MEDICARE FOR ALL RESOLUTIONS

Local, State, and National Resolutions

Donald Bourne, MPH; Max Brockwell; Michael Kaplan, MD

SNaHP Students for a National Health Program

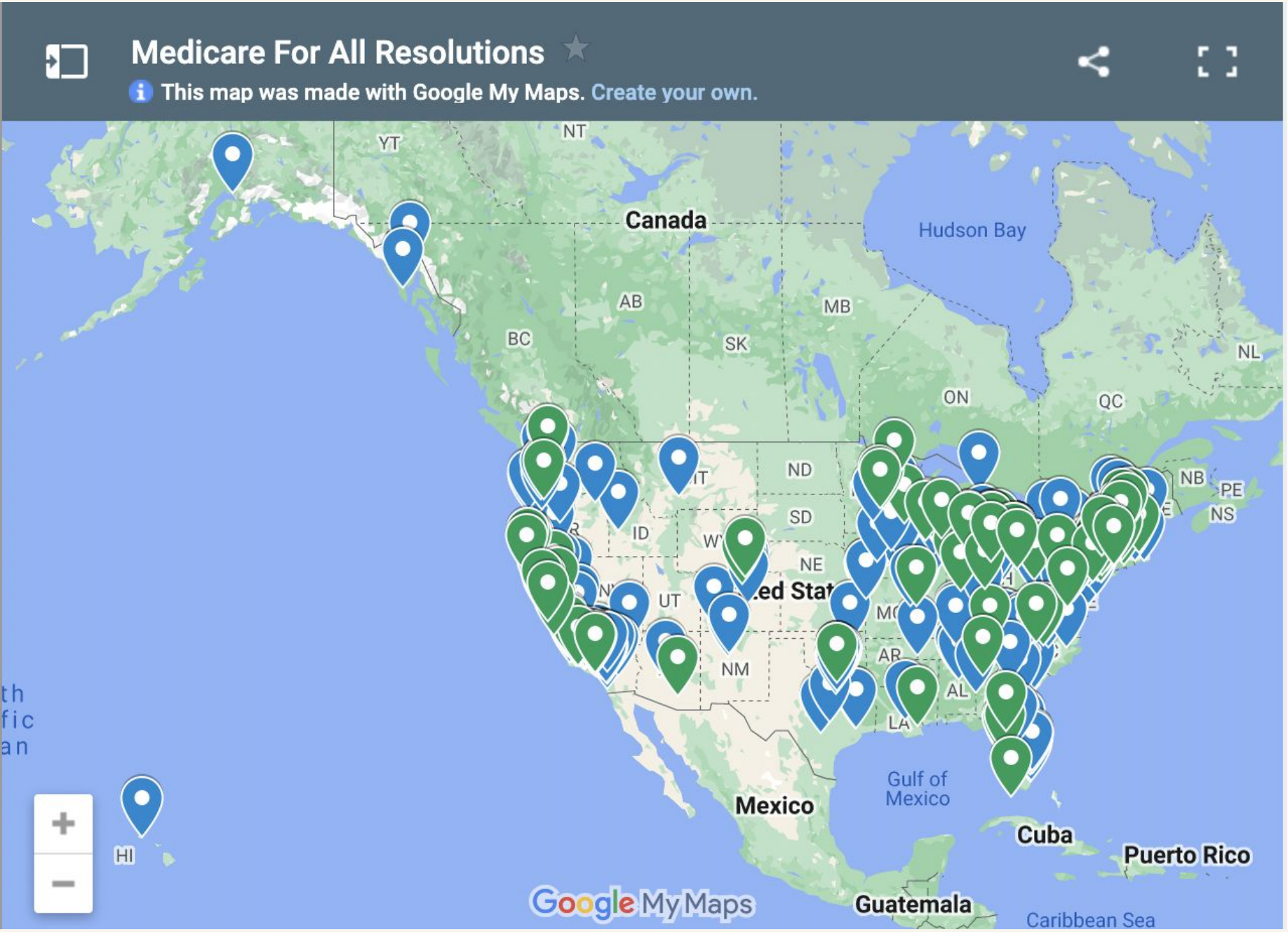
PNHP PHYSICIANS FOR A NATIONAL HEALTH PROGRAM

Introductions

Donald Bourne, MPH

Max Brockwell, BS
SNaHP, Northeast Ohio Medical University
VP of Political Advocacy

Michael Kaplan, MD
Chair, AAFP Single Payer Member Interest Group



Map Key

Passed Resolution

Join this organizing effort

Attend an upcoming event

https://www.medicare4allresolutions.org/is-a-local-resolution-already-underway-in-your-community/

Local Resolutions

Local Government Resolutions

- Building grassroots movements
- Accessible to students
- Balance of preparation vs. efficiency
- Best resource available:
  - Medicare4AllResolutions

Timeline

July 2022

Meetings with City Council Members

Met with council members throughout July + August

Sep 13th

Board of Health Resolution Passed

Sep 21st

First Testimony Before General City Council Meeting

Voted unanimously to be added to agenda for Oct 5th

Oct 5th

M4A Presentation Before Subcommittee Meeting

Voted 5 - 2 to be passed on to general council meeting

Oct 19th

Final Testimony Before General City Council Meeting

Voted 7 - 2 in favor of a resolution supporting M4A

Build a Resolution Team

- Begin with a small core team
- Potential allies
    - Members of your SNaHP or PNHP chapter
    - Local or State single-payer organizations
    - Public Health Dept
    - Local union members

Profile Building

- Identify voting members
- Search for information
  - Social media
  - LinkedIn
  - Political information sites
  - Previous meeting minutes
- Categorize according to likelihood of vote
- Identify possible champions

Draft your Resolution

- Include specific locality data
  - Uninsured rate in city and state, poverty rate, etc.
- Work with legislators to create a resolution that is acceptable
- Sample resolutions and whereas clauses available
  - Sample M4A Resolution Language

RESOLUTION 2022 -107

A RESOLUTION OF THE CITY OF KENT, OHIO ENDORSING THE MEDICARE FOR ALL ACT OF 2022 (S.4204); AND DECLARING THAT ACCESS TO QUALITY AFFORDABLE HEALTHCARE IS A HUMAN RIGHT, AND DECLARING AN EMERGENCY.

WHEREAS almost 5% of residents in the city of Kent, over 1,300 people, do not have health insurance while many more are underinsured; and

WHEREAS almost 24% of residents in the city of Kent, over 6,500 people, live below the federal poverty threshold; and

WHEREAS every resident of Kent deserves affordable and convenient access to high quality healthcare, and everyone's health is at risk when our neighbors cannot receive care; and

WHEREAS preventative health models create a healthy population, ensuring a reliable workforce and productive business environment, thereby strengthening local business; and

WHEREAS in the state of Ohio over 700,000 people do not have health insurance, while many more are underinsured; and

WHEREAS many people delay seeking needed health care due to an inability to pay, leading to a sicker and poorer population in the long run; and

WHEREAS the number of Americans without health insurance before the COVID-19 pandemic was still nearly 30 million, with more than 40 million Americans underinsured, despite important gains made since the implementation of the Affordable Care Act; and

WHEREAS, such a population is significantly more likely to develop serious illness if exposed to COVID-19 and will subsequently face higher mortality rates from the disease; and

WHEREAS the ever-increasing costs of health care, which are further elevated due to the pandemic, may challenge our already strapped state and municipal budgets; and

WHEREAS in order to equitably and effectively address the health care burden of the COVID-19 crisis, we must urge the United States Congress to expand health insurance coverage to provide comprehensive coverage to every resident of the United States without any cost sharing; and

WHEREAS the Medicare for All Act of 2022 would provide national health insurance for every person in the United States for all necessary medical care including prescription drugs; hospital, surgical and outpatient services; primary and preventive care; emergency services; dental, vision, hearing, and mental health care; reproductive care; and long-term care; and

WHEREAS the Medicare for All Act of 2022 would provide coverage without copays, deductibles or other out-of-pocket costs, and would slash bureaucratic fees, protect the doctor- patient relationship and assure patients a free choice of doctors; and

WHEREAS recent polls show that a majority of Americans support Medicare for All; and

WHEREAS the Medicare for All Act of 2022 will guarantee that all residents of Kent will be fully covered for health care without copays, deductibles or other out-of-pocket costs, and would save millions in taxpayer dollars now spent on premiums that provide often inadequate health insurance coverage for government employees; and

WHEREAS the quality of life for the residents of Kent will vastly improve through increased access to ongoing care they need, instead of waiting until they have a medical emergency that could upend their lives as well as further burden local resources; and

NOW, THEREFORE, BE IT RESOLVED by the Council of the City of Kent, Portage County, Ohio:

SECTION 1. That Kent City Council members to support legislation to enact emergency legislation to provide universal, comprehensive health coverage with zero cost-sharing for patients during this crisis and enthusiastically supports the Medicare for All Act of 2022 (S. 4204) and calls on our federal legislators to work toward its immediate enactment, assuring appropriate and efficient health care for all residents of the United States.

SECTION 2. That it is found and determined that all formal actions of this Council concerning and relating to the adoption of this Resolution were adopted in an open meeting of this Council and that all deliberations of this Council, and of any of its committees that resulted in such formal action, were in meetings open to the public in compliance with all legal requirements of Section 121.22 of the Ohio Revised Code.

SECTION 3. That this Resolution is hereby declared to be an emergency measure necessary for the immediate preservation of the public peace, health, safety, and welfare of the residents of this City, for which reason and other reasons manifest to this Council this Resolution is hereby declared to be an emergency measure and shall take effect and be in force immediately after passage.

PASSED: October 19, 2022
Date

EFFECTIVE: October 19, 2022
Date

ATTEST: Amy Wilkens
Amy Wilkens
Clerk of Council

Jerry T. Fiala
Mayor and President of Council

Meet with Councilmembers

- Getting started
  - In person meeting if possible
  - Arrange via phone call, email, or letter
    - Be respectful, but persistent
- During the meeting
  - Provide policy education on M4A
  - Handouts should be simple
  - Discuss timeline & being placed on agenda
- Afterwards
  - Follow up via email
  - Gather necessary resources

Provide Testimony

- Generally between 90s - 3 mins
- Types of testimony
  - Logic and statistics
  - Personal experience
  - Healthcare worker perspective
- The more people showing up to council the better
- You should have an idea of where each councilmember stands before presenting


Congratulations!
You Just Passed a
M4A Resolution

Spread the Word

- Prepare a press release
- Reach out to local news
  - Newspapers
  - TV stations
  - Radio stations
- Post on social media
  - Instagram, Twitter, Facebook, etc.
  - Blogs, influencers
  - University accounts
- Share with your State & Federal representatives
- Petitions on state ballot
  - Can advocate for state level single payer

Credits

- <ahref="https://www.freepik.com/free-vector/employers-choosing-candidates-job-interview_7732612.htm#query=cartoon%20people%20professionals&position=11&from_view=search&track=sph">Image by pch.vector on Freepik
- <ahref="https://www.freepik.com/free-vector/company-employees-planning-task-brainstorming_9174471.htm#query=cartoon%20people%20professionals&position=4&from_view=search&track=sph#position=4&query=cartoon%20people%20professionals">Image by pch.vector on Freepik
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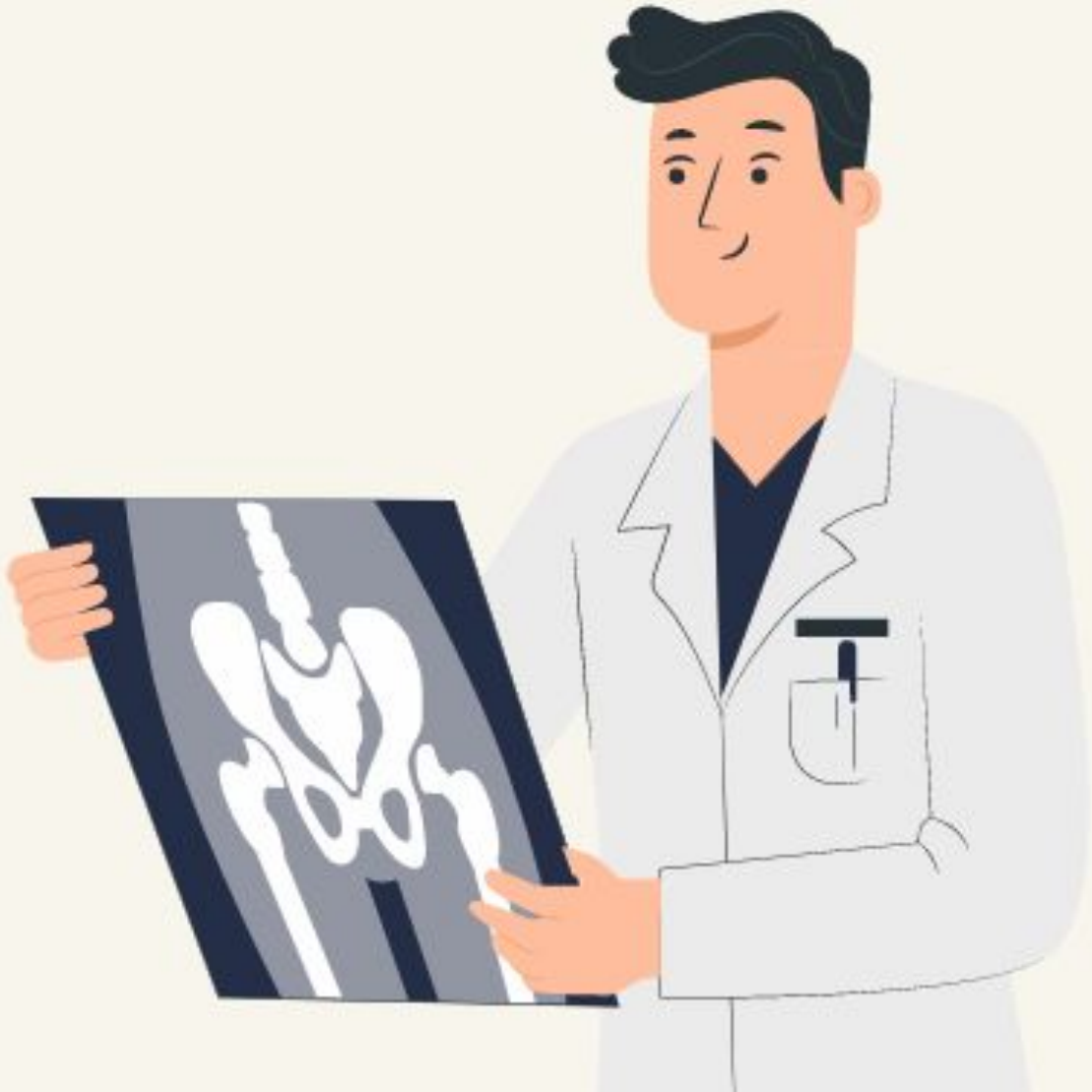
- <ahref="https://www.freepik.com/free-vector/news-concept-landing-page_5156461.htm#query=press&position=27&from_view=search&track=sph">Image by pikisuperstar on Freepik
- <ahref="https://www.freepik.com/free-vector/celebration-banner-with-gold-balloons-stars_5541491.htm#query=celebration&position=2&from_view=search&track=sph">Image by kjpargeter on Freepik

State Medical Society Resolutions

Overview

- Why write a resolution
- Anatomy of a resolution
- Policy process*
- Strategy
- Resources

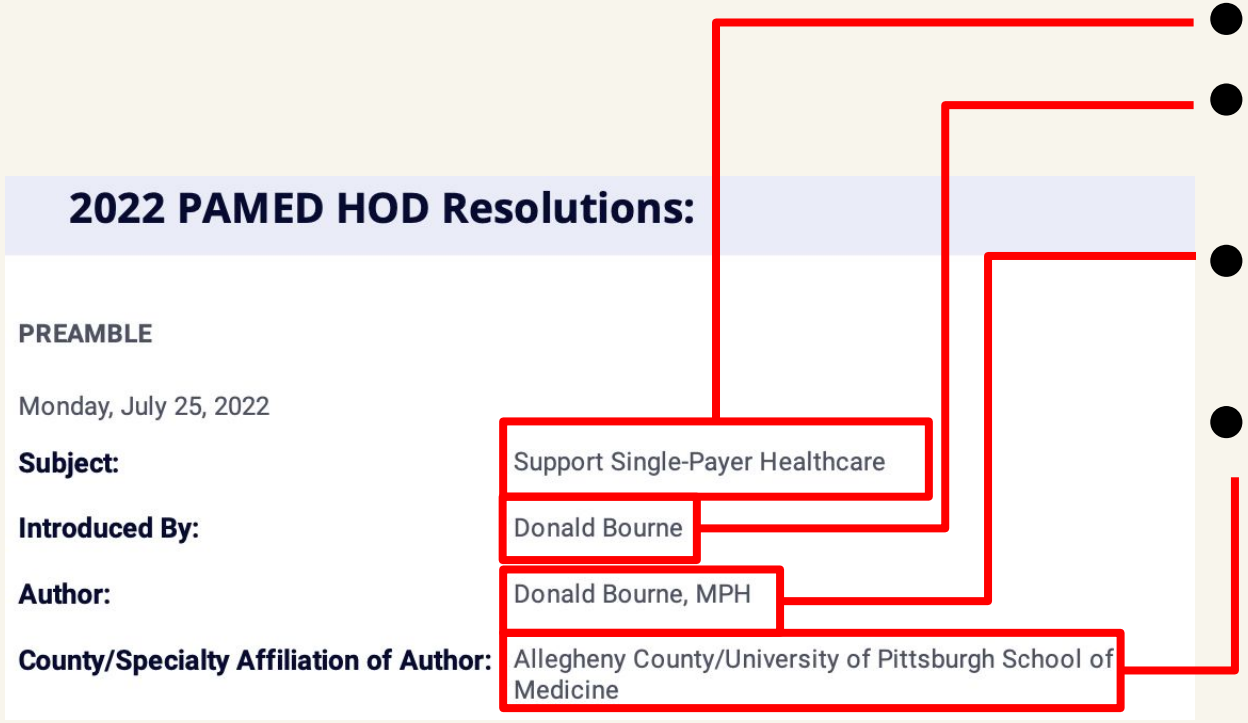
*My experience is in Pennsylvania, other states may be different



Why Write a Resolution

- A resolution is a proposed statement of policy or a call to action
  - A method for individuals to formally suggest an idea or course of action at a meeting of a large parliamentary body
- Shine light on a poorly understood problem in healthcare
- Increase awareness of a potential solution
- Gain hands-on experience in organized medicine and advocacy

Anatomy of a Resolution



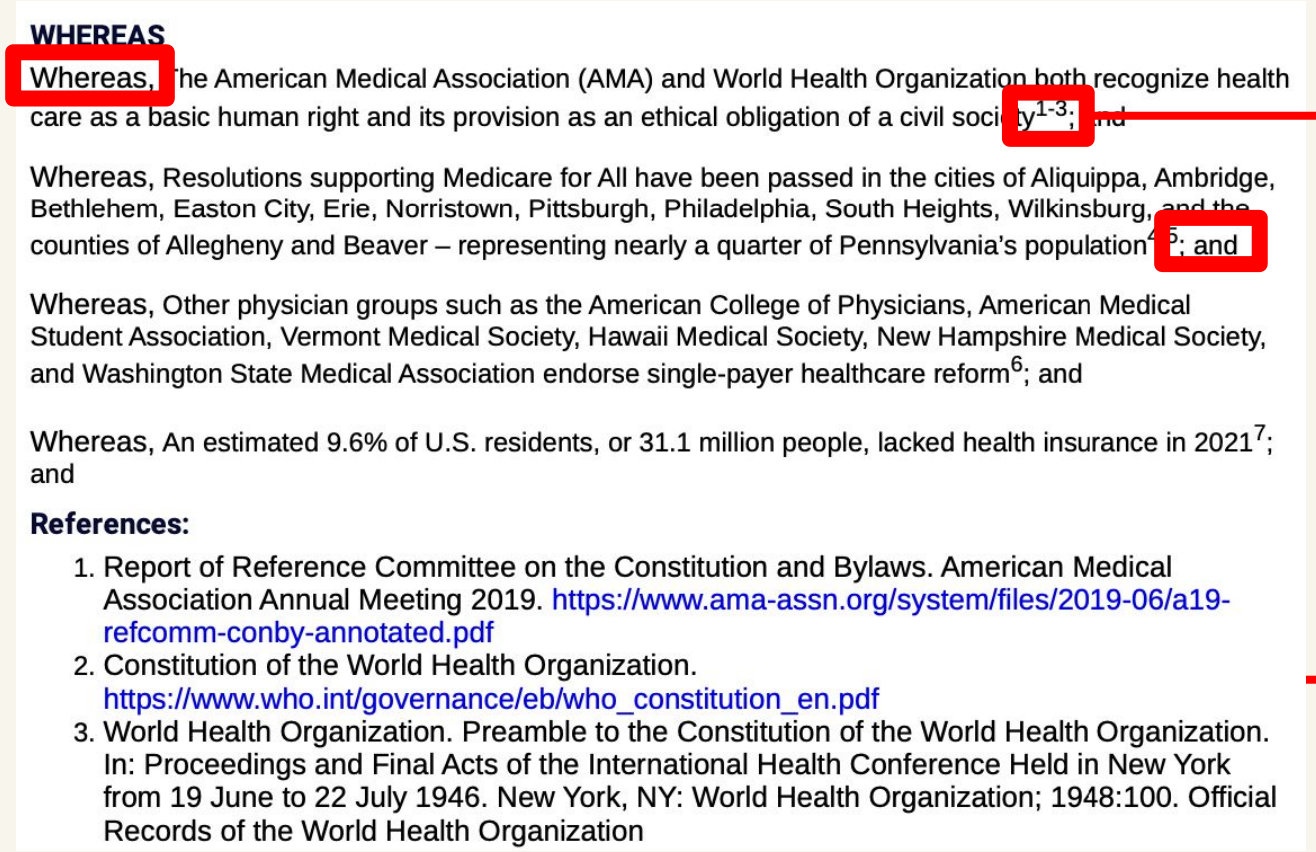
Header

- Title of resolution
- Only voting delegates can introduce a resolution
- The original authors + any add'l sponsors
- Author affiliations

Anatomy of a Resolution

Whereas Clauses

- Purpose: The "Why"
  - Justifies the action requested in the Resolved Clauses
- Format
  - Each new idea presented in its own clause beginning with "Whereas,"
  - In-line citations for ALL claims
- Structure
  - Background information on topic / explanation of problem
  - Details of proposed solution with supporting evidence
  - Demonstration of gap in existing policy



WHEREAS

Whereas, The American Medical Association (AMA) and World Health Organization both recognize health care as a basic human right and its provision as an ethical obligation of a civil society[1-3]; and

Whereas, Resolutions supporting Medicare for All have been passed in the cities of Aliquippa, Ambridge, Bethlehem, Easton City, Erie, Norristown, Pittsburgh, Philadelphia, South Heights, Wilkinsburg, and the counties of Allegheny and Beaver – representing nearly a quarter of Pennsylvania's population[4,5]; and

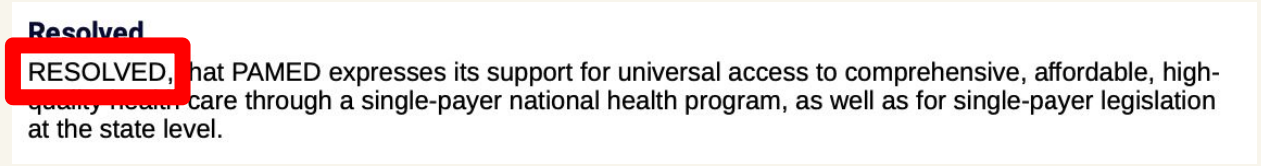
Whereas, Other physician groups such as the American College of Physicians, American Medical Student Association, Vermont Medical Society, Hawaii Medical Society, New Hampshire Medical Society, and Washington State Medical Association endorse single-payer healthcare reform[6]; and

Whereas, An estimated 9.6% of U.S. residents, or 31.1 million people, lacked health insurance in 2021[7]; and

References:

1. Report of Reference Committee on the Constitution and Bylaws. American Medical Association Annual Meeting 2019. https://www.ama-assn.org/system/files/2019-06/a19-refcomm-conby-annotated.pdf
2. Constitution of the World Health Organization. https://www.who.int/governance/eb/who_constitution_en.pdf
3. World Health Organization. Preamble to the Constitution of the World Health Organization. In: Proceedings and Final Acts of the International Health Conference Held in New York from 19 June to 22 July 1946. New York, NY: World Health Organization; 1948:100. Official Records of the World Health Organization

Anatomy of a Resolution



Resolved

RESOLVED, [illegible]hat PAMED expresses its support for universal access to comprehensive, affordable, high-quality health care through a single-payer national health program, as well as for single-payer legislation at the state level.

Resolved Clauses

- Purpose: The "What"
  - Formal statement of requested action
  - If adopted, used to guide action by Officers and Staff (without Whereas clauses)
    - Keep in mind when composing Resolves, should capture the essence of the action justified in the Whereas clauses, but without rehashing them
- Format
  - Each new action presented in its own clause beginning with "RESOLVED,"
  - Amendments of existing policy
    - Additions indicated by underlining
    - Deletions indicated by ~~strikethrough~~

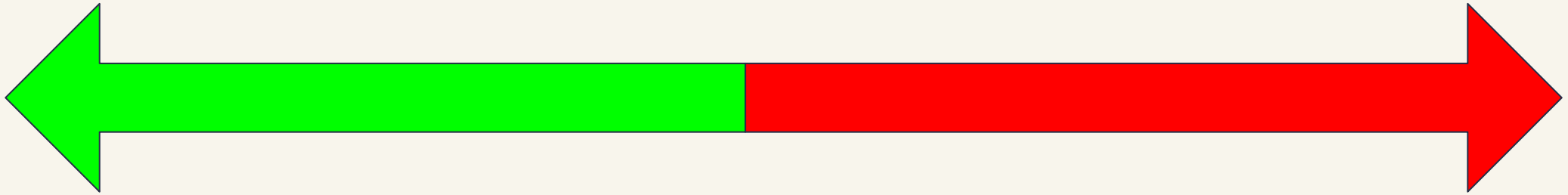
Anatomy of a Resolution

Passive Resolved Language

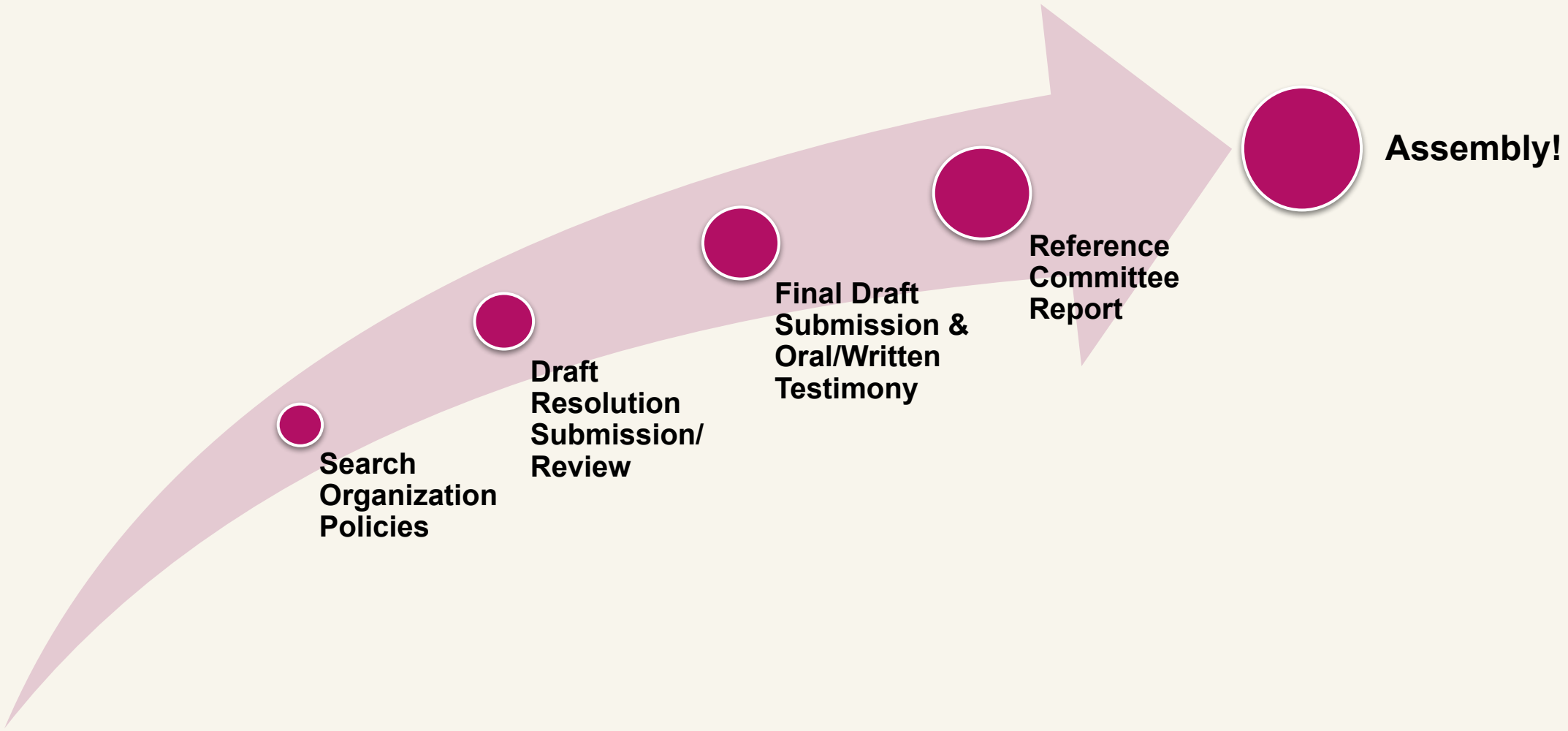
- Recognize
- Support
- Research/Study
- Develop

Active Resolved Language

- Promote
- Encourage/Urge
- Advocate/Lobby/Call upon
- Oppose/Condemn/Object to



Policy Process



Delegate and Alternate Delegate

ROADMAP TO HOD

BUCKLE UP! THE HOD JOURNEY BEGINS!

RESOLUTIONS ARE POSTED ONLINE
SEPT. 7

CLICK HERE TO VIEW

Resolutions can be found at www.pamedsoc.org/Resolutions for all members to view

PROVIDE WRITTEN TESTIMONY
BY SEPT. 20: Round 1
BY OCT. 14: Round 2

CLICK HERE TO VIEW

All members wishing to provide input on any resolutions or proposed bylaws changes are strongly encouraged to do so.

INTERIM REFERENCE COMMITTEE REPORT IS PUBLISHED AND WRITTEN TESTIMONY REOPENS
OCT.5

CLICK HERE TO VIEW

GET TRAINED TO EFFORTLESSLY USE THE VIRTUAL HOD PLATFORM

Access Training & Attestation

This is a new structure for 2021 ALL Delegates and Alternate Delegates ***MUST*** train on the virtual platform so that you may fully and effortlessly engage in the House of Delegates meeting.

PROVIDE ORAL TESTIMONY
SIGN UP BY OCT. 7

LOGIN

While all members wishing to provide input on any resolutions or proposed bylaws changes are strongly encouraged to provide written testimony, there is also a virtual live option.

FINAL REFERENCE COMMITTEE REPORT IS PUBLISHED
OCT. 26

CLICK HERE TO VIEW

Delegate and Alternate Delegate

ROADMAP TO HOD

PARTICIPATE IN SECTION MEETINGS

SIGN UP BY OCT. 24

MEDICAL STUDENT SECTION: OCT.27 at 7:30 P.M.

RESIDENT AND FELLOW SECTION: OCT. 28 at 7:30 P.M.

EARLY CAREER PHYSICIAN SECTION: OCT.27 at 7:00 P.M.

INTERNATIONAL MEDICAL GRADUATE SECTION: OCT. 28 at 7:00 P.M.

WOMEN PHYSICIANS SECTION: OCT. 27 at 7:00 P.M.

Each special section is holding their annual business meeting prior to the House of Delegates Meeting.

PARTICIPATE IN THE PAMPAC & PAMED VIRTUAL SOCIAL

It's not to late to join in on the fun

LOGIN TO JOIN THE SOCIAL

We miss you! As has historically been done when we are in person, we're holding a social the Friday before the HOD.

PARTICIPATE IN THE VIRTUAL HOUSE OF DELEGATES OCT. 30

SIGN UP BY OCT. 26 at NOON

REGISTRATION CLOSED
We look forward to seeing you!

Sign up to have access as a Delegate or Alternate Delegate to the online platform that will be used to conduct the HOD.

YOU HAVE REACHED YOUR DESTINATION!

HOD HELP CENTER
Everything you need for this year's HOD
CLICK HERE

2021 PAMED HOD Resolutions: 21-302

PREAMBLE

Subject: Remove opposition to single-payer health care

Introduced By: Donald Bourne

Author: Donald Bourne

County/Specialty Affiliation of Author: Allegheny County

WHEREAS

WHEREAS, resolutions supporting Medicare for All have been passed in Aliquippa, Ambridge, Bethlehem, Easton City, Erie, Norristown, Pittsburgh, Philadelphia, South Heights, Wilkinsburg, and Allegheny County, Beaver County – which combined are home to over 3 million Pennsylvanians (nearly 25% of the population) (1, 2), and

WHEREAS, other physician groups such as the American College of Physicians, the Vermont Medical Society, and the Hawaii Medical Society endorse single-payer health care reform, and

WHEREAS, 29.6 million Americans lacked health insurance in 2019 (3), and

WHEREAS, COVID-19 has exposed the fragility of job-connected health insurance for people and employers as evidenced by millions of Americans losing employer sponsored health insurance (4), and

WHEREAS, compared to ten other high-income countries, the U.S. ranks last in health care affordability, and has the highest rate of infant mortality and mortality amenable to health care (5), and

WHEREAS, employer-sponsored health plans are increasingly unaffordable for workers since 85% of these plans include an annual deductible and the average deductible was $1,573 for single coverage in 2018 (6), and

WHEREAS, in 2017 the U.S. spent $3.7 trillion on health care, or 17.9% of GDP (7), twice as much per capita on health care as the average of wealthy nations that provide universal coverage (8), and

WHEREAS, illness and medical bills contribute to 66.5% of all bankruptcies, a figure that is virtually unchanged since before the passage of the Affordable Care Act (ACA), and 530,000 families suffer bankruptcies each year that are linked to illness or medical bills (9), and

WHEREAS, overhead consumes 12.2% of private insurance premiums (10), while the overhead of fee-for-service Medicare is less than 2% (11), and

WHEREAS, providers are forced to spend tens of billions more dealing with insurers' billing and documentation requirements (12), bringing total administrative costs to 34.2% of U.S. health spending, compared to 17.0% in Canada (13), and

WHEREAS, the U.S. could save over $500 billion annually on administrative costs with a single-payer system (14), and

WHEREAS, billing-driven documentation that contributes to physician burnout would be greatly reduced

under a single-payer reform (15), and

WHEREAS, the savings from slashing bureaucracy would be enough to cover all of the uninsured and eliminate cost sharing for everyone else (16), and

WHEREAS, a single-payer system could control costs through proven-effective mechanisms such as global budgets for hospitals and negotiated drug prices (17), thereby making health care financing sustainable, and

WHEREAS, a single-payer reform will reduce malpractice lawsuits and insurance costs because injured patients won't have to sue for coverage of future medical expenses, and

WHEREAS, a single-payer system would facilitate health planning, directing capital funds to build and expand health facilities where they are needed, rather than being driven by the dictates of the market, and

WHEREAS, a single-payer reform will dramatically reduce, although not eliminate, health disparities. The passage of Medicare in 1965 led to the rapid desegregation of 99.6% of U.S. hospitals (18), and

WHEREAS, a single-payer system will allow patients to freely choose their doctors, gives physicians a choice of practice setting, and protect the doctor-patient relationship, and

WHEREAS, there is single-payer legislation in both houses of Congress, H.R. 1384 (19) and S. 1129, therefore

Resolved

RESOLVED, That the Pennsylvania Medical Society (PAMED) amend current policy **165.997** Managed Competition to remove language opposing single-payer systems by deletion as follows:

Managed Competition

(1) PAMED adopts the following policy position: Health system reform proposals that unfairly concentrate the market power of payers are 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 that fall within such a definition should continue to be opposed by PAMED~~. Reform proposals should balance fairly the market power between payers and physicians or be opposed.

(2) PAMED continues to support a pluralistic health care system, with no preferential treatment by government that gives a competitive advantage to any form of health insurance/health care delivery organization. In particular, integrated systems should be given no competitive advantage.

(3) PAMED will propose and support legislative or regulatory action requiring employers to offer a benefit payment schedule plan, in addition to other plans.

(4) PAMED will continue to advocate strongly to Congress, the Department of Justice, and the Federal Trade Commission the need for changes in relevant antitrust laws to allow physicians and physician organizations to engage in group negotiations with collective purchasers, managed care plans, insurers, and other payers.

(5) Society support for any "managed competition" proposal is contingent, in part, on: (a) relief from existing antitrust laws with respect to the right of physicians and physician organizations to engage in group negotiation; and (b) modifications to ERISA to ensure that any rules and negotiation requirements apply equally to self-insured and insured health benefit plans. (Res. 522, H-1994; revised, Res. 303, H-2019)

CONCLUSION

Fiscal Note: N/A

Reference Materials

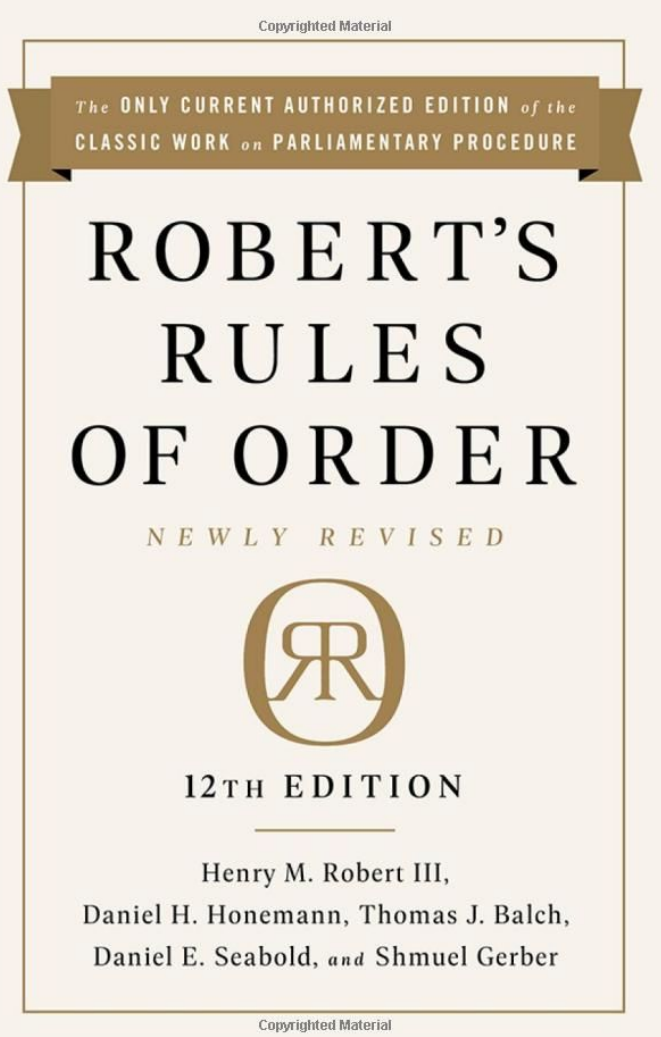
References:

1. "Unions for Single Payer Health Care H.R. 676." UnionsForSinglePayer, (n.d.), https://unionsforsinglepayer.org/more/.
2. "Partial List of Past Local Resolutions." Medicare For All, 3 Apr. 2019, www.medicare4allresolutions.org/partial-list-of-past-local-resolutions/.
3. "Health Insurance Coverage in the United States: 2019," U.S. Census Bureau, September 2020.
4. Bivens and Zipperer, "Health insurance and the COVID-19 shock," Economic Policy Institute, August 2020.
5. Schneider, et al., "Mirror, Mirror 2017: International comparison reflects flaws and opportunities for better U.S. health care," Commonwealth Fund, July 17, 2017.
6. Claxton, et al., "Health benefits in 2018: Modest growth in premiums, higher worker contributions at firms with more low-wage workers," Health Affairs, October 2018.
7. "National Health Expenditures Fact Sheet 2017," U.S. Centers for Medicare & Medicaid Services, December 2018.
8. Sawyer and Cox, "How does health spending in the U.S. compare to other countries?" Kaiser Family Foundation, December 7, 2018.
9. Himmelstein et al., "Medical bankruptcy: Still common despite the Affordable Care Act," American Journal of Public Health, March 1, 2019.
10. National Health Expenditure Accounts, U.S. Centers for Medicare & Medicaid Services, December 2018.
11. 2018 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, June 2018.
12. Morra, et al., "U.S. physician practices versus Canadians: spending nearly four times as much money interacting with payers," Health Affairs, August 2011.
13. Himmelstein, et al., "Health care administrative costs in the United States and Canada, 2017," Annals of internal medicine, January 21, 2020.
14. Woolhandler and Himmelstein, "Single-payer reform: The only way to fulfill the President's pledge of more coverage, better benefits, and lower costs," Annals of Internal Medicine, April 2017.
15. Downing, et al., "Physician burnout in the electronic health record era: Are we ignoring the real cause?" Annals of Internal Medicine, July 3, 2018.
16. Pollin, et al., "Economic analysis of Medicare for All," Political Economy Research Institute, University of Massachusetts-Amherst, November 30, 2018.
17. Marmor and Oberlander, "From HMOs to ACOs: The Quest for the Holy Grail in U.S. Health Policy," Journal of General Internal Medicine, March 13, 2012.
18. Himmelstein and Woolhandler, "Medicare's rollout vs. Obamacare's glitches brew," Health Affairs blog, Jan. 2, 2014.
19. H.R.1976 - Medicare for All Act of 2021, Congress.gov, introduced March 7, 2021

Name Donald Bourne

Strategizing

- Authorship
- Endorsements
- Language
- Incremental steps
  - Oppose→Neutralize→Support→Advocate
- Understand Robert's Rules of Order
- Referring
  - Call to question
  - Refer for study
  - Refer to board for decision

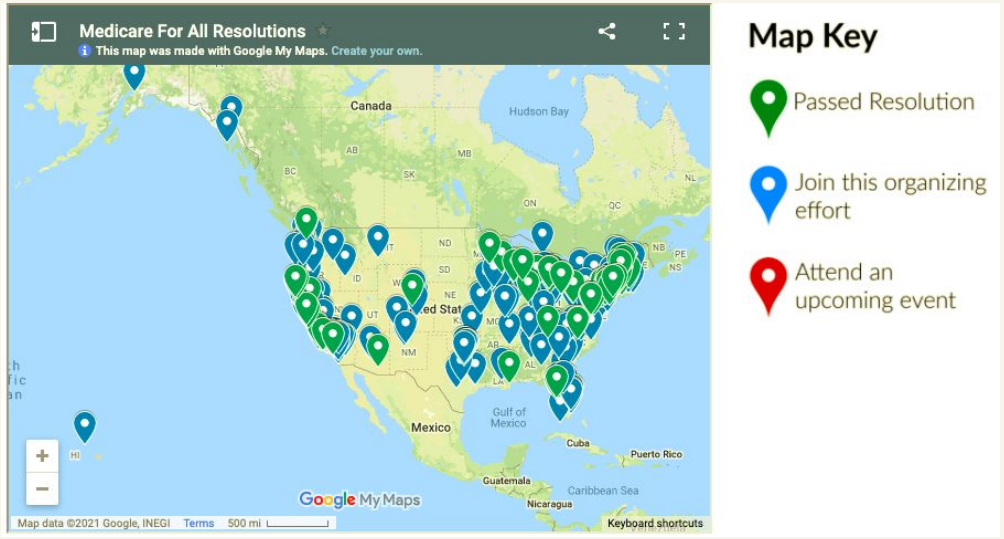


What have we accomplished in PAMED?

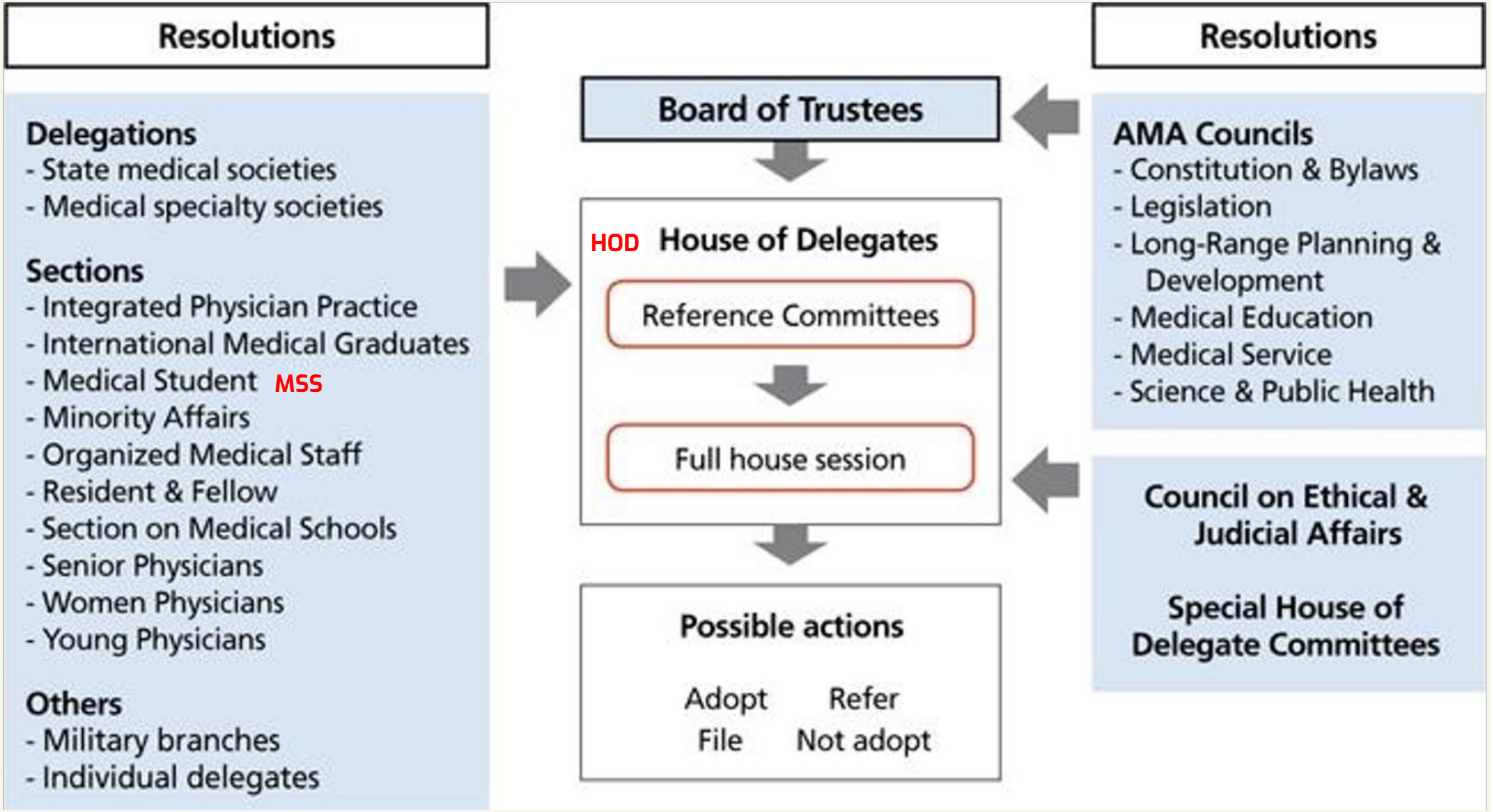
- 2021
  - Neutralized language against single-payer
  - Support for single-payer was at 37%
- 2022
  - Support for single-payer was at 41%
  - Resolution against DCEs/ACO REACH was referred to the board for decision

Resources

- https://medicalsocietyresolutions.org/sample-resolution/
  - Sample Medical Society Resolution
- https://www.medicare4allresolutions.org/tools-for-activists/
  - Sample Local Resolution
- https://www.medicare4allresolutions.org/is-a-local-resolution-already-underway-in-your-community/
  - Ongoing/Passed Resolutions



AMA Resolutions


Resolutions
Delegations
- State medical societies
- Medical specialty societies
Sections
- Integrated Physician Practice
- International Medical Graduates
- Medical Student MSS
- Minority Affairs
- Organized Medical Staff
- Resident & Fellow
- Section on Medical Schools
- Senior Physicians
- Women Physicians
- Young Physicians
Others
- Military branches
- Individual delegates
Board of Trustees
HOD House of Delegates
Reference Committees
Full house session
Possible actions
Adopt
Refer
File
Not adopt
Resolutions
AMA Councils
- Constitution & Bylaws
- Legislation
- Long-Range Planning & Development
- Medical Education
- Medical Service
- Science & Public Health
Council on Ethical & Judicial Affairs
Special House of Delegate Committees

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution X
(I-22)

Introduced by:

Subject: Against Direct Contracting Entities

Sponsored by:

Referred to: MSS Reference Committee
(TBA, Chair)

Whereas, Under the Trump administration, the Center for Medicare and Medicaid Innovation

RESOLVED, That our AMA oppose any attempts to implement Direct Contracting Entities, such as Accountable Care Organization Realizing Equity, Access, and Community Health (ACO-REACH) program, and their relationship with Medicare; and be it further

RESOLVED, That our AMA develop educational materials for physicians regarding Direct Contracting Entities, such as Accountable Care Organization Realizing Equity, Access, and Community Health (ACO-REACH) program so that they are aware of the implications of their individual or their employer's participation in this program; and be it further

RESOLVED, That this resolution be immediately forwarded to the AMA House of Delegates.

aligning them with that DCE[1-3]; and

Specialty Society/ Interest Group Resolutions

American Academy of Family Physicians (AAFP)
Single Payer Health Care Member Interest Group

- AAFP developed a Member Interest Group (MIG) program in 2015
- The Single Payer Health Care MIG founded that year with required 50 members. Currently over 400 members.
- The Single Payer Health Care MIG aims to educate AAFP members on the ability of single payer financed health care to streamline and simplify patient care and improve family physicians' professional satisfaction by greatly decreasing administrative complexities and burdens.

Health Care is a Right - 2017 Introduced by the Massachusetts, California, Colorado, Maine, New York, Illinois, California and New Hampshire Chapters

- **RESOLUTION NO. 503 (Co-Sponsored C)**
- **Health Care is a Right**
- RESOLVED, That the American Academy of Family Physicians recognize that health care is a basic human right for every person and not a privilege.
- Referred to the Reference Committee on Advocacy
- **Amended on the Floor:**
  RESOLVED, That the American Academy of Family Physicians recognizes that health is a basic human right for every person, and be it further
- **RESOLVED, That the right to health includes universal access to timely, acceptable and affordable health care of appropriate quality.**
- Added as policy statement entitled "Health is a Right" to the policy website.

How did the MMS get there?

- In 2017 the Berkshire District Medical Society introduce a resolution at HOD that
- **RESOLVED, That the Massachusetts Medical Society recognizes that health care is a basic human right for every person and not a privilege.**
- This was referred to the Board of Trustees to report back. The next year a recommendation to have a **Conference** on **Health as a Human Right** was passed. This occurred at our fall 2018 meeting, 3 experts spoke and it was well attended. A straw poll of the group indicated a minority of those present wanted Single Payer (similar to the House of Delegates as a whole),
- The conference convinced the leadership to have the Medical Society **"ASSERT that HEALTH, which includes HEALTH CARE, is a Human Right"**, wording that was passed at the annual meeting in 2019.

MA

une 2019

owledged that equitable access to medical care is a core component of a basic human ri

AMA holds that physicians have an ethical responsibility to ensure that all persons have a

There are many pathways to providing patients with equitable access to medical care and

2021: Health Care not tethered to employment AAFP Congress of Delegates, adopted

Health Care Funding Should Not Be Bound to Employment

RESOLVED, That the American Academy of Family Physicians support and advocate that the funding of any future health care system be capable of supporting access to universal, high quality, equitable, and affordable health care without tethering health insurance to employment.

ACP: Better is Possible adopted at AAFP 2022

RESOLVED, That the American Academy of Family Physicians revise the list of Health Care for All approaches to include the following three preferred models (single payer, public option with Bismarck Approach, Primary Care Coverage for All) with a report back on progress to the 2023 Congress of Delegates, and be it further

RESOLVED, that the American Academy of Family Physicians collect information from member input and through commissions' expertise to generate a report to develop a long-term plan to achieve Health Care for All, and be it further,

RESOLVED, That the American Academy of Family Physicians collaborate with primary care stakeholders, giving consideration to incorporating the American College of Physicians' Better is Possible research, with the goal of achieving Healthcare for All, and report back on any collaborative efforts to the 2023 Congress of Delegates.

ADOPTED at COD 2022

2023: Opposing REACH

e Systems that Decrease Health Equity, Decrease Access to Care, Decrease Patient Choice, Increase Administrative Burden, and Increase Taxpayer Spending; A Case Example for AAFP Opposition: Privatization of Tra

s come out strongly in support of health equity, increased access to affordable care, and decreased administrative burden, and

of health care has consistently shown to decrease health equity and access to care while increasing administrative overhead and burden and therefore cost, and

n the AAFP supports untethering employment from health insurance is because of issues with access, health equity, and affordability, and

aditional Medicare and adding private equity to Traditional Medicare runs counter to the AAFP's support of a health care system whose funding is capable of supporting health equity and access to affordable and appr

ble Care Organization Realizing Equity, Access, and Community Health model (REACH) (REACH is an update on the model of using Direct Contracting Entities (DCEs) via the proposed Global and Professional Direct C
ace have a plan to increase health equity by giving bonuses for reporting demographics and enrolling people living in underserved areas – however there is no overarching goal to increase quality - and reporting demo
of those who are underserved will increase commercial reimbursement (and increase taxpayer burden and administrative burden) without truly improving health equity,

ave a system of Medicare with Medicare Advantage which has narrow networks, decreased health equity where people when they become sick have trouble accessing specialists and are forced to travel farther to get
locking back to Traditional Medicare from Medicare Advantage when they become ill), and

dy have the choice of a privatized model of Medicare with Medicare Advantage and privatizing Traditional Medicare takes away patient choice, and

e would be unimaginably impeded often without their knowledge by automatically enrolling them into REACH (and the current plan for patients to get out of REACH is to change their primary care provider which risks
and

kely increase physician administrative burden (practices will now have to track 3 Medicare revenue streams instead of 2, collect and provide more data and metrics for the same or less reimbursement, fill out questionn
, increase burnout, decrease reimbursement, and narrow networks (despite claims to the contrary that patients can see any Medicare provider they wish, REACH will in effect disincentivize clinicians from referring to c
way of narrowing networks without officially narrowing them), and

ave a system of Medicare fraught with financial and administrative waste and abuse done by overcoding via Hierarchical Care Codes (HCC) where taxpayers then bear the burden of being overcharged by commercial I
oding (there is a correction factor controlled by Congress, but it has not kept up with coding inflation which has resulted in overpayment to commercial insurers of billions of dollars annually – REACH will control this by
scores over time which doesn't make sense because sicker patients typically live in Traditional Medicare and are therefore at increased risk of getting more sick over time which would decrease physician reimburseme
lt in an effective pay cut for physicians; in effect what is most likely to happen is this will skew practices that participate in REACH to those with healthier populations unlikely to have a sizeable increase in their risk sco
pool of the sickest patients in Traditional Medicare while commercial insurers make their money off selectively privatizing Medicare as previously stated), and

edicare has about 2% overhead, Medicare Advantage is allowed 15% overhead and profit, and REACH has the strong possibility to achieve greater than 15% overhead and profit (as now written REACH can get to 25

odel of care is in opposition with current AAFP policy, therefore, be it

hat the AAFP vehemently oppose any changes to Traditional Medicare that risk decreasing a patient's choice of c
decrease health equity, increase administrative burden, and decrease access to affordable care, and be it furthe

Future: Surveying membership

Surveying AAFP Members on Health Care System Support and Knowledge of Current Policy

WHEREAS current AAFP policy is to support either a publicly funded privately delivered system (also known as Single Payer or Medicare for All), a highly regulated private system with public option (also known as Bismarck with public option), or a universal system of primary care, and

WHEREAS there is a continuing shift in public opinion and now about two thirds of people believe the government should provide health care for all, and

WHEREAS there is continuing shift in physician opinion in support of the government providing health care, with over half and in some polls two thirds of physicians in favor, and

WHEREAS the AAFP has no current mechanism of knowing their current members' knowledge or opinions of health care systems, therefore, be it

RESOLVED that the American Academy of Family Physicians (AAFP) poll its members on education level on health care systems, of education of current AAFP health care system policy, and level of support of the AAFP's favored health care systems in their policy.

Questions