

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 will consider 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.

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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 5 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: On 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.

AMERICAN MEDICAL ASSOCIATION
MEDICAL STUDENT SECTION

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 Kepler, 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

-
- 1 Whereas, 48 million Americans lacked health insurance in 2012,¹ and an estimated 31 million
2 Americans will remain uninsured in 2024 despite advances made by the *Patient Protection and*
3 *Affordable Care Act*;² and
4
5 Whereas, Underinsurance is expanding as many patients are forced into private health insurance
6 plans with high deductibles (> \$1,000) and narrow provider networks;³ and
7
8 Whereas, 28 million low-income Americans will cross between Medicaid and the subsidized
9 private health insurance exchanges annually, an effect called “churning”, which erodes
10 continuity of care;⁴ and

1
2 Whereas, The United States ranks last out of 19 high-income countries in preventing deaths
3 amenable to medical care before age 75;⁵ and

4
5 Whereas, The United States ranks last out of 7 wealthy nations in health care access, patient
6 safety, coordination, efficiency, and equity;⁶ and

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

10
11 Whereas, Medicare overhead costs are less than 2%,⁸ and private health insurance overhead costs
12 range from 7% to 30%, with an average of 12%;⁹

13
14 Whereas, Providers are forced to spend tens of billions more dollars dealing with insurers'
15 billing and documentation requirements,¹⁰ bringing total administrative costs to 31% of U.S.
16 health spending, compared to 16.7% in Canada;¹¹ and

17
18 Whereas, The United States could save more than \$380 billion annually on administrative costs
19 with a single-payer system,¹¹ enough to cover all of the uninsured and eliminate or dramatically
20 reduce cost-sharing (deductibles, co-payments, co-insurance) for everyone else;¹² and

21
22 Whereas, A single-payer Medicare-for-All national health insurance system would
23 fundamentally simplify the financing of health care in the United States;¹³ and

24
25 Whereas, A single-payer system would cover every American from birth for all necessary
26 medical care and would virtually eliminate health uninsurance and underinsurance in the United
27 States;¹³ and

28
29 Whereas, A single-payer system would increase patients' freedom to choose among health care
30 providers and not be constrained by arbitrary private insurance networks;¹³ and

31
32 Whereas, A single-payer system would protect the physician-patient relationship from
33 interference by for-profit health insurance companies whose purpose is to maximize profit;¹³ and

34
35 Whereas, A single-payer system would facilitate regional health system planning, directing
36 capital funds to build and expand health facilities based on evidence of need, rather than being
37 driven by the dictates of the market, which increases geographical inequality;¹³ and

38
39 Whereas, Hospitals and clinics could remain private not-for-profit organizations under a
40 government-financed single-payer system, in contrast to the government-operated hospitals of
41 the Veterans Administration;¹³ and

42
43 Whereas, A single-payer system would control costs through proven-effective mechanisms such
44 as negotiated global budgets for hospitals and negotiated drug prices, thereby making health care
45 financing sustainable;¹⁴ and

46
47 Whereas, Support among physicians for government legislation to establish national health
48 insurance increased from 49% in 2002 to 59% in 2007;¹⁵ and

49

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

3
4 Whereas, There is single-payer legislation in both houses of Congress, H.R. 676 and S. 1782,
5 that outlines the transition to an expanded and improved Medicare for all, including re-training
6 programs for private health insurance workers whose jobs would be lost;^{17,18} and

7
8 Whereas, Vermont passed legislation in 2011 to create a “pathway to single-payer” in that state
9 starting in 2017,¹⁹ the soonest allowed under Section 1332 of the Affordable Care Act,²⁰ and
10 many other state legislatures are considering similar legislation;^{21,22,23,24,25} therefore be it

11
12 **RESOLVED**, That our American Medical Association shall advocate for legislation to
13 implement a single-payer health insurance system.

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22. Massachusetts State Legislature. H. 1035, *An Act to provide improved Medicare for all*. Available at <https://malegislature.gov/Bills/188/House/H1035>.
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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

- 1 Whereas, 48 million Americans lacked health insurance in 2012,¹ and an estimated 31 million
2 Americans will remain uninsured in 2024 despite advances made by the *Patient Protection and*
3 *Affordable Care Act*;² and
4
- 5 Whereas, Underinsurance is expanding as many patients are forced into private health insurance
6 plans with high deductibles (> \$1,000) and narrow provider networks;³ and
7
- 8 Whereas, 28 million low-income Americans will cross between Medicaid and the subsidized
9 private health insurance exchanges annually, an effect called “churning”, which erodes
10 continuity of care;⁴ and
11
- 12 Whereas, The United States ranks last out of 19 high-income countries in preventing deaths
13 amenable to medical care before age 75;⁵ and
14
- 15 Whereas, The United States ranks last out of 7 wealthy nations in health care access, patient
16 safety, coordination, efficiency, and equity;⁶ and
17
- 18 Whereas, The United States spends twice as much per capita on health care compared to the
19 average of wealthy nations that provide universal coverage;⁷ and
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- 21 Whereas, Medicare overhead costs are less than 2%,⁸ and private health insurance overhead costs
22 range from 7% to 30%, with an average of 12%;⁹
23
- 24 Whereas, Providers are forced to spend tens of billions more dollars dealing with insurers’
25 billing and documentation requirements,¹⁰ bringing total administrative costs to 31% of U.S.
26 health spending, compared to 16.7% in Canada;¹¹ and
27
- 28 Whereas, The United States could save more than \$380 billion annually on administrative costs
29 with a single-payer system,¹¹ enough to cover all of the uninsured and eliminate or dramatically
30 reduce cost-sharing (deductibles, co-payments, co-insurance) for everyone else;¹² and
31

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

3
4 Whereas, A single-payer system would cover every American from birth for all necessary
5 medical care and would virtually eliminate health uninsurance and underinsurance in the United
6 States;¹³ and

7
8 Whereas, A single-payer system would increase patients' freedom to choose among health care
9 providers and not be constrained by arbitrary private insurance networks;¹³ and

10
11 Whereas, A single-payer system would protect the physician-patient relationship from
12 interference by for-profit health insurance companies whose purpose is to maximize profit;¹³ and

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

17
18 Whereas, Hospitals and clinics could remain private not-for-profit organizations under a
19 government-financed single-payer system, in contrast to the government-operated hospitals of
20 the Veterans Administration;¹³ and

21
22 Whereas, A single-payer system would control costs through proven-effective mechanisms such
23 as negotiated global budgets for hospitals and negotiated drug prices, thereby making health care
24 financing sustainable;¹⁴ and

25
26 Whereas, Support among physicians for single-payer health insurance was 42% in 2009;¹⁵ and

27
28 Whereas, Support among the general United States population for a single-payer health care
29 system climbed from 28% in 1979 to 49% in 2009;¹⁶ and

30
31 Whereas, There is single-payer legislation in both houses of Congress, H.R. 676 and S. 1782,
32 that outlines the transition to an expanded and improved Medicare for all, including re-training
33 programs for private health insurance workers whose jobs would be lost;^{17,18} and

34
35 Whereas, Vermont passed legislation in 2011 to create a "pathway to single-payer" in that state
36 starting in 2017,¹⁹ the soonest allowed under Section 1332 of the Affordable Care Act,²⁰ and
37 many other state legislatures are considering similar legislation,^{21,22,23,24,25} therefore be it

38
39 **RESOLVED**, That our AMA-MSS supports legislation by states to implement single-payer
40 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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18. U.S. Senate. 113th Congress. *S. 1782, American Health Security Act of 2013*. Available at <http://thomas.loc.gov/cgi-bin/bdquery/z?d113:s.1782:>.
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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

1 Whereas, Despite many attempts at health system reform, the United States health care system
2 remains plagued by continued rates of uninsurance, excessive expense, unequal health outcomes
3 based on race and socioeconomic status, and is mired in inefficiency and waste;¹⁻⁴ and
4
5 Whereas, In 2016, there remained a substantial segment of uninsured adults ages 19-64 in the
6 United States with a large variability in uninsurance between states, with an overall estimate of
7 12% of working age adults across the US being uninsured;⁵ and
8
9 Whereas, Lack of insurance is associated with higher mortality in pediatric and adult trauma
10 patients, as well as increased rates of undiagnosed illness complicating hospital stays for adult
11 trauma patients;^{6,7} and
12
13 Whereas, Uninsurance results in approximately 30,428 “excess” deaths of working age adults
14 compared to privately-insured working age adults;⁸ and
15
16 Whereas, Uninsured Americans are more than twice as likely to be unable or delayed in getting
17 needed medical care, dental care, or prescription medicines compared to those with private
18 insurance;⁹ and
19
20 Whereas, The United States spends about 1.5-2 times as much per capita on healthcare than
21 comparable nations (as defined by UN Human Development Index) yet continues to rank poorly
22 among its peers in many markers of health outcomes including infant mortality and mortality
23 amenable to medical care;¹⁰⁻¹³ and
24
25 Whereas, Private health insurance companies operate on average with 11-12% administrative
26 overhead costs while Medicare operates with ~4.9% overhead costs;^{14,15} and
27

1 Whereas, Medicare per capita spending grew an average of 1.4% annually between 2010 and
2 2015 while private insurance per capita spending grew 3.0% annually;¹⁶

3
4 Whereas, Healthcare expenditures attributable to billing and insurance-related activities (\$471
5 billion) comprised 15.7% of total expenditures (\$3.0 trillion) in 2015, of which an estimated
6 \$375 billion could be saved under simplified financing;¹⁶⁻¹⁸ and

7
8 Whereas, The private health insurance industry accounts for about \$200 billion annually in
9 billing and administrative costs, which would be eliminated by a single payer reform, not
10 counting the additional costs accrued by hospitals and physicians;¹⁸ and

11
12 Whereas, Private insurance companies have significantly greater variation in the amount they
13 pay to providers/facilities, resulting in considerable variation in spending and complexity in
14 health care administration compared to public insurance providers (e.g. Medicare);¹⁹ and

15
16 Whereas, US providers spend a cumulative \$144 billion annually (physician practices: \$70
17 billion, hospitals: \$74 billion) on insurance billing and documentation-related costs, while recent
18 survey data shows Canadian providers spend only 27% per capita of what US providers spend
19 for these payer-related costs;^{18,20} and

20
21 Whereas, Despite gains in individual adult coverage via Medicaid expansion, from 2001 to 2014
22 the poorest 5% of Americans had almost no gains in survival while those in middle income or
23 high income brackets have increased their life expectancy by over 2 years;³ and

24
25 Whereas, Evidence shows that Americans with complex care needs are more likely than those
26 with similar health conditions in comparable countries to defer seeking recommended care
27 partially because of the fragmented nature of our health delivery system;²¹ and

28
29 Whereas, Equal access to care has been shown to reduce racial and socioeconomic disparities,
30 for example in improved health outcomes among children of lower socioeconomic status and
31 racial minorities with perforated appendicitis;²² and

32
33 Whereas, Expanding access to care in Massachusetts through the MA health reform has not
34 affected hospital outcomes such as ICU mortality and length of stay, and expanding access in the
35 US through the ACA has not increased wait times for primary care visits;^{23,24} and

36
37 Whereas, Following the expansion of access through the implementation of the ACA, coverage
38 disparities between White, Black, and Hispanic adults declined and Black and Latino adults
39 indicated their quality of care had improved;²⁵⁻²⁷ and

40
41 Whereas, The noninterference clause preventing negotiation of drug prices by the government
42 under Medicare is specific to Part D and would not affect separate legislation;²⁸ and

43
44 Whereas, A single payer system could allow the government to effectively negotiate drug and
45 device prices for all consumers, a process currently in practice within the VA system and
46 Department of Defense, allowing them to pay roughly half as much paid by retail
47 pharmacies;^{29,30} and

48

1 Whereas, In 2016, 58% of Americans support a federally-funded healthcare program providing
 2 insurance for all Americans and in 2015, a plurality of those polled supported a single payer
 3 system;^{31,32} and
 4

5 Whereas, While the AMA currently opposes a single payer solution because it may limit patient
 6 freedom of choice (H-165.888), current private health insurance companies limit patients via
 7 narrow provider networks, high deductibles, high premiums, and limited benefits;³³ and
 8

9 Whereas, Previous legislative proposals indicate a national single payer system would include
 10 every licensed participating provider, making the concept of provider networks obsolete;³⁴ and
 11

12 Whereas, A national single payer system would protect the patient-physician relationship from
 13 interference by health insurance companies, such as inconsistent access to Multiple Sclerosis
 14 disease-modifying therapies or allergen immunotherapy;^{35,36} and
 15

16 Whereas, The AMA-MSS currently supports a variety of solutions to expand access to care and
 17 reduce costs for patients, the spirit of which would be captured in a national single payer system
 18 in delivering equitable and accessible healthcare to all Americans (165.003MSS, 165.007MSS,
 19 165.011MSS, 165.015MSS, 165.019MSS); and
 20

21 Whereas, The AMA-MSS has existing policies on this topic that are outdated (165.007MSS(3))
 22 and for which corresponding HOD policy has already been rescinded (165.005MSS); and
 23

24 Whereas, The AMA-MSS supports universal healthcare, the expansion of healthcare coverage,
 25 reform that achieves universal healthcare, and has asked that universal healthcare be “the number
 26 one priority of the American Medical Association” (165.009MSS, 165.012MSS, 165.017MSS);
 27 therefore be it
 28

29 RESOLVED, That our AMA-MSS support the implementation of a national single payer system;
 30 and be it further
 31

32 RESOLVED, That our AMA-MSS rescind policy 165.005MSS and formal support of HOD
 33 policy H-165.920; and be it further
 34

35 RESOLVED, That our AMA-MSS amend policy 165.007MSS by addition and deletion as
 36 follows:
 37

38 165.007MSS Steps in Advancing towards Affordable Universal Access to Health Insurance
 39

- 40 (1) AMA-MSS recognizes the efforts of the American Medical Association (AMA) in
 41 assembling proposals for the advancement toward affordable universal access to health
 42 insurance and supports *Expanding Health Insurance: The AMA Proposal for Reform*;
- 43 (2) AMA-MSS recognizes the efforts of the American Academy of Family Physicians
 44 (AAFP) and the American College of Physicians-American Society of Internal Medicine
 45 (ACP-ASIM) in assembling proposals for advancing towards affordable universal access
 46 to health insurance and supports engaging in discussions with appropriate members to
 47 continue to refine existing policies;
- 48 ~~(3) AMA-MSS supports AMA policy D-165.974, Achieving Health Care Coverage for All:
 49 That our American Medical Association join with interested medical specialty societies~~

1 ~~and state medical societies to advocate for enactment of a bipartisan resolution in the US~~
2 ~~Congress establishing the goal of achieving health care coverage through a pluralistic~~
3 ~~system for all persons in the United States on or before January 1, 2009 that is consistent~~
4 ~~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: Trevor Cline, UC Davis School of Medicine; Adam Roussas, The University of Arizona College of Medicine, Tucson; Brad Zehr, Boston University School of Medicine; Ajeet Singh, Loyola Stritch School of Medicine; Eric Xie, Johns Hopkins School of Medicine

Subject: Realigning the AMA Health System Reform Debate

Referred to: MSS Reference Committee
(_____, Chair)

- 1 Whereas, Our AMA’s mission is to “promote the art and science of medicine and the betterment
2 of public health;” and
3
- 4 Whereas, Current AMA policy H-165.847 states, “1. Comprehensive health system reform,
5 which achieves access to quality health care for all Americans while improving the physician
6 practice environment, is of the highest priority for our AMA. 2. Our AMA recognizes that as our
7 health care delivery system evolves, direct and meaningful physician input is essential and must
8 be present at every level of debate.”; and
9
- 10 Whereas, Our AMA is limited in its ability to engage in open and honest debate about all health
11 care reform options by blanket opposition of single payer financing mechanisms, and
12
- 13 Whereas, Single payer proposals constitute one possible pathway to accomplishing the goals of
14 many AMA policies including advancing universal coverage and obtaining further physician
15 freedoms; and
16
- 17 Whereas, The term “single payer” is commonly used to describe a wide variety of health care
18 financing and delivery systems with nuanced implementations, though it is often misconstrued to
19 directly refer to often interpreted as a judgment on “socialized medicine” systems such as the
20 United Kingdom’s National Health Service and Canada’s Medicare; and
21
- 22 Whereas, There is evidence to suggest that our AMA does not currently represent the majority of
23 physicians, with two recent surveys by the Merritt Hawkins and the Chicago Medical Society
24 each reporting a majority of physicians either strongly or somewhat supporting the concept of a
25 broadly labeled single payer health care system;^{1,2} and
26
- 27 Whereas, Several US senators have recently supported legislation to move forward with a
28 Universal Health Care system, and as such the AMA must be equipped to have open, productive
29 discussions on the matter in the coming years;³ and
30

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

3
4 RESOLVED, That our AMA rescind HOD policy H-165.844; and be it further

5
6 RESOLVED, That our AMA rescind HOD policy H-165.985; and be it further

7
8 RESOLVED, That our AMA amend by deletion HOD policy H-165.888 as follows:

9
10 1. Our AMA will continue its efforts to ensure that health system reform proposals adhere to the
11 following principles:

12
13 A. Physician's maintain primary ethical responsibility to advocate for their patients' interests and
14 needs.

15
16 B. Unfair concentration of market power of payers is detrimental to patients and physicians, if
17 patient freedom of choice or physician ability to select mode of practice is limited or denied.
18 ~~Single-payer systems clearly fall within such a definition and, consequently, should continue to~~
19 ~~be opposed by the AMA.~~ Reform proposals should balance fairly the market power between
20 payers and physicians or be opposed.

21
22 C. All health system reform proposals should include a valid estimate of implementation cost,
23 based on all health care expenditures to be included in the reform; and supports the concept that
24 all health system reform proposals should identify specifically what means of funding (including
25 employer-mandated funding, general taxation, payroll or value-added taxation) will be used to
26 pay for the reform proposal and what the impact will be.

27
28 D. All physicians participating in managed care plans and medical delivery systems must be able
29 without threat of punitive action to comment on and present their positions on the plan's policies
30 and procedures for medical review, quality assurance, grievance procedures, credentialing
31 criteria, and other financial and administrative matters, including physician representation on the
32 governing board and key committees of the plan.

33
34 E. Any national legislation for health system reform should include sufficient and continuing
35 financial support for inner-city and rural hospitals, community health centers, clinics, special
36 programs for special populations and other essential public health facilities that serve
37 underserved populations that otherwise lack the financial means to pay for their health care.

38
39 F. Health system reform proposals and ultimate legislation should result in adequate resources to
40 enable medical schools and residency programs to produce an adequate supply and appropriate
41 generalist/specialist mix of physicians to deliver patient care in a reformed health care system.

42
43 G. All civilian federal government employees, including Congress and the Administration,
44 should be covered by any health care delivery system passed by Congress and signed by the
45 President.

46
47 H. True health reform is impossible without true tort reform.
48

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

5
 6 3. Our AMA supports health care reform that meets the needs of all Americans including people
 7 with mental illness and substance use / addiction disorders and will advocate for the inclusion of
 8 full parity for the treatment of mental illness and substance use / addiction disorders in all
 9 national health care reform legislation.

10
 11 4. Our AMA supports health system reform alternatives that are consistent with AMA principles
 12 of pluralism, freedom of choice, freedom of practice, and universal access for patients.; and be it
 13 further

14
 15 RESOLVED, That our AMA amend by deletion HOD policy H-165.838 as follows:

16
 17 1. Our American Medical Association is committed to working with Congress, the
 18 Administration, and other stakeholders to achieve enactment of health system reforms that
 19 include the following seven critical components of AMA policy:

20 a. Health insurance coverage for all Americans

21 b. Insurance market reforms that expand choice of affordable coverage and eliminate denials for
 22 pre-existing conditions or due to arbitrary caps

23 c. Assurance that health care decisions will remain in the hands of patients and their physicians,
 24 ~~not insurance companies or government officials~~

25 d. Investments and incentives for quality improvement and prevention and wellness initiatives

26 e. Repeal of the Medicare physician payment formula that triggers steep cuts and threaten
 27 seniors' access to care

28 f. Implementation of medical liability reforms to reduce the cost of defensive medicine

29 g. Streamline and standardize insurance claims processing requirements to eliminate unnecessary
 30 costs and administrative burdens

31
 32 2. Our American Medical Association advocates that elimination of denials due to pre-existing
 33 conditions is understood to include rescission of insurance coverage for reasons not related to
 34 fraudulent representation.

35
 36 3. Our American Medical Association House of Delegates supports AMA leadership in their
 37 unwavering and bold efforts to promote AMA policies for health system reform in the United
 38 States.

39
 40 4. Our American Medical Association supports health system reform alternatives that are
 41 consistent with AMA policies concerning pluralism, freedom of choice, freedom of practice, and
 42 universal access for patients.

43
 44 5. AMA policy is that insurance coverage options offered in a health insurance exchange be
 45 self-supporting, have uniform solvency requirements; not receive special advantages from
 46 government subsidies; include payment rates established through meaningful negotiations and
 47 contracts; not require provider participation; and not restrict enrollees' access to out-of-network
 48 physicians.

49

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

3
 4 ~~7. Our AMA will actively and publicly oppose the Independent Medicare Commission (or other
 5 similar construct), which would take Medicare payment policy out of the hands of Congress and
 6 place it under the control of a group of unelected individuals.~~

7
 8 8. Our AMA will actively and publicly oppose, in accordance with AMA policy, inclusion of the
 9 following provisions in health system reform legislation:

10 a. Reduced payments to physicians for failing to report quality data when there is evidence that
 11 widespread operational problems still have not been corrected by the Centers for Medicare and
 12 Medicaid Services

13 b. Medicare payment rate cuts mandated by a commission that would create a double-jeopardy
 14 situation for physicians who are already subject to an expenditure target and potential payment
 15 reductions under the Medicare physician payment system

16 c. Medicare payments cuts for higher utilization with no operational mechanism to assure that
 17 the Centers for Medicare and Medicaid Services can report accurate information that is properly
 18 attributed and risk-adjusted

19 d. Redistributed Medicare payments among providers based on outcomes, quality, and risk-
 20 adjustment measurements that are not scientifically valid, verifiable and accurate

21 e. Medicare payment cuts for all physician services to partially offset bonuses from one specialty
 22 to another

23 f. Arbitrary restrictions on physicians who refer Medicare patients to high quality facilities in
 24 which they have an ownership interest

25
 26 9. Our AMA will continue to actively engage grassroots physicians and physicians in training in
 27 collaboration with the state medical and national specialty societies to contact their Members of
 28 Congress, and that the grassroots message communicate our AMA's position based on AMA
 29 policy.

30
 31 10. Our AMA will use the most effective media event or campaign to outline what physicians
 32 and patients need from health system reform.

33
 34 11. AMA policy is that national health system reform must include replacing the sustainable
 35 growth rate (SGR) with a Medicare physician payment system that automatically keeps pace
 36 with the cost of running a practice and is backed by a fair, stable funding formula, and that the
 37 AMA initiate a "call to action" with the Federation to advance this goal.

38
 39 ~~12. AMA policy is that creation of a new single payer, government run health care system is not
 40 in the best interest of the country and must not be part of national health system reform.~~

41
 42 13. AMA policy is that effective medical liability reform that will significantly lower health care
 43 costs by reducing defensive medicine and eliminating unnecessary litigation from the system
 44 should be part of any national health system reform.; and be it further

45
 46 RESOLVED, that our AMA amend by deletion D-165.974 to read as follows:

47
 48 Achieving Health Care Coverage for All -- Our American Medical Association joins with
 49 interested medical specialty societies and state medical societies to advocate for enactment of a

- 1 bipartisan resolution in the US Congress establishing the goal of achieving health care coverage
- 2 ~~through a pluralistic system~~ for all persons in the United States consistent with relevant AMA
- 3 policy.

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