Single-Payer Resolutions in the AMA-Medical Student Section

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Background

The American Medical Association (AMA) has a decades-long history of staunch opposition to single-payer health care reform. In 1949, the AMA spent a record-breaking sum of money lobbying against President Truman's national health insurance proposal.[1] The AMA created medicine's first-ever political action committee (AMPAC) in 1961 specifically to counter the growing political momentum for the creation of Medicare.[2] Despite its membership comprising a declining share of American physicians (approximately 15 percent in 2011 and falling),[3] the AMA remains the most powerful physician lobbying organization in Washington, D.C., and ranks among the top-ten highest-spending lobbying organizations in the nation.[4] The original student organization affiliated with the AMA – the Student American Medical Association (SAMA) – was established in 1950 but dissociated from the AMA in 1967 due to its more progressive positions on civil rights, universal health care, and war.[5] In 1975, SAMA changed its name to the American Medical Student Association (AMSA), an organization that continues to advocate for universal health care in the form of national single-payer health insurance.[6] The AMA-Medical Student Section (AMA-MSS) started in 1979 as an internal sub-section of the AMA, and it has functioned historically as a social conscience within the AMA, placing "principle before political expediency, patient advocacy before professional trade unionism."[7] However, the AMA-MSS had not taken a position on single-payer until a 2014 resolution led by Brad Zehr of Boston University School of Medicine.[8] In June 2017, the AMA-MSS adopted a resolution in support of national single-payer reform,[9] and in November 2017, the AMA-MSS adopted a resolution recommending the AMA House of Delegates rescind its longstanding anti-single-payer policies in favor of a neutral stance to facilitate a national conversation on single-payer reform. This resolution will be brought to the AMA House of Delegates by the MSS Delegate Jerome Jeevarajan (a PNHP student member) for debate at the AMA Annual Meeting in Chicago, June 9-13, 2018.

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Contents of Packet

Pages 3-7: AMA-MSS Annual Meeting, June 2014
Resolution as submitted with 61 medical student co-authors from 18 medical schools. The resolution asked the AMA to advocate for single-payer health insurance. The AMA-MSS Reference Committee recommended against adoption based on the argument that the resolution was politically futile given the AMA House of Delegates' longstanding policy opposing single-payer. The resolution was not adopted. However, the authors received feedback from AMA-MSS leadership recommending we bring a more politically feasible resolution to the next meeting such as making it "support" rather than "advocate," state-based rather than national, and internal to the medical student section of the AMA rather than pertaining to the entire AMA.

Pages 8-12: AMA-MSS Interim Meeting, November 2014
Resolution as submitted with 2 state delegations and 2 medical school delegations as co-authors. The resolution asked the AMA-MSS to support legislation by states to implement single-payer. The AMA-MSS Reference Committee recommended adoption with amendment as follows: "AMA-MSS supports state-level legislation to implement innovative programs to achieve universal health care, such as single-payer health insurance." During floor debate, further wordsmithing and compromise took place. The final language as adopted is: "AMA-MSS supports state-level legislation to implement innovative programs to achieve universal health care, including but not limited to single-payer health insurance." Despite its substantial weakening from the original resolution in June 2014, this resolution was historic in that it was the first ever instance of an AMA section expressing support for the concept of single payer.

Pages 13-19: AMA-MSS Annual Meeting, June 2017
Resolution as submitted with 2 regional delegations and 8 medical student co-authors. The resolution asked the AMA-MSS to support implementation of a national single-payer system, as well as some other extraneous policy clean-up. The AMA-MSS Reference Committee recommended adoption with amendment (some changes to the extraneous policy clean-up but keeping the major Resolve clause about MSS support for national single payer). The resolution was adopted, marking the first time ever an AMA section voiced support for national single-payer reform.

Pages 20-25: AMA-MSS Interim Meeting, November 10-11, 2017
Resolution as submitted with 1 region co-author and 8 medical student co-authors. The resolution asks the AMA to rescind several policies that voice explicit opposition to single payer health insurance. The goal is to address a discrepancy in AMA policy: One the one hand, AMA H-165.847 states that "Comprehensive health system reform, which achieves access to quality health care for all Americans while improving the physician practice environment, is of the highest priority for our AMA"; but on the other hand, AMA has several policies with blanket opposition to one of the most popular proposals for universal health care: national single payer health insurance. The resolution was adopted by the AMA-MSS, with title changed from "Normalizing AMA position on Single-Payer Health Care Reform" to "Expanding AMA's position on healthcare reform options." It will be debated in the AMA House of Delegates at the Annual Meeting in June 2018.

Resolution ##
(A-14)

Introduced by: Bradley Zehr (brzehr@bu.edu), Samuel Sheffield, Chi-Fong Wang, Calvin Fong, Janine Petito, Vishal Gupta, Celeste Peay, Genevieve Guyol, Liat Bird, Laura Ha, Robert Carey, Nadeem Abou-Arraj, Katrina Ciraldo, Hannah Harp, Nahiris Bahamon, and Jawad Husain, Boston University School of Medicine; Matthew Young and Samia Osman, Harvard Medical School; Christina Weed, Luyang Liu, and Astrid Gleaton, Tufts University School of Medicine; Nicole Mushero, University of Massachusetts Medical School; Xin Guan, Daniel Kent, Janice Lee, Victoria Chee, Justin Pegueros, and Ajay Major, Albany Medical College; Catherine Marando, Samuel Rosner, Hannah Keppler, and Rachel Herold, Albert Einstein College of Medicine; Nicholas Abt, Johns Hopkins School of Medicine; Danielle Baurer, Temple University School of Medicine; John E. Demko, Leah Swanzy, Ben Ware, Akash Goyal, Kishan Thadikonda, Matt Kwon, Arjun Prabhu, Melina Rad, and Ryan Williamson, University of Pittsburgh School of Medicine; Audrey Bowes, Victoria Powell, Kimberly Bowman, Jake Wayman, and Aaron Lam, Virginia Commonwealth University School of Medicine; Andrew Morrow, Indiana University School of Medicine; Joshua Faucher, Eric Jackson, Dominic Caruso, Swathi Damodaran, and Ashley Cobb, Mayo Medical School; Scott Goldberg, University of Chicago Pritzker School of Medicine; Jose-Marc Techner and Margaret Russell, Northwestern University Feinberg School of Medicine; Phillip Zegelbone, University of South Florida Morsani College of Medicine; James Besante, University of New Mexico School of Medicine; Allison Wood, University of Colorado School of Medicine; Jessica Reid, University of Southern California Keck School of Medicine.

Subject: Advocacy for Single-Payer Health Insurance

Referred to: MSS Reference Committee

Whereas, 48 million Americans lacked health insurance in 2012,[1] and an estimated 31 million Americans will remain uninsured in 2024 despite advances made by the *Patient Protection and Affordable Care Act*;[2] and

Whereas, Underinsurance is expanding as many patients are forced into private health insurance plans with high deductibles (> $1,000) and narrow provider networks;[3] and

Whereas, 28 million low-income Americans will cross between Medicaid and the subsidized private health insurance exchanges annually, an effect called “churning”, which erodes continuity of care;[4] and

Whereas, The United States ranks last out of 19 high-income countries in preventing deaths amenable to medical care before age 75;[5] and

Whereas, The United States ranks last out of 7 wealthy nations in health care access, patient safety, coordination, efficiency, and equity;[6] and

Whereas, The United States spends twice as much per capita on health care compared to the average of wealthy nations that provide universal coverage;[7] and

Whereas, Medicare overhead costs are less than 2%,[8] and private health insurance overhead costs range from 7% to 30%, with an average of 12%;[9]

Whereas, Providers are forced to spend tens of billions more dollars dealing with insurers' billing and documentation requirements,[10] bringing total administrative costs to 31% of U.S. health spending, compared to 16.7% in Canada;[11] and

Whereas, The United States could save more than $380 billion annually on administrative costs with a single-payer system,[11] enough to cover all of the uninsured and eliminate or dramatically reduce cost-sharing (deductibles, co-payments, co-insurance) for everyone else;[12] and

Whereas, A single-payer Medicare-for-All national health insurance system would fundamentally simplify the financing of health care in the United States;[13] and

Whereas, A single-payer system would cover every American from birth for all necessary medical care and would virtually eliminate health uninsurance and underinsurance in the United States;[13] and

Whereas, A single-payer system would increase patients' freedom to choose among health care providers and not be constrained by arbitrary private insurance networks;[13] and

Whereas, A single-payer system would protect the physician-patient relationship from interference by for-profit health insurance companies whose purpose is to maximize profit;[13] and

Whereas, A single-payer system would facilitate regional health system planning, directing capital funds to build and expand health facilities based on evidence of need, rather than being driven by the dictates of the market, which increases geographical inequality;[13] and

Whereas, Hospitals and clinics could remain private not-for-profit organizations under a government-financed single-payer system, in contrast to the government-operated hospitals of the Veterans Administration;[13] and

Whereas, A single-payer system would control costs through proven-effective mechanisms such as negotiated global budgets for hospitals and negotiated drug prices, thereby making health care financing sustainable;[14] and

Whereas, Support among physicians for government legislation to establish national health insurance increased from 49% in 2002 to 59% in 2007;[15] and

Whereas, Support among the general United States population for a single-payer health care system climbed from 28% in 1979 to 49% in 2009;[16] and

Whereas, There is single-payer legislation in both houses of Congress, H.R. 676 and S. 1782, that outlines the transition to an expanded and improved Medicare for all, including re-training programs for private health insurance workers whose jobs would be lost;[17,18] and

Whereas, Vermont passed legislation in 2011 to create a "pathway to single-payer" in that state starting in 2017,[19] the soonest allowed under Section 1332 of the Affordable Care Act,[20] and many other state legislatures are considering similar legislation;[21,22,23,24,25] therefore be it

RESOLVED, That our American Medical Association shall advocate for legislation to implement a single-payer health insurance system.

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AMERICAN MEDICAL ASSOCIATION
MEDICAL STUDENT SECTION

Resolution ##
(I-14)

Introduced by: Massachusetts Delegation (Corresponding Author: Brad Zehr, zehr.brad@gmail.com); Wisconsin Delegation; University of Vermont School of Medicine; State University of New York Downstate College of Medicine.

Subject: MSS Support for State-by-State Single-Payer Health Insurance

Referred to: MSS Reference Committee

Whereas, 48 million Americans lacked health insurance in 2012,[1] and an estimated 31 million Americans will remain uninsured in 2024 despite advances made by the *Patient Protection and Affordable Care Act*;[2] and

Whereas, Underinsurance is expanding as many patients are forced into private health insurance plans with high deductibles (> $1,000) and narrow provider networks;[3] and

Whereas, 28 million low-income Americans will cross between Medicaid and the subsidized private health insurance exchanges annually, an effect called "churning", which erodes continuity of care;[4] and

Whereas, The United States ranks last out of 19 high-income countries in preventing deaths amenable to medical care before age 75;[5] and

Whereas, The United States ranks last out of 7 wealthy nations in health care access, patient safety, coordination, efficiency, and equity;[6] and

Whereas, The United States spends twice as much per capita on health care compared to the average of wealthy nations that provide universal coverage;[7] and

Whereas, Medicare overhead costs are less than 2%,[8] and private health insurance overhead costs range from 7% to 30%, with an average of 12%;[9]

Whereas, Providers are forced to spend tens of billions more dollars dealing with insurers' billing and documentation requirements,[10] bringing total administrative costs to 31% of U.S. health spending, compared to 16.7% in Canada;[11] and

Whereas, The United States could save more than $380 billion annually on administrative costs with a single-payer system,[11] enough to cover all of the uninsured and eliminate or dramatically reduce cost-sharing (deductibles, co-payments, co-insurance) for everyone else;[12] and

Whereas, A single-payer Medicare-for-All national health insurance system would fundamentally simplify the financing of health care in the United States;[13] and

Whereas, A single-payer system would cover every American from birth for all necessary medical care and would virtually eliminate health uninsurance and underinsurance in the United States;[13] and

Whereas, A single-payer system would increase patients' freedom to choose among health care providers and not be constrained by arbitrary private insurance networks;[13] and

Whereas, A single-payer system would protect the physician-patient relationship from interference by for-profit health insurance companies whose purpose is to maximize profit;[13] and

Whereas, A single-payer system would facilitate regional health system planning, directing capital funds to build and expand health facilities based on evidence of need, rather than being driven by the dictates of the market, which increases geographical inequality;[13] and

Whereas, Hospitals and clinics could remain private not-for-profit organizations under a government-financed single-payer system, in contrast to the government-operated hospitals of the Veterans Administration;[13] and

Whereas, A single-payer system would control costs through proven-effective mechanisms such as negotiated global budgets for hospitals and negotiated drug prices, thereby making health care financing sustainable;[14] and

Whereas, Support among physicians for single-payer health insurance was 42% in 2009;[15] and

Whereas, Support among the general United States population for a single-payer health care system climbed from 28% in 1979 to 49% in 2009;[16] and

Whereas, There is single-payer legislation in both houses of Congress, H.R. 676 and S. 1782, that outlines the transition to an expanded and improved Medicare for all, including re-training programs for private health insurance workers whose jobs would be lost;[17,18] and

Whereas, Vermont passed legislation in 2011 to create a "pathway to single-payer" in that state starting in 2017,[19] the soonest allowed under Section 1332 of the Affordable Care Act,[20] and many other state legislatures are considering similar legislation;[21,22,23,24,25] therefore be it

RESOLVED, That our AMA-MSS supports legislation by states to implement single-payer health insurance.

References:

1. U.S. Census Bureau. (2013) Income, poverty and health insurance coverage in the U.S.: 2012. Available at https://www.census.gov/prod/2013pubs/p60-245.pdf.

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Interim 2014 Final Policy as Adopted

165.017MSS	MSS Support for State-by-State Universal Health Care: AMA-MSS supports state-level legislation to implement innovative programs to achieve universal health care, including but not limited to single-payer health insurance. (MSS Res 13, I-14)

https://www.ama-assn.org/sites/default/files/media-browser/public/mss/mss-digest-of-policy-actions.pdf

AMERICAN MEDICAL ASSOCIATION
MEDICAL STUDENT SECTION

Resolution ##
(A-17)

Introduced by: Region 3; Region 5; Trevor Cline, UC Davis School of Medicine; Eric Xie, Johns Hopkins University School of Medicine; Adam Roussas, University of Arizona College of Medicine; Steven Young, Tufts University School of Medicine; Anna Yap, Loma Linda University School of Medicine; Dan Adam, Creighton University School of Medicine; Divya Iyer, University of Connecticut Medical Center; Rohan Rastogi, Boston University School of Medicine

Subject: National Healthcare Finance Reform: Single Payer Solution

Referred to: MSS Reference Committee

Whereas, Despite many attempts at health system reform, the United States health care system remains plagued by continued rates of uninsurance, excessive expense, unequal health outcomes based on race and socioeconomic status, and is mired in inefficiency and waste;[1-4] and

Whereas, In 2016, there remained a substantial segment of uninsured adults ages 19-64 in the United States with a large variability in uninsurance between states, with an overall estimate of 12% of working age adults across the US being uninsured;[5] and

Whereas, Lack of insurance is associated with higher mortality in pediatric and adult trauma patients, as well as increased rates of undiagnosed illness complicating hospital stays for adult trauma patients;[6,7] and

Whereas, Uninsurance results in approximately 30,428 “excess” deaths of working age adults compared to privately-insured working age adults;[8] and

Whereas, Uninsured Americans are more than twice as likely to be unable or delayed in getting needed medical care, dental care, or prescription medicines compared to those with private insurance;[9] and

Whereas, The United States spends about 1.5-2 times as much per capita on healthcare than comparable nations (as defined by UN Human Development Index) yet continues to rank poorly among its peers in many markers of health outcomes including infant mortality and mortality amenable to medical care;[10-13] and

Whereas, Private health insurance companies operate on average with 11-12% administrative overhead costs while Medicare operates with ~4.9% overhead costs;[14,15] and

Whereas, Medicare per capita spending grew an average of 1.4% annually between 2010 and 2015 while private insurance per capita spending grew 3.0% annually;[16]

Whereas, Healthcare expenditures attributable to billing and insurance-related activities ($471 billion) comprised 15.7% of total expenditures ($3.0 trillion) in 2015, of which an estimated $375 billion could be saved under simplified financing;[16-18] and

Whereas, The private health insurance industry accounts for about $200 billion annually in billing and administrative costs, which would be eliminated by a single payer reform, not counting the additional costs accrued by hospitals and physicians;[18] and

Whereas, Private insurance companies have significantly greater variation in the amount they pay to providers/facilities, resulting in considerable variation in spending and complexity in health care administration compared to public insurance providers (e.g. Medicare);[19] and

Whereas, US providers spend a cumulative $144 billion annually (physician practices: $70 billion, hospitals: $74 billion) on insurance billing and documentation-related costs, while recent survey data shows Canadian providers spend only 27% per capita of what US providers spend for these payer-related costs;[18,20] and

Whereas, Despite gains in individual adult coverage via Medicaid expansion, from 2001 to 2014 the poorest 5% of Americans had almost no gains in survival while those in middle income or high income brackets have increased their life expectancy by over 2 years;[3] and

Whereas, Evidence shows that Americans with complex care needs are more likely than those with similar health conditions in comparable countries to defer seeking recommended care partially because of the fragmented nature of our health delivery system;[21] and

Whereas, Equal access to care has been shown to reduce racial and socioeconomic disparities, for example in improved health outcomes among children of lower socioeconomic status and racial minorities with perforated appendicitis;[22] and

Whereas, Expanding access to care in Massachusetts through the MA health reform has not affected hospital outcomes such as ICU mortality and length of stay, and expanding access in the US through the ACA has not increased wait times for primary care visits;[23,24] and

Whereas, Following the expansion of access through the implementation of the ACA, coverage disparities between White, Black, and Hispanic adults declined and Black and Latino adults indicated their quality of care had improved;[25-27] and

Whereas, The noninterference clause preventing negotiation of drug prices by the government under Medicare is specific to Part D and would not affect separate legislation;[28] and

Whereas, A single payer system could allow the government to effectively negotiate drug and device prices for all consumers, a process currently in practice within the VA system and Department of Defense, allowing them to pay roughly half as much paid by retail pharmacies;[29,30] and

Whereas, In 2016, 58% of Americans support a federally-funded healthcare program providing insurance for all Americans and in 2015, a plurality of those polled supported a single payer system;[31,32] and

Whereas, While the AMA currently opposes a single payer solution because it may limit patient freedom of choice (H-165.888), current private health insurance companies limit patients via narrow provider networks, high deductibles, high premiums, and limited benefits;[33] and

Whereas, Previous legislative proposals indicate a national single payer system would include every licensed participating provider, making the concept of provider networks obsolete;[34] and

Whereas, A national single payer system would protect the patient-physician relationship from interference by health insurance companies, such as inconsistent access to Multiple Sclerosis disease-modifying therapies or allergen immunotherapy;[35,36] and

Whereas, The AMA-MSS currently supports a variety of solutions to expand access to care and reduce costs for patients, the spirit of which would be captured in a national single payer system in delivering equitable and accessible healthcare to all Americans (165.003MSS, 165.007MSS, 165.011MSS, 165.015MSS, 165.019MSS); and

Whereas, The AMA-MSS has existing policies on this topic that are outdated (165.007MSS(3)) and for which corresponding HOD policy has already been rescinded (165.005MSS); and

Whereas, The AMA-MSS supports universal healthcare, the expansion of healthcare coverage, reform that achieves universal healthcare, and has asked that universal healthcare be "the number one priority of the American Medical Association" (165.009MSS, 165.012MSS, 165.017MSS); therefore be it

RESOLVED, That our AMA-MSS support the implementation of a national single payer system; and be it further

RESOLVED, That our AMA-MSS rescind policy 165.005MSS and formal support of HOD policy H-165.920; and be it further

RESOLVED, That our AMA-MSS amend policy 165.007MSS by addition and deletion as follows:

165.007MSS Steps in Advancing towards Affordable Universal Access to Health Insurance

(1) AMA-MSS recognizes the efforts of the American Medical Association (AMA) in assembling proposals for the advancement toward affordable universal access to health insurance and supports *Expanding Health Insurance: The AMA Proposal for Reform*;

(2) AMA-MSS recognizes the efforts of the American Academy of Family Physicians (AAFP) and the American College of Physicians-American Society of Internal Medicine (ACP-ASIM) in assembling proposals for advancing towards affordable universal access to health insurance and supports engaging in discussions with appropriate members to continue to refine existing policies;

~~(3) AMA-MSS supports AMA policy D-165.974, Achieving Health Care Coverage for All: That our American Medical Association join with interested medical specialty societies~~

~~and state medical societies to advocate for enactment of a bipartisan resolution in the US Congress establishing the goal of achieving health care coverage through a pluralistic system for all persons in the United States on or before January 1, 2009 that is consistent with relevant AMA policy.~~

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Annual 2017 Final Policy as Adopted

165.020MSS	National Healthcare Finance Reform: Single Payer Solution: (1) AMA-MSS supports the implementation of a national single payer system; and (2) while our AMA-MSS shall prioritize its support of a federal single payer system, our AMA-MSS may continue to advocate for intermediate federal policy solutions including but not limited to a federal Medicare, Medicaid, or other public insurance option that abides by the guidelines for health systems reform in 165.019MSS. (MSS Res 12, A-17)

https://www.ama-assn.org/sites/default/files/media-browser/public/mss/mss-digest-of-policy-actions.pdf

AMERICAN MEDICAL ASSOCIATION
MEDICAL STUDENT SECTION

Resolution
(I-17)

Introduced by: Region 1; Brad Zehr, Boston University School of Medicine; Ajeet Singh, Loyola Stritch School of Medicine; Eric Xie, Johns Hopkins School of Medicine; Daniel Adam, Creighton University School of Medicine; Celeste Peay, Boston University School of Medicine; Luis Seija, Texas A&M College of Medicine; Rohan Rastogi, Boston University School of Medicine; Jennifer Nordhauser, Long School of Medicine at UT Heath San Antonio

Subject: Normalizing the AMA Position on Single-Payer Health Care Reform

Referred to: MSS Reference Committee
(-----, Chair)

Whereas, Current AMA policy H-165.847 establishes that comprehensive health system reform achieving quality healthcare for all Americans is of the highest priority of our AMA; and

Whereas, Our AMA is limited in its ability to engage in open and honest debate about all health care reform options via its blanket opposition of single payer financing mechanisms (AMA policy H-165.838); and

Whereas, Evidence suggests that our AMA's stance on single payer does not currently represent the majority of physicians, with two recent surveys by the Merritt Hawkins and the Chicago Medical Society each reporting a majority of physicians either strongly or somewhat supporting the concept of a broadly labeled single payer health care system;[1,2] and

Whereas, Several US senators have recently supported legislation to move forward with a national single-payer health care financing reform, and as such our AMA must be equipped to have open, productive discussions on the matter in the coming years;[3] and

Whereas, H.R. 676 - Expanded & Improved Medicare For All Act, has 117 cosponsors, and as such will likely come to the AMA for debate in the near future;[4] therefore be it

RESOLVED, That our AMA rescind HOD policy H-165.844; and be it further

RESOLVED, That our AMA rescind HOD policy H-165.985; and be it further

RESOLVED, That our AMA amend by deletion HOD policy H-165.888 as follows:

1. Our AMA will continue its efforts to ensure that health system reform proposals adhere to the following principles:

A. Physician's maintain primary ethical responsibility to advocate for their patients' interests and needs.

~~B. Unfair concentration of market power of payers is detrimental to patients and physicians, if patient freedom of choice or physician ability to select mode of practice is limited or denied. Single payer systems clearly fall within such a definition and, consequently, should continue to be opposed by the AMA. Reform proposals should balance fairly the market power between payers and physicians or be opposed.~~

C. All health system reform proposals should include a valid estimate of implementation cost, based on all health care expenditures to be included in the reform; and supports the concept that all health system reform proposals should identify specifically what means of funding (including employer-mandated funding, general taxation, payroll or value-added taxation) will be used to pay for the reform proposal and what the impact will be.

D. All physicians participating in managed care plans and medical delivery systems must be able without threat of punitive action to comment on and present their positions on the plan's policies and procedures for medical review, quality assurance, grievance procedures, credentialing criteria, and other financial and administrative matters, including physician representation on the governing board and key committees of the plan.

E. Any national legislation for health system reform should include sufficient and continuing financial support for inner-city and rural hospitals, community health centers, clinics, special programs for special populations and other essential public health facilities that serve underserved populations that otherwise lack the financial means to pay for their health care.

F. Health system reform proposals and ultimate legislation should result in adequate resources to enable medical schools and residency programs to produce an adequate supply and appropriate generalist/specialist mix of physicians to deliver patient care in a reformed health care system.

G. All civilian federal government employees, including Congress and the Administration, should be covered by any health care delivery system passed by Congress and signed by the President.

H. True health reform is impossible without true tort reform.

2. Our AMA supports health care reform that meets the needs of all Americans including people with injuries, congenital or acquired disabilities, and chronic conditions, and as such values function and its improvement as key outcomes to be specifically included in national health care reform legislation.

3. Our AMA supports health care reform that meets the needs of all Americans including people with mental illness and substance use / addiction disorders and will advocate for the inclusion of full parity for the treatment of mental illness and substance use / addiction disorders in all national health care reform legislation.

4. Our AMA supports health system reform alternatives that are consistent with AMA principles of pluralism, freedom of choice, freedom of practice, and universal access for patients.; and be it further

RESOLVED, That our AMA amend by deletion HOD policy H-165.838 as follows:

1. Our American Medical Association is committed to working with Congress, the Administration, and other stakeholders to achieve enactment of health system reforms that include the following seven critical components of AMA policy:
a. Health insurance coverage for all Americans
b. Insurance market reforms that expand choice of affordable coverage and eliminate denials for pre-existing conditions or due to arbitrary caps
c. Assurance that health care decisions will remain in the hands of patients and their physicians, not insurance companies or government officials
d. Investments and incentives for quality improvement and prevention and wellness initiatives
e. Repeal of the Medicare physician payment formula that triggers steep cuts and threaten seniors' access to care
f. Implementation of medical liability reforms to reduce the cost of defensive medicine
g. Streamline and standardize insurance claims processing requirements to eliminate unnecessary costs and administrative burdens

2. Our American Medical Association advocates that elimination of denials due to pre-existing conditions is understood to include rescission of insurance coverage for reasons not related to fraudulent representation.

3. Our American Medical Association House of Delegates supports AMA leadership in their unwavering and bold efforts to promote AMA policies for health system reform in the United States.

4. Our American Medical Association supports health system reform alternatives that are consistent with AMA policies concerning pluralism, freedom of choice, freedom of practice, and universal access for patients.

5. AMA policy is that insurance coverage options offered in a health insurance exchange be self-supporting, have uniform solvency requirements; not receive special advantages from government subsidies; include payment rates established through meaningful negotiations and contracts; not require provider participation; and not restrict enrollees' access to out-of-network physicians.

6. Our AMA will actively and publicly support the inclusion in health system reform legislation the right of patients and physicians to privately contract, without penalty to patient or physician.

7. Our AMA will actively and publicly oppose the Independent Medicare Commission (or other similar construct), which would take Medicare payment policy out of the hands of Congress and place it under the control of a group of unelected individuals.

8. Our AMA will actively and publicly oppose, in accordance with AMA policy, inclusion of the following provisions in health system reform legislation:
a. Reduced payments to physicians for failing to report quality data when there is evidence that widespread operational problems still have not been corrected by the Centers for Medicare and Medicaid Services
b. Medicare payment rate cuts mandated by a commission that would create a double-jeopardy situation for physicians who are already subject to an expenditure target and potential payment reductions under the Medicare physician payment system
c. Medicare payments cuts for higher utilization with no operational mechanism to assure that the Centers for Medicare and Medicaid Services can report accurate information that is properly attributed and risk-adjusted
d. Redistributed Medicare payments among providers based on outcomes, quality, and risk-adjustment measurements that are not scientifically valid, verifiable and accurate
e. Medicare payment cuts for all physician services to partially offset bonuses from one specialty to another
f. Arbitrary restrictions on physicians who refer Medicare patients to high quality facilities in which they have an ownership interest

9. Our AMA will continue to actively engage grassroots physicians and physicians in training in collaboration with the state medical and national specialty societies to contact their Members of Congress, and that the grassroots message communicate our AMA's position based on AMA policy.

10. Our AMA will use the most effective media event or campaign to outline what physicians and patients need from health system reform.

11. AMA policy is that national health system reform must include replacing the sustainable growth rate (SGR) with a Medicare physician payment system that automatically keeps pace with the cost of running a practice and is backed by a fair, stable funding formula, and that the AMA initiate a "call to action" with the Federation to advance this goal.

~~12. AMA policy is that creation of a new single payer, government-run health care system is not in the best interest of the country and must not be part of national health system reform.~~

13. AMA policy is that effective medical liability reform that will significantly lower health care costs by reducing defensive medicine and eliminating unnecessary litigation from the system should be part of any national health system reform.

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Interim 2017 Final Policy as Adopted (with title change)

Expanding AMA's position on healthcare reform options: that AMA (1) rescind policy H-165.844 (2) rescind policy H-165.985 (3) that policy H-165.888 be amended by deletion of Part B and (4) that policy H-165.838 be amended by deletion of Part 12.

AMA Policy Finder:
https://searchpf.amaassn.org/SearchML/policyFinderPages/policyhomepage.jsp

AMA-MSS Digest of Policy Actions:
https://www.ama-assn.org/sites/default/files/media-browser/public/mss/mss-digest-of-policy-actions.pdf