2019-24

RESOLUTION

Subject: Removing Opposition to a Single-Payer Healthcare System

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Referred to: Reference Committee

WHEREAS, the American Medical Association and World Health Organization both recognize health care as a basic human right and its provision as an ethical obligation of a civil society[1,2]; and

WHEREAS, lack of insurance is associated with higher morbidity and mortality rates, and despite the efforts of the Patient Protection and Affordable Care Act, 27 million Americans remain uninsured[3,4,5,6,7]; and

WHEREAS, the U.S. spends 17.9% of its GDP on health care, double the Organization for Economic Co-operation and Development (OECD) average, and yet has a health system that ranks only 37th in the world, producing higher infant mortality rates, higher disease burden, and a lower life expectancy than other developed nations[8,9,10,11,12,13]; and

WHEREAS, the U.S. spends over 8% of its healthcare dollars on administration, which is 2.5 times the OECD average, more than any other OECD country[14]; and

WHEREAS, narrow provider networks incentivized by the current health insurance system prevent patients from having the freedom to choose their doctors, and employer-based private health insurance restricts patients from having full freedom to choose their insurance plan[15,16,17,18]; and

WHEREAS, due to extensive, pressing problems of our current healthcare system, organized medicine should be open to consideration of all potential solutions, including a single payer system; and

WHEREAS, several independent analyses of federal single-payer legislation have found that the administrative savings and other efficiencies of a single-payer program would provide more than enough resources to provide coverage to everyone in the country with no increase in overall U.S. health spending[19, 20,21,22]; and

WHEREAS, polls have indicated a majority of physicians support single-payer healthcare systems, making the AMA and KMA's position of strong unequivocal opposition not representative[23,24,25,26,27]; and

WHEREAS, there is a significant difference between current proposed forms of nationalized health care plans. (i.e. single payer vs. Medicare for All vs. a public option, etc.) This is a significant point of confusion for physicians and the public[28,29,30]; and

WHEREAS, unequivocal opposition to single-payer healthcare prevents medical societies from being able to evaluate all healthcare proposals objectively; and

WHEREAS, comprehensive health system reform is a priority of the AMA (AMA policy H-165.847) and KMA (p. 26, Medicaid, Section 4); as leaders of the healthcare field, we must remain open to engaging in productive discussions to create a healthcare system that mutually benefits patients and physicians; now, therefore, be it

RESOLVED, that the Kentucky Medical Association revise existing policy to remove opposition to single-payer systems while preserving the principles of pluralism, freedom of choice, freedom of practice, and universal access for patients.

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RELEVANT KMA POLICY:

Res Final Reports of BOT & AMA Delegates, 1969 HOD; Reaffirmed 2000, 2010

National Health Insurance: KMA opposes any form of compulsory national health insurance.

Res COSLA HOD 1999; Reaffirmed 2009

Universal Health Insurance Coverage: KMA affirms its support for a pluralistic approach to health care delivery systems and financing mechanisms in achieving universal health insurance coverage. We recommend a plan that provides a standard set of benefits and includes a fee-for-service option. There are a variety of approaches to Universal Coverage, including employer mandate, individual mandate, or Medical Savings Accounts. KMA strongly supports the patient's freedom and responsibility to choose his/her physician, insurance carrier, and health insurance. Nationalized or socialized health care plans, or single payer systems are not in the best interest of the patient, physician, or the nation and should be opposed.

Res 2008-22, 2008 HOD, p. 620; Reaffirmed 2018

2) Principles for Reducing the Number of Uninsured Individuals: KMA will consider the following principles when developing or determining policy on initiatives that purport to reduce the number of uninsured:
• Universal access to care and coverage for that care must be made available to citizens through a pluralistic approach
• Efforts to reform healthcare to achieve universal access and coverage should include a physician-centered oversight authority insulated from both political and commercial interests
• Health insurers, health-related manufacturers, and pharmaceutical companies should either make concessions to reduce burdens or receive additional oversight that reduces overhead, maximizes efficiency, and increases the proportion of premium and product dollars that are applied to the delivery of healthcare. Such oversight would mandate that health insurers make public the percentage of premiums used to pay administrative costs and stockholder profit
• Cost effective and medically appropriate resource initiatives for patients, insurers, physicians, non-physicians, and other healthcare-related organizations are imperative
• Regionalizing healthcare to meet a population's health needs is important to eliminate risks specific to the area as well as to provide regions with the ability to determine how health dollars are spent
• Patient choice and preservation of the patient-physician relationship are essential; and
• A progressive financing system should be based on personal responsibility and, in part an individual's ability to pay.

Res 2017-20, 2017 HOD

KMA supports the continuation of federal funding for the population covered under Medicaid to ensure that low-income patients are able to secure affordable and adequate coverage.

KMA continues to evaluate various proposals relating to coverage, access, delivery, and economic sustainability of health care in Kentucky.

KMA will advocate for a focus on preventative care as a means to decrease overall health care cost.

KMA supports the American Medical Association Vision on Health Reform as stated in its document of November 15, 2016.

RELEVANT AMA POLICY:

H-165.839 Health Insurance Exchange Authority and Operation

1. Our American Medical Association adopts the following principles for the operation of health insurance exchanges:

A) Health insurance exchanges should maximize health plan choice for individuals and families purchasing coverage. Health plans participating in the exchange should provide an array of choices, in terms of benefits covered, cost-sharing levels, and other features.

B) Any benefits standards implemented for plans participating in the exchange and/or to determine minimum creditable coverage for an individual mandate should be designed with input from patients and actively practicing physicians.

C) Physician and patient decisions should drive the treatment of individual patients.

D) Actively practicing physicians should be significantly involved in the development of any regulations addressing physician payment and practice in the exchange environment, which would include any regulations addressing physician payment by participating public, private or non-profit health insurance options.

E) Regulations addressing physician participation in public, private or non-profit health insurance options in the exchange that impact physician practice should ensure reasonable implementation timeframes, with adequate support available to assist physicians with the implementation process.

F) Any necessary federal authority or oversight of health insurance exchanges must respect the role of state insurance commissioners with regard to ensuring consumer protections such as grievance procedures, external review, and oversight of agent practices, training and conduct, as well as physician protections including state prompt pay laws, protections against health plan insolvency, and fair marketing practices.

2. Our AMA: (A) supports using the open marketplace model for any health insurance exchange, with strong patient and physician protections in place, to increase competition and maximize patient choice of health plans, (B) will advocate for the inclusion of actively practicing physicians and patients in health insurance exchange governing structures and against the categorical exclusion of physicians based on conflict of interest provisions; (C) supports the involvement of state medical associations in the legislative and regulatory processes concerning state health insurance exchanges; and (D) will advocate that health insurance exchanges address patient churning between health plans by developing systems that allow for real-time patient eligibility information.

H-165.856 Health Insurance Market Regulation

Our AMA supports the following principles for health insurance market regulation:

(1) There should be greater national uniformity of market regulation across health insurance markets, regardless of type of sub-market (e.g., large group, small group, individual), geographic location, or type of health plan;

(2) State variation in market regulation is permissible so long as states demonstrate that departures from national regulations would not drive up the number of uninsured, and so long as variations do not unduly hamper the development of multi-state group purchasing alliances, or create adverse selection;

(3) Risk-related subsidies such as subsidies for high-risk pools, reinsurance, and risk adjustment should be financed through general tax revenues rather than through strict community rating or premium surcharges;

(4) Strict community rating should be replaced with modified community rating, risk bands, or risk corridors. Although some degree of age rating is acceptable, an individual's genetic information should not be used to determine his or her premium;

(5) Insured individuals should be protected by guaranteed renewability;

(6) Guaranteed renewability regulations and multi-year contracts may include provisions allowing insurers to single out individuals for rate changes or other incentives related to changes in controllable lifestyle choices;

(7) Guaranteed issue regulations should be rescinded;

(8) Health insurance coverage of pre-existing conditions with guaranteed issue within the context of an individual mandate, in addition to guaranteed renewability.

(9) Insured individuals wishing to switch plans should be subject to a lesser degree of risk rating and pre-existing conditions limitations than individuals who are newly seeking coverage; and

(10) The regulatory environment should enable rather than impede private market innovation in product development and purchasing arrangements. Specifically:

(a) Legislative and regulatory barriers to the formation and operation of group purchasing alliances should, in general, be removed; (b) Benefit mandates should be minimized to allow markets to determine benefit packages and permit a wide choice of coverage options; and (c) Any legislative and regulatory barriers to the development of multi-year insurance contracts should be identified and removed.

H-165.838 Health System Reform Legislation

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.

H-165.844 Educating the American People About Health System Reform

Our AMA reaffirms support of pluralism, freedom of enterprise, and strong opposition to a single payer system.

H-165.847 Comprehensive Health System Reform

1. 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. 2. Our AMA recognizes that as our health care delivery system evolves, direct and meaningful physician input is essential and must be present at every level of debate.

H-165.881 Expanding Choice in the Private Sector

Our AMA will continue to actively pursue strategies for expanding patient choice in the private sector by advocating for greater choice of health plans by consumers, equal-dollar contributions

by employers irrespective of an employee's health plan choice, and expanded individual selection and ownership of health insurance where plans are truly accountable to patients.

H-165.882 Improving Access for the Uninsured and Underinsured

Our AMA:

(1) Will assist state medical associations and local medical societies to work with states and the insurance industry to design value-based private group and individual health insurance policies. Such policies should cover with low cost-sharing those services adjudged to have the greatest health benefit, should be affordable, and should be equivalent to or an improvement over the Medicaid coverage in that state, so as to provide a continuum of gradually enhanced coverage.

(2) Supports federal legislation to encourage the formation of small employer and other voluntary choice cooperatives by exempting insurance plans offered by such cooperatives from selected state regulations regarding mandated benefits, premium taxes, and small group rating laws, while safeguarding state and federal patient protection laws. Any support for such small employer and voluntary purchasing cooperatives shall be strictly contingent upon safeguarding state and federal patient protections. For purposes of such legislation, small employers should be defined in terms of the number of lives insured, not the total number employed.

(3) Through appropriate channels, encourages unions, trade associations, health insurance purchasing cooperatives, farm bureaus, fraternal organizations, chambers of commerce, churches and religious groups, ethnic coalitions, and similar groups to serve as voluntary choice cooperatives for both children and the general uninsured population, with emphasis on formation of such pools by organizations which are national or regional in scope.

(4) Supports continued study of all approaches to providing health services for the uninsured and cooperation with business groups to develop approaches that are best suited to the needs of small employers.

(5) Encourages physicians, through their local county medical societies, to explore ways to work within their communities to address the expanding problem of inadequate access to care for the uninsured and underinsured and openly communicate with one another to share information about successful programs.

(6) Will offer advice or assistance to states in advocating that the Consumer Operated and Oriented Plan (COOP) advisory board and HHS ensure that new insurance issuers, including those with physician involvement, benefit from start-up loans.

(7) Will take action to restore necessary funding for new health insurance co-operatives which had applied prior to enactment of the American Tax Relief Act of 2012, which eliminated this funding, and will work with the National Alliance of State Health Co-Ops (NASHCO) and other stakeholders to request the United States Congress and the US Department of Health and Human Services to re-establish funding to support new health insurance Co-Ops, which had applied prior to the enactment of the American Tax Relief Act of 2012.

H-165.888 Evaluating Health System Reform Proposals

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

A. Physicians 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

H-165.920 Individual Health Insurance

Our AMA:

(1) affirms its support for pluralism of health care delivery systems and financing mechanisms in obtaining universal coverage and access to health care services;

(2) recognizes incremental levels of coverage for different groups of the uninsured, consistent with finite resources, as a necessary interim step toward universal access;

(3) actively supports the principle of the individual's right to select his/her health insurance plan and actively support ways in which the concept of individually selected and individually owned health insurance can be appropriately integrated, in a complementary position, into the Association's position on achieving universal coverage and access to health care services. To do this, our AMA will:

(a) Continue to support equal tax treatment for payment of health insurance coverage whether the employer provides the coverage for the employee or whether the employer provides a financial contribution to the employee to purchase individually selected and individually owned health insurance coverage, including the exemption of both employer and employee contributions toward the individually owned insurance from FICA (Social Security and Medicare) and federal and state unemployment taxes;

(b) Support the concept that the tax treatment would be the same as long as the employer's contribution toward the cost of the employee's health insurance is at least equivalent to the same dollar amount that the employer would pay when purchasing the employee's insurance directly;

(c) Study the viability of provisions that would allow individual employees to opt out of group plans without jeopardizing the ability of the group to continue their employer sponsored group coverage; and

(d) Work toward establishment of safeguards, such as a health care voucher system, to ensure that to the extent that employer direct contributions made to the employee for the purchase of individually selected and individually owned health insurance coverage continue, such contributions are used only for that purpose when the employer direct contributions are less than the cost of the specified minimum level of coverage. Any excess of the direct contribution over the cost of such coverage could be used by the individual for other purposes;

(4) will identify any further means through which universal coverage and access can be achieved;

(5) supports individually selected and individually-owned health insurance as the preferred method for people to obtain health insurance coverage; and supports and advocates a system where individually-purchased and owned health insurance coverage is the preferred option, but employer-provided coverage is still available to the extent the market demands it;

(6) supports the individual's right to select his/her health insurance plan and to receive the same tax treatment for individually purchased coverage, for contributions toward employer-provided coverage, and for completely employer provided coverage;

(7) supports immediate tax equity for health insurance costs of self-employed and unemployed persons;

(8) supports legislation to remove paragraph (4) of Section 162(l) of the US tax code, which discriminates against the self-employed by requiring them to pay federal payroll (FICA) tax on health insurance premium expenditures;

(9) supports legislation requiring a "maintenance of effort" period, such as one or two years, during which employers would be required to add to the employee's salary the cash value of any health insurance coverage they directly provide if they discontinue that coverage or if the employee opts out of the employer-provided plan;

(10) encourages through all appropriate channels the development of educational programs to assist consumers in making informed choices as to sources of individual health insurance coverage;

(11) encourages employers, unions, and other employee groups to consider the merits of risk-adjusting the amount of the employer direct contributions toward individually purchased coverage. Under such an approach, useful risk adjustment measures such as age, sex, and family status would be used to provide higher-risk employees with a larger contribution and lower-risk employees with a lesser one;

(12) supports a replacement of the present federal income tax exclusion from employees' taxable income of employer-provided health insurance coverage with tax credits for individuals and families, while allowing all health insurance expenditures to be exempt from federal and state payroll taxes, including FICA (Social Security and Medicare) payroll tax, FUTA (federal unemployment tax act) payroll tax, and SUTA (state unemployment tax act) payroll tax;

(13) advocates that, upon replacement, with tax credits, of the exclusion of employer-sponsored health insurance from employees' federal income tax, any states and municipalities conforming to this federal tax change be required to use the resulting increase in state and local tax revenues to finance health insurance tax credits, vouchers or other coverage subsidies; and

(14) believes that refundable, advanceable tax credits inversely related to income are preferred over public sector expansions as a means of providing coverage to the uninsured.

(15) Our AMA reaffirms our policies committed to our patients and their individual responsibility and freedoms consistent with our United States Constitution.

H-185.974 Parity for Mental Illness, Alcoholism, and Related Disorders in Medical Benefits Programs

Our AMA supports parity of coverage for mental illness, alcoholism and substance use.

H-165-985 Opposition to Nationalized Health Care

Our AMA reaffirms the following statement of principles as a positive articulation of the Association's opposition to socialized or nationalized health care:

(1) Free market competition among all modes of health care delivery and financing, with the growth of any one system determined by the number of people who prefer that mode of delivery, and not determined by preferential federal subsidy, regulations or promotion.

(2) Freedom of patients to select and to change their physician or medical care plan, including those patients whose care is financed through Medicaid or other tax-supported programs, recognizing that in the choice of some plans the patient is accepting limitations in the free choice of medical services. (Reaffirmed: BOT Rep. I-93-25; Reaffirmed: CMS Rep. I-93-5)

(3) Full and clear information to consumers on the provisions and benefits offered by alternative medical care and health benefit plans, so that the choice of a source of medical care delivery is an informed one.

(4) Freedom of physicians to choose whom they will serve, to establish their fees at a level which they believe fairly reflect the value of their services, to participate or not participate in a particular insurance plan or method of payment, and to accept or decline a third party allowance as payment in full for a service.

(5) Inclusion in all methods of medical care payment of mechanisms to foster increased cost awareness by both providers and recipients of service, which could include patient cost sharing in an amount which does not preclude access to needed care, deferral by physicians of a specified portion of fee income, and voluntary professionally directed peer review.

(6) The use of tax incentives to encourage provision of specified adequate benefits, including catastrophic expense protection, in health benefit plans.

(7) The expansion of adequate health insurance coverage to the presently uninsured, through formation of insurance risk pools in each state, sliding-scale vouchers to help those with marginal incomes purchase pool coverage, development of state funds for reimbursing providers of uncompensated care, and reform of the Medicaid program to provide uniform adequate benefits to all persons with incomes below the poverty level.

(8) Development of improved methods of financing long-term care expense through a combination of private and public resources, including encouragement of privately prefunded long-term care financing to the extent that personal income permits, assurance of access to needed services when personal resources are inadequate to finance needed care, and promotion of family caregiving.

H-185.986 Nondiscrimination in Health Care Benefits

Our AMA reaffirms its opposition to discriminatory benefit limitations, copayments or deductibles for the treatment of psychiatric illness under existing health care plans and opposes discrimination in any proposed plans for national health care coverage or universal access for the people who are uninsured.

D-165.936 Updated Study on Health Care Payment Models

Our AMA will research and analyze the benefits and difficulties of a variety of health care financing models, with consideration of the impact on economic and health outcomes and on health disparities and including information from domestic and