WHEREAS, The concepts of pluralism and patient choice in the healthcare payment system are long standing AMA policy (D-330.924, H-165.844, H-390.854), and

WHEREAS, The Medicaid healthcare payment model in the United States violates these concepts of pluralism and patient choice by only allowing its recipients to use government funds for the payment and by limiting recipients to a single defined benefit and pharmacy package, and

WHEREAS, These flaws in the Medicaid health care delivery system are contributing to the need for Medicaid Payment System reform, therefore be it

RESOLVED, That our American Medical Association support reform of the Medicaid health care delivery model using the principles of expanded individual choice, individual opportunity, individual and governmental responsibility (New HOD Policy); and be it further

RESOLVED, That our AMA support reform of the Medicaid healthcare delivery model which provide the individual patient the opportunity and responsibility to make wise choices in their own health care delivery model, and to share in the financial savings when using the Medicaid healthcare delivery system wisely (New HOD Policy); and be it further

RESOLVED, That our AMA encourage pluralism and patient choice in the Medicaid healthcare delivery model by requesting the Centers for Medicare and Medicaid Services develop multiple patient choice healthcare payment options at the Federal level, or by approving waivers at the state level, that include but are not limited to the following:

Option 1: Maintenance of the traditional legacy Medicaid program whereby the recipient is allotted a defined contribution per member per month and is provided a government issued identification card, which upon presentation entitles that recipient to receive healthcare services from any willing provider according to a defined benefit package and prescription formulary. Recipients desiring expanded healthcare services or pharmacy benefits may obtain this by paying the additional cost out-of-pocket.

Option 2: Creation of a Medicaid Advantage program similar to a Medicare Advantage program where the defined Medicaid contribution for the recipient is assigned to a third party which in turn must provide the health care services to the recipient. This third party then utilizes the principles of managed care to generate savings which can then be applied to the recipient in the form of expanded services and pharmacy benefits.

Option 3: Creation of a Medicaid voucher system whereby the recipient could then apply that Medicaid defined contribution toward the purchase of private healthcare coverage of their choice. The recipient could choose a coverage plan similar to the defined benefit package of traditional Medicaid, and if they could find such coverage for a lower premium the recipient could apply the savings toward the purchase of expanded service or pharmacy benefit. The premium for that basic benefit package could be required by insurance rule never to be more than the defined contribution amount provided by Medicaid. This protects the recipient from excess personal expense. The recipient could also choose to contribute employer sponsored health care plan premium funds, personal funds, or other funds such as a those provided by a philanthropic organization to expand the premium and thus choose to enhance the healthcare or pharmacy benefit.

Option 4: Creation of a Medicaid Medical Savings Account program in which the Medicaid defined contribution allotted for each recipient is then assigned to an account created for the recipient. The recipient can then choose the health care delivery model best for them, with the cost then assigned to that model. Healthcare coverage is maintained for wellness care, illness care and accident care by participation in in a health system payment model, but the recipient is incentivized to maintain healthy lifestyle and judiciously use the healthcare delivery system by sharing in any savings they help to create. These savings can then be used contemporaneously to acquire expanded healthcare or pharmacy services, or be retained in that recipient account until such time as they reach the age of eligibility for Medicare. Those lifetime accumulated savings could then be used to purchase Medicare supplemental insurance coverage, or the savings could be transferred to the recipient’s Social Security or other retirement plan for any use in their retirement years. (New HOD Policy)

Fiscal Note: Not yet determined

Received: 04/11/18

RELEVANT AMA POLICY

Preservation of Physician-Patient Relationships and Promotion of Continuity of Patient Care H-160.901 - Our AMA supports: (1) policies that encourage the freedom of patients to choose the health care delivery system that best suits their needs and provides them with a choice of physicians; (2) the freedom of choice of physicians to refer their patients to the physician practice or hospital that they think is most able to provide the best medical care when
appropriate care is not available within a limited network of providers; and (3) policies that encourage patients to return to their established primary care provider after emergency department visits, hospitalization or specialty consultation. Citation: Res. 815, I-16

Health Insurance Exchange Authority and Operation H-165.839 - 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 choice 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. Citation: CMS Rep 3, I-09, Reaffirmation A-10, Reaffirmation in lieu of Res. 105, A-10, Appended: CMS Rep. 6, I-11, Reaffirmed in lieu of Res. 812, I-13, Reaffirmed: Sub Res. 813, I-13, Reaffirmed: Res. 108, A-17.

Educatng the American People About Health System Reform H-165.844 - Our AMA reaffirms support of pluralism, freedom of enterprise and strong opposition to a single payer system. Citation: Res. 717, I-07, Reaffirmation A-09

State Efforts to Expand Coverage to the Uninsured H-165.845 - Our AMA supports the following principles to guide in the evaluation of state health system reform proposals: 1. Health insurance coverage for state residents should be universal, continuous, and portable. Coverage should be mandatory only if health insurance subsidies are available for those living below a defined poverty level. 2. The health care system should emphasize patient choice of plans and health benefits, including mental health, which should be value-based. Existing federal guidelines regarding types of health insurance coverage (e.g., Title 26 of the US Tax Code and Federal Employees Health Benefits Program [FEHBP] regulations) should be used as references when considering if a given plan would provide meaningful coverage. 3. The delivery system should ensure choice of health insurance and physician for patients, choice of participation and payment method for physicians, and preserve the patient/physician relationship. The delivery system should focus on providing care that is safe, timely, efficient, effective, patient-centered, and equitable. 4. The administration and governance system should be simple, transparent, accountable, and efficient in order to reduce administrative costs and maximize funding for patient care. 5. Health insurance coverage should be equitable, affordable, and sustainable. The financing strategy should strive for simplicity, transparency, and efficiency. It should emphasize personal responsibility as well as societal obligations. Citation: CMS Rep. 3, I-07, Reaffirmed: Res. 239, A-12.


Expanding Choice in the Private Sector H-165.881 - 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. Citation: BOT Rep. 23, A-97, Reaffirmed BOT Rep. 6, A-98, Reaffirmation A-02, Reaffirmed: CMS Rep. 4, A-12
Individual Health Insurance H-165.920 - 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 employee 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. Citation: BOT Rep. 41, I-93CMS Rep. 11, I-94Reaffirmed by Sub. Res. 125 and Sub. Res. 10 A-95 Amended by CMS Rep. 2, I-96 Amended and Reaffirmed by CMS Rep. 7, A-97 Reaffirmation A-97 Reaffirmed: CMS Rep. 5, I-97 Res. 212, I-97 Appendix and Amended by CMS Rep. 9, A-98 Reaffirmation I-98 Reaffirmation I-98 Res. 105 & 108, A-99 Reaffirmation A-99 Reaffirmed: CMS Rep. 5 and 7, I-99 Modified: CMS Rep. 4, CMS Rep. 5, and Affirmation by Res. 220, A-00 Reaffirmation I-00 Reaffirmed: CMS Rep. 2, I-01 Reaffirmed CMS Rep. 5, A-02 Reaffirmation A-03 Reaffirmed: CMS Rep. 1 and 3, A-02 Reaffirmed: CMS Rep. 3, A-02 Reaffirmed: CMS Rep. 3, A-03 Reaffirmation I-03 Reaffirmation A-04 Consolidated: CMS Rep. 7, I-05 Modified: CMS Rep. 3, A-06 Reaffirmed in lieu of Res. 105, A-06 Reaffirmation A-07Appended and Modified: CMS Rep. 5, A-08 Modified: CMS Rep. 8, A-08 Reaffirmation A-10 Reaffirmed: CMS Rep. 9, A-11 Reaffirmation A-11Reaffirmed: Res. 239, A-12 Appended: Res. 239, A-12 Reaffirmed: CMS Rep. 6, A-12 Reaffirmed: CMS Rep. 9, A-14 Reaffirmed in lieu of: Res. 805, I-17

See also: Transforming Medicaid and Long-Term Care and Improving Access to Care for the Uninsured H-290.982; Affordable Care Act Medicaid Expansion H-290.985; Medicaid Expansion Options and Alternatives H-290.986; Health Savings Accounts in the Medicaid Program H-290.972; Access to Care by Medicaid Patients H-290.989; Reform the Medicare System D-330.924; Patient Information and Choice H-373.998; Health Care Reform Physician Payment Models D-385.963; Freedom of Choice H-380.854; Informed Choice for Patients H-415.988; Moving to Alternative Payment Models H-450.931