attempted to partner together to increase their respective memberships via the Membership Committee. This did not result in a significant increase in membership for either party, which again suggests underlying organizational structural problems.

MSMS and CMS create complex dues pricing with more than 2,300 different membership combinations. Group bills take weeks to produce because they cross counties and require a roster. Group practices that span multiple counties often question the value of CMS membership. The task of assigning members to the appropriate county and calculating an

invoice considering the counties varying dues levels is cumbersome at best, and at worst a deterrent to membership. There are real costs associated with billing dues and managing county relationships. The customized membership database with state and county information is complex and expensive. Although MSMS would no longer receive county billing fees (\$47,000 in 2025), costs would decrease overall due to software costs and significant staff time.

The practice of medicine in Michigan has changed dramatically over the past decades, and our membership structure should reflect that reality. Many physicians now work as contracted employees, often practicing in multiple locations or across state lines. Mandatory county membership is impractical for these mobile physicians. Michigan is also increasingly an outlier in requiring joint membership. Many states allow physicians to choose county, state, or both independently. Options for dues modernizes MSMS's structure and makes membership more competitive and attractive to physicians relocating from other states.

The Task Force believes CMS are best positioned to understand and address local needs. Independent dues restore the county medical society's flexibility to establish membership policies that reflect individual community priorities, making those societies more responsive and attractive to local physicians. For example, a county could focus on a local health system or medical school. A special project or initiative could be developed that local physicians would like to participate in without the dual dues of the state. MSMS has heard for years that conservative or liberal policies have turned off local physicians from joining. Under this scenario, local physicians could join the county without the conflict of a state position. This encourages both county societies and MSMS to deliver tangible value to their members, enhancing the strength and relevance of organized medicine in Michigan. This change ensures our societies remain inclusive, relevant, and responsive to all physicians. Done well, the counties and the state could all have increases in membership by better meeting the needs of their communities.

As MSMS has lost members, the same is true for the counties. As previously mentioned, MSMS does not have access to CMS financials. MSMS does have county member numbers and membership revenue. See the 5-year report below. Some counties have remained consistent like Macomb (+9), Lapeer (+13), Kalamazoo (+2), St. Clair (-17) and Muskegon (-15). Other counties have experienced more severe declines in members and revenue like Grand Traverse (-74 and -\$2,110), Kent (-80 and -\$35,389), Ingham (-139 and -\$59,690), Oakland (-161 and -\$54,803), Washtenaw (-361 and -\$89,093), Wayne (-1,620 and -\$222,135). Many of these more significant declines can be attributed to the losses of large groups. Revenue for Saginaw and Jackson counties is not included as they bill for themselves.

MSMS and County Societies have had relationship challenges for decades – this spans dozens of physician leaders, staff and external consultants. Most recently, in 2018, MSMS hired an experienced medical society consultant to facilitate a process for better

communication and understanding between the state and the counties. After a full year and cost of \$21,975 to MSMS, the consultant concluded for many reasons an effective relationship is not impossible, but it remains a challenge in the current environment. Moreover, an incorrect interpretation of the MSMS bylaws caused some counties to believe they had oversight of MSMS business, financial and operations decisions. This is clearly not the case, the MSMS Board has “the custody and entire control of all funds and property of the Society” (Article IX, Section 2). This misunderstanding of the organizational structure continues to distract from the mission of MSMS and its ability to advocate on behalf of physicians and patients. The Task Force discussed that removing the joint membership could reset the relationship to function more like other successful partnerships, to the benefit of all organizations.

Mandatory joint membership can discourage participation. Removing this barrier opens the door for more physicians to join either or both organizations, ultimately strengthening county and state organizations. Separating county and state society dues is practical, forward-looking reform that reflects the realities of modern medical practice, welcomes a broader range of physicians, decreases legal risks, and strengthens organized medicine in Michigan.

MSMS and the County Medical Societies are stronger together. The financial requirement does not change our relationship or partnership to represent physicians in Michigan. This is not being proposed and will not change. All organizations will continue to work on policy and advocacy together.

Organizational Partnership Recommendation

The Task Force recommends the bylaws be amended to allow MSMS and CMS to function independently, therefore adhering to legal recommendations of risk to MSMS; allows counties to focus locally and MSMS at the state level; and applies the same opportunities to MSMS and CMS to be responsible for their own membership and revenue. Partnership and collaboration would remain.

Transition Options for Counties

Strong county medical societies and a strong state society are in the best interest of physicians and organized medicine in Michigan. To assist in the transition to independence, the Task Force also asks the Board of Directors to consider offering county societies the following:

- MSMS will bill 2027 dues at no cost to allow time for counties to research billing and marketing options
- The MSMS Foundation will provide grant opportunities to assist with transition costs identified by county leadership, examples might be to purchase billing software or developing county specific marketing
- Access to membership reporting portal (excel reports) through 2027

- MSMS CEO, CFO and COO are available as a resource in reviewing revenue and expenditures
- Provide insurance and benefit consultation
- Continued assistance with legislative meetings, alerts, etc.
- Continuation of one CME application per year at no cost
- Continued assistance with internal and external speakers

Organizational Partnership Resources

A. County Dues Data

County	Active Dues
Allegan	\$0
Alpena (Alpena/Alcona/Presque Isle)	\$0
Barry	\$0
Bay	\$150
Berrien	\$25
Branch	\$200
Calhoun	\$0
Cass	\$0
Chippewa (Chippewa/Mackinac)	\$0
Clinton	\$0
Delta	\$0
Dickinson (Dickinson/ Iron)	\$0
Eaton	\$0
Genesee	\$415
Gogebic	\$0
Grand Traverse (Grand Traverse/Benzie/Leelanau)	\$50
Gratiot	\$50
Hillsdale	\$0
Houghton (Houghton/Baraga/Keweenaw)	\$200
Huron	\$0
Ingham	\$350
Ionia (Ionia/Montcalm)	\$0
Iosco (Iosco/Arenac)	\$0
Isabella (Isabella/Clare)	\$200
Jackson	\$200
Kalamazoo	\$250
Kent	\$295
Lapeer	\$100
Lenawee	\$150
Livingston	\$0
Luce	\$0
Macomb	\$260
Manistee	\$0
Marquette (Marquette/Alger)	\$150
Mason	\$0
Mecosta (Mecosta/Lake/Osceola)	\$0
Medical (Crawford/Gladwin/Kalkaska/Montmorency/Otsego/Roscommon)	\$0
Menominee	\$0

Midland	\$0
Monroe	\$100
Muskegon	\$275
Newaygo	\$0
Northern (Antrim/Charlevoix/Cheboygan/Emmet)	\$0
Oakland	\$295
Oceana	\$0
Ogemaw (Ogemaw/Oscoda)	\$0
Ontonagon	\$0
Ottawa	\$125
Saginaw	\$300
Sanilac	\$0
Schoolcraft	\$0
Shiawassee	\$0
St Clair	\$225
St Joseph	\$0
Tuscola	\$0
Van Buren	\$0
Washtenaw	\$300
Wayne	\$325
Wexford (Wexford/ Missaukee)	\$0

B. County Member and Revenue

	Bay County Medical Society	Berrien County Medical Society	Branch County Medical Society	Genesee County Medical Society	Grand Traverse County Medical Society	Gratiot County Medical Society	Houghton- Baraga County Medical Society	Ingham County Medical Society	Isabella-Clare County Medical Society
2020									
Members	114	14	6	231	325	6	3	342	7
Revenue	9,135	\$1,350	\$1,200	\$83,949.25	\$9,202.50	\$250.00	\$600	\$99,522.50	\$1,210.00
2021									
Members	121	16	4	205	330	24	3	124	36
Revenue	\$9,960	\$400	\$800	\$74,764.75	\$10,232.50	\$885.00	\$600	\$40,197.50	\$5,240.00
2022									
Members	109	11	4	201	314	28	2	120	41
Revenue	\$8,650	\$275	\$800	\$74,728.50	\$9,635.00	\$1,010.00	\$400.00	\$38,990.00	\$6,020.00
2023									
Members	110	11	3	215	290	30	2	105	38
Revenue	\$8,750	\$275.00	\$600	\$77,551.85	\$8,950.00	\$1,110.00	\$400.00	\$34,422.50	\$5,680.00
2024									
Members	103	11	3	223	281	62	2	372	41
Revenue	11,047.50	\$224.19	\$540	\$75,759.72	\$7,870.50	\$1,863.00	\$360.00	\$40,955	\$5,490.00
2025									
Members	85	10	1	165	251	8	4	203	16
Revenue	\$9,351.00	\$225.00	\$200.00	\$63,546.93	\$7,083.00	\$360	\$630.00	\$39,832	\$2,358.00

	Jackson County Medical Society	Kalamazoo Academy of Medicine	Kent County Medical Society	Lapeer County Medical Society	Macomb County Medical Society	Marquette-Alger County Medical Society	Monroe County Medical Society	Muskegon County Medical Society
2020								
Members	136	118	468	3	285	34	15	86
Revenue	\$18,200.00	\$34,175.00	\$135,478.75	\$300	\$47,054.00	\$10,125.00	\$1,300	\$23,225.00
2021								
Members	145	115	453	4	279	33	16	92
Revenue	\$18,250.00	\$28,300.00	\$129,438.75	\$400.00	\$49,730.00	\$4,950.00	\$1,450	\$23,900.00
2022								
Members	152	111	460	8	258	34	12	89
Revenue	\$18,826.44	\$26,875.00	\$132,278.00	\$753.92	\$50,778.00	\$5,025.00	\$1,150	\$22,812.50
2023								
Members	150	106	452	7	273	38	12	83
Revenue	\$18,580.00	\$25,450.00	\$128,988.75	\$700.00	\$52,845.00	\$5,700	\$1,150	\$21,462.50
2024								
Members	189	121	426	17	408	40	14	74
Revenue	No Info Bill on Ow	\$22,761.00	\$110,962.12	\$1,188.00	\$51,508.00	\$4,500.00	\$1,125.00	\$17,640.00
2025								
Members	193	120	388	16	294	45	14	71
Revenue	No Info Bill on Ow	\$23,627.25	\$100,089.10	\$1,098.00	52,594.00	5,906.25	\$1,125.00	\$17,235.00

	Muskegon County Medical Society	Oakland County Medical Society	Ottawa County Medical Society	Saginaw County Medical Society	St. Clair County Medical Society	Washtenaw County Medical Society	Wayne County Medical Society Southeast MI	MSMS
2020								
Members	86	843	52	245	135	475	2,010	6,768
Revenue	\$23,225.00	\$184,812.50	\$5,100	\$72,165.00	\$19,416.25	\$111,840.00	\$302,455.20	\$2,162,417.19
2021								
Members	92	667	57	281	133	377	3,539	7519
Revenue	\$23,900.00	\$130,657.75	\$5,600.00	\$80,880.00	\$19,215.00	\$83,972.50	\$244,704.00	\$2,053,266.75
2022								
Members	89	573	41	280	131	277	1,111	5,123
Revenue	\$22,812.50	\$112,435.39	\$4,937.50	\$81,180.00	\$18,533.00	\$43,693.41	\$150,932.00	\$1,701,949.64
2023								
Members	83	615	28	270	123	207	2321	5790
Revenue	\$21,462.50	\$124,236.54	\$3,437.50	\$78,780.00	\$17,379.00	\$51,015.00	\$157,457.49	\$1,767,766.47
2024								
Members	74	714	31	350	125	137	1527	5054
Revenue	\$17,640.00	\$125,804.63	\$3,425.63	No Info Bill on Ow	\$16,181.88	\$29,325.80	\$104,541.55	\$1,713,817.25
2025								
Members	71	682	27	313	118	114	390	3960
Revenue	\$17,235.00	\$130,009.11	\$2,981.25	No Info Bill on Ow	\$19,807.60	\$22,747.00	\$80,320.60	\$1,417,049.00

of Association Executives (ASAE) Foundation adds that right-sizing boards improves strategic performance. Their study of 1,583 associations found that effectiveness depends on aligning board size with mission scope, emphasizing strategy and skills over representation. Smaller, skills-based boards are recommended for profit-oriented governance models. Non-profits under \$3 million in revenue, like MSMS, typically have seven to 13 board members. Larger boards with 25 – 40+ are usually reserved for national, multi-division organizations. For example, the Texas Medical Association has 18 Board members, 50 percent less than MSMS with 10 times the revenue and 15 times the members. The American Medical Association has 21 Board members with 150 times the revenue.

With declining membership and revenue there is a need to modernize not just the size, but the composition of the board to reflect these financial challenges. This would include a change from representational governance to skill-based governance. All board members are physicians, but with distinct leadership, finance, and strategic skills. Intent would also include diversity of geography, specialty and practice. Examples of a diverse composition:

- Employed Physician Leaders: System-level insight and strategic connections
- Private Practice Physicians: Independent practice and entrepreneurial discipline
- Academic Medicine: Training, research, and early-career engagement
- Public Health/Community Physician: Population, urban and rural health perspective
- Physician with Finance/Business Background: Financial expertise
- At-Large/Emerging Leader: Innovation and digital insight

The officer structure would have a Chair to lead the board and set strategic direction, Vice-Chair to oversee initiatives and succession, Treasurer/Secretary to direct financial strategy and act as the recording officer and President and President-Elect to represent MSMS internally and externally.

The current board term is three, three-year terms (nine years) plus three more years if holding an officer position (maximum of 12 years). MSMS has annual elections for President, President Elect, Immediate Past President, Treasurer and Secretary (maximum 12 years).

President-Elect and Board members would be elected by members. Officers/Nominating Committee will administer the application process. Chair and Vice Chair would be elected by the Board annually with two-year limits. The Treasurer/Secretary would also be elected by the Board with a six-year limit. Terms would be staggered.

Current Board members not chosen for the new Board would be given priorities for leadership positions in the new Ad Hoc Board Advisory Committee, MSMS Committees, Task Forces and other Boards.

In summary a smaller, more skill-based board with diversity of geography, specialty and practice type of 13 will strengthen efficient decision-making, align governance with current resources and allow a focus on strategic renewal and membership recovery. These changes further position the society for long-term sustainability.

Board of Directors Recommendation

The Task Force on Reorganization recommends the MSMS Board of Directors be comprised of 13 skill-based board members.

6. Judicial Commission

The current MSMS bylaws require CMS to maintain a standing Peer Review and Ethics Committee and for MSMS to maintain a standing Judicial Commission. Most CMS are in non-compliance with this bylaw. The Judicial Commission would be activated by a referral from a CMS Peer Review and Ethics Committee that has recommended an action against one of its members. These processes predate the development of modern boards of medicine and osteopathy.

Most state and specialty medical societies have eliminated these committees or commissions and instead direct complainants to the appropriate licensing body. With the dissolution of Peer Review and Ethics Committees and Judicial Commissions, state medical societies have deferred to their boards to handle disciplinary matters. If a member's professional license is suspended, their membership is automatically suspended.

Eliminating the Judicial Commission and Peer Review Committees reflects common practice among other state medical societies and streamlines governance by referring complaints to appropriate professional licensing boards while retaining MSMS authority over membership status.

Judicial Commission Recommendation

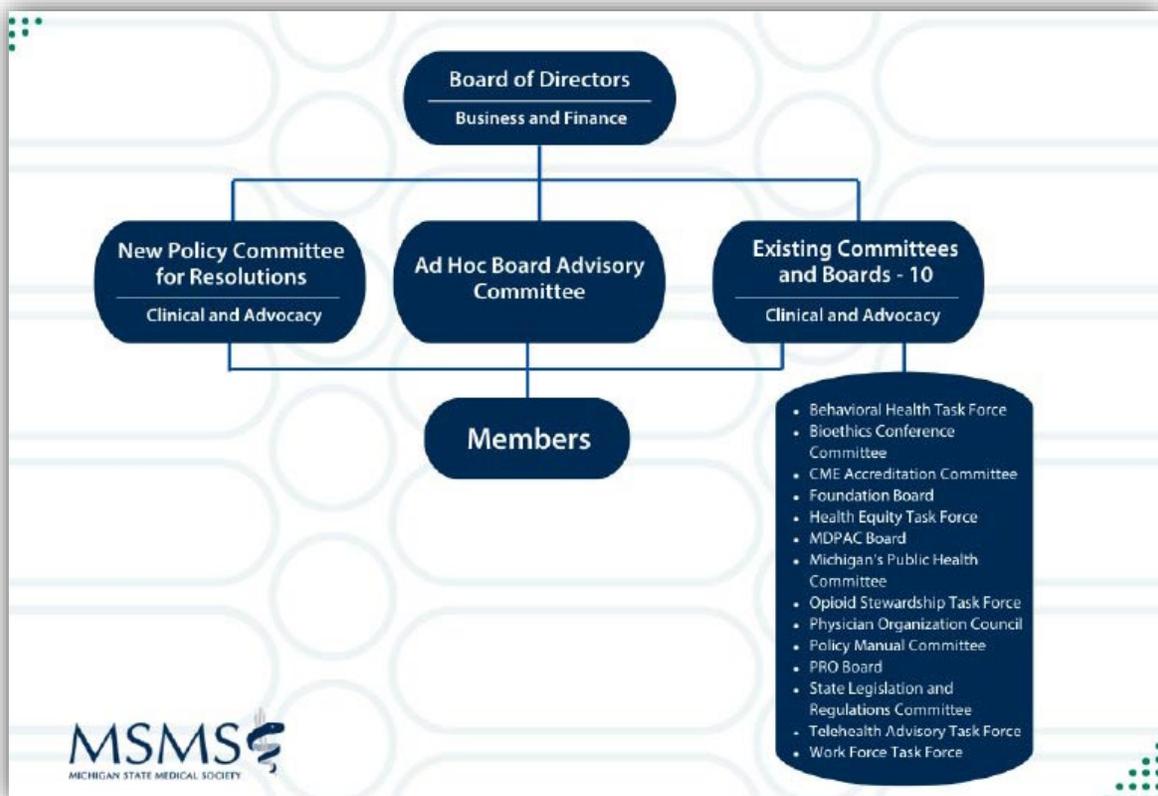
The Task Force on Reorganization recommends eliminating the Judicial Commission and Peer Review Committees and transfer disciplinary authority to the Board of Directors.

7. New Organization Model

After reviewing these financial challenges and decline in membership, the Task Force on Reorganization have recommended replacing the House of Delegates with a Policy Committee process, eliminating the joint membership requirement and reducing the size of the board and changing composition. These changes improve governance efficiencies by reducing costs, improving staff efficiencies, modernizing policy and decision making

and lowering membership prices resulting in increasing the probabilities of maintaining current service levels and reversing declining membership/revenue.

As mentioned previously, each of these recommendations were developed with a new financial and policy structure and reorganization of MSMS. While there are several parts to this report, the Task Force asks the Board of Directors and the House of Delegates to consider this as a comprehensive plan in creating a new path forward and a revisioning of organized medicine in Michigan. An organization chart can be found below to better represent the Board, Policy Committee, the 10 existing Committees and Boards and members.



8. Reorganization Report Distribution and Approval Plan

Approval Process

- Final Meeting of the Task Force to Review and Approve Report – January 7, 2026
- Presentation to the MSMS Board via zoom – January 21, 2026
- MSMS Board Meeting to Further Discuss and Vote – January 28, 2026, and February 26, 2026
- Reference Committee C – March 25, 2026

- House of Delegates - April 18, 2026

Forums – February and March

- Request to speak at County Medical Society Meetings – February 15, 2026
- County President Meeting – February 3, 2026
- County Executive Meeting – February 4, 2026
- Specialty President Meetings – February 10, 2026
- Live Delegate and Member Forums – February 10, 2026, and March 3, 2026, 5:30 pm
- Recorded Video Presentation – Released February 14, 2026

Written Communications

- Delegate Emails – February 6, February 20, March 6 and March 20
- Medigram - February 6, February 14, February 20, February 27, March 6 and March 20

9. Other Options to Reorganization

Should the Board of Directors or the House of Delegates reject the Task Force’s recommendations and trends continue, MSMS will need to implement another plan to reduce more costs to maintain profitability immediately. Much of this would mirror MSMS’s current working relationship with specialty societies. Some parts of that plan could include:

- The House could be converted to online system like 2020 with no live meeting or testimony. Policy making would be simplified and streamlined.
- Eliminate dues billing for county medical societies. This will simplify the billing process to allow MSMS to downsize the membership CRM system to save costs. Cost savings would be greater than the loss of CMS dues billing revenue. This will also reduce staff administration time.
- Transition monthly staff and legislative meetings to as needed and available.
- Create efficiencies with the Board of Directors. This could include reducing meeting times, eliminating one or more meetings, eliminating Board Committees, transition to virtual meetings and utilizing a consent calendar.
- Eliminate MSMS Committees and Task Forces.
- Eliminate external coalition work like Coalition for Auto No Fault, Vaccine Advocacy Groups, MIDOCs, BCBSM Tri-Staff.

Leadership will explore all ideas to operate governance more efficiently without requiring bylaw changes. These changes will not be as efficient as the Task Force recommendations so the probability of MSMS downsizing its operations in the near future will remain high.

Downsizing Sequence, Process and Options (Could Start as Early as 2026)

For more than two decades, MSMS has been quietly weathering the storm of declining revenue. At first, it was manageable, closing unprofitable businesses, cutting non-

essential services and restructuring staff (i.e. fewer staff doing more work). This was all done in hope the tide would turn. However, 25 years later, MSMS is not just in a rough patch, it is the new reality. In fact, 2026 has started with membership revenue projected to decline by over seven percent which is greater than the five and 10-year average year over year loss of just over five percent. If revenue continues to decline, MSMS will no longer be able to maintain the same level of staffing or services once offered and remain profitable. Additional staff consolidations are not possible. There is little left to cut that would not significantly change the organization. Without governance changes, MSMS is close to either using reserves to fund operating deficits or capitulating and downsize the organization to approximately three staff. The three remaining staff would be the CEO, one advocacy staff and one membership staff. In this context, MSMS is essentially surrendering to the financial pressures it's been facing. After decades of declining membership and revenue, the organization acknowledges that it can no longer sustain its current operations, services or staffing levels. The timing would be determined by the Board of Directors based on revenue trends and deficit budgets.

Given this context, it is important for the Board and the House of Delegates to understand the optimal sequence in which operations should be reduced or discontinued. An orderly sequence protects the organization's financial position, maintains legal and regulatory compliance and preserves the value of business assets that will be sold or closed. The downsizing process should begin with the areas that are the least essential to the organization's final stage of operations and that can be eliminated quickly without complex transition requirements.

- **Advocacy (Reduce Staff from three to one)** - Advocacy should be reduced first. Although valued by many members, it does not generate revenue directly and is entirely discretionary from a financial standpoint. Substantially reducing advocacy operations provides immediate expense relief and reduces staff workload without requiring significant lead time. The loss of advocacy effectiveness is a meaningful impact, but in the context of a multi-decade membership and revenue decline, it does not affect the viability of the wind-down.
- **Education (Close Down)** - Education should follow as the next area to downsize. Educational programs are time-intensive, require marketing and administrative support and consume staff resources that the society can no longer afford. While education is visible to members and some join for the free CME, it can be discontinued almost immediately and the financial risk of doing so is minimal. Reducing education programs helps realign operations with the society's reduced capacity and shifting future structure.
- **Membership (Reduce Staff from three to one)** - The membership/marketing department should not be eliminated outright but should be scaled down to a minimal administrative function. Even during a downsizing or wind-down scenario, the society still requires basic membership administrative support including

maintaining member records, processing dues that are still received and distributing any legally required notices related to organizational changes or governance votes. Active membership recruitment or retention strategies are no longer practical, but administrative continuity remains essential.

- **MSMS Subsidiaries (PIA, PCVS, PSI, PHC - Sell or Close Down)** - While MSMS departments can be reduced quickly, subsidiary businesses require a different approach. These businesses cannot be shut down abruptly without significant financial and regulatory consequences. The winddown of these business units requires early planning but later execution.
 - **PIA** – As the for-profit insurance agency, PIA is a department of PSI (see PSI below). Due to its financial importance, PIA should remain operational in the near term while the organization prepares it for sale. This preparation includes improving financial reporting, cleaning customer and policy data, engaging valuation experts, meeting regulatory requirements and positioning the business for maximum market value. Prematurely cutting staff or limiting operations in the agency could reduce its valuation and eliminate one of MSMS’s few remaining revenue streams.
 - **PCVS** - The non-profit credential verification company is smaller with a break-even budget. It also requires proper planning to unwind any contracts with hospitals and other customers. It has little value due to its operating net, but selling should be explored. If a buyer cannot be found, it should be closed down. It cannot be closed abruptly, but its transition can occur earlier than PIA once formal notice periods and transition support plans are established.
 - **PSI** – PSI, the for-profit management company, holds a contract with Physicians Review Organization (PRO). PSI would need to work with PRO to cancel this contract in a reasonable time frame. Since PIA is the largest business segment, PSI will not be closed until PIA is sold off.
 - **PHC** – PHC, the for-profit holding company, has no business activities but does hold the stock in PSI and PCVS. PHC can be closed after PSI and PCVS have been sold or closed.
- **COO, CFO, Finance** - The organization’s operational leadership, the Chief Operating Officer (COO), should remain in place through the final-stage of downsizing. The COO will be critical in overseeing program closures, staff reductions, transitions involving business units and operational realignment. Only once all operational functions have been completed should the COO role be eliminated. The finance department or an equivalent outsourced finance function must be preserved until the final stage of the organization’s operations. Finance is essential for audit work, tax compliance, reserve management, business sale transactions, payroll processing, severance calculations, contract terminations and final dissolution filings. Eliminating finance too early would create serious fiduciary, legal, and regulatory risks for the board and the organization. For this reason, the Chief Financial Officer (CFO) is expected to remain until the end, ensuring accurate

financial reporting and compliant closure of all financial and legal obligations. Once completed, the CFO role will be eliminated.

The appropriate sequence of downsizing begins with the rapid elimination or reduction of advocacy and education, followed by a reduction of membership activities to administrative support only. At the same time, MSMS should begin preparing its businesses for transition, recognizing that PCVS can likely be closed earlier, while PIA must be maintained until it can be sold or transitioned without loss of value. Operational and financial management can be reduced once the work is complete and the MSMS reaches its final stage of wind-down and business closures.

In summary, if membership and revenue continue to decline without recommended structural changes, MSMS will need to use reserves to fund operating deficits and eventually downsize the organization by selling businesses, eliminating services and reducing staff from 20 to three.

The Board of Directors has a fiduciary duty to operate the organization in fiscally responsible ways. Making structural changes to improve governance efficiencies is one way the Board and the House can fulfill this duty. Improving efficiencies are best practice and needed in times of financial distress.

10. Task Force Members

- Brian Stork, MD, Chair - Muskegon
- Paul Bozyk, MD - Oakland
- Nick Fletcher, MD - Kent
- Mark Komorowski, MD - Bay
- Eric Larson, MD - Kent
- Gary Sarafa, MD - Oakland
- Richard Schultz, MD – Grand Traverse
- Salim Siddiqui, MD - Wayne
- Brad Uren, MD - Livingston
- John Waters, MD - Genesee
- David Whalen, MD - Kent
- Claudia Zacharek, MD - Saginaw
- Romy Shubitowski, County Executive - Oakland

3/19/26

