Whereas, The Patient Protection and Affordable Care Act of 2010 (ACA) reduced the uninsurance rate in the United States but has not achieved universal coverage;

Whereas, Tens of millions of Americans are either uninsured or underinsured with insurance that is too expensive to actually be used, significantly limiting their access to affordable healthcare;

Whereas, Many individual insurance plans offered on the ACA’s Health Insurance Marketplaces (hereafter referred to as “ACA Exchanges”) have high premiums, deductibles, and other out-of-pocket costs that leave beneficiaries exposed to financial risk and limit their access to healthcare;

Whereas, Some ACA Exchanges, particularly those covering rural areas, offer only a small number of plans that are limited by very few insurers participating, which has been shown to lead to higher costs and faster premium growth due to limited competition;

Whereas, Plans offered on the ACA Exchanges frequently have narrow provider networks, which reduces access to care and can lead to high out-of-pocket costs if patients go out-of-network;

Whereas, A federally-managed public insurance plan (“public option”) has been proffered as a mechanism to improve competition, increase access to affordable healthcare, and lower costs, particularly in areas where there are few participating insurers and a commensurate lack of competition between plans;

Whereas, A recent analysis from the Urban Institute found that various public option proposals with different eligibility criteria and payment rates would all decrease the uninsured rate, significantly reduce premiums, and reduce the federal deficit;

Whereas, RAND modeled four different scenarios under which a public option could be implemented and found that under all scenarios, premium costs in the public option were lower than in private plans, leading to more people being covered;

Whereas, A Commonwealth Fund analysis of various healthcare reform proposals found that a public option would reduce the uninsured rate and significantly reduce costs to the federal government, permitting the implementation of more generous premium tax credits that could further reduce the uninsurance rate;
Whereas, A public option would have significant leverage during price negotiations with hospitals, pharmaceutical companies, pharmacy benefit managers, and other healthcare providers due to its large size and would likely have lower administrative costs per beneficiary than smaller private plans, leading to lower premiums and cost-sharing for beneficiaries and lower costs to the federal government; and

Whereas, A 2021 CBO report on key design considerations for a public option showed that the benchmark premium for insurance plans offered on the ACA Exchanges is closely correlated with the number of insurers participating in the market with more insurers leading to lower premiums, suggesting that the public option, as an additional insurer, would reduce premiums for public and private insurers alike; and

Whereas, Though there are concerns that a public option may reduce overall physician reimbursement through lower provider payment rates, CBO estimates of the impacts of Medicare-for-All proposals on physician reimbursement show that lower provider payment rates may be balanced by increased healthcare utilization after the expansion of public insurance programs, leading to small overall changes in physician reimbursement and a net increase in some scenarios; and

Whereas, Recent studies published by the CBO, JAMA, and AAFP have discussed the inherent tradeoffs between lowering costs through reduced provider reimbursement and developing provider networks attractive enough to convince prospective beneficiaries to enroll in the public option, highlighting how careful design of a public option can maximize benefit to patients and physicians alike; and

Whereas, The state of Washington created a public option-like program called Cascade Care in 2019 that designed overall reimbursement to exceed no more than 160% of Medicare rates with a minimum reimbursement of 135% of Medicare rates for primary care practices, showing how a public option can be designed to reduce costs and expand coverage in ways that do not unduly burden physicians; and

Whereas, The AMA passed Policy H-165.823 in November 2020, which lays out a variety of criteria that a public option should meet, but does not go so far as to explicitly support a public option; and

Whereas, H-165.823 already contains provisions to protect physicians and their practices, including a requirement that the public option not tie participation to participation in other public insurance programs, a requirement that contracts with physicians must be subject to meaningful negotiation, and a requirement that reimbursement exceed prevailing Medicare rates and be at levels sufficient to sustain the costs of medical practice; and

Whereas, Based in large part upon on this policy, the AMA recently sent a letter to Congress regarding a public option, which highlighted the standards codified in H-165.823 while failing to mention the potential benefits or explicitly endorse a public option; and

Whereas, multiple physician groups, including the American College of Physicians, American Academy of Family Physicians, American Academy of Pediatrics, American College of Obstetricians and Gynecologists, American Osteopathic Association, American Psychiatric Association, and the Society of General Internal Medicine, have endorsed a public option; therefore be it
RESOLVED, That our American Medical Association amend Policy H-165.823, “Options to Maximize Coverage under the AMA Proposal for Reform”, by addition and deletion to read as follows:

1. Our AMA will advocate that any public option to expand health insurance coverage must meet the following standards:
   a. The primary goals of establishing a public option are to maximize patient choice of health plan and maximize health plan marketplace competition.
   b. Eligibility for premium tax credit and cost-sharing assistance to purchase the public option is restricted to individuals without access to affordable employer-sponsored coverage that meets standards for minimum value of benefits.
   c. Physician payments under the public option are established through meaningful negotiations and contracts. Physician payments under the public option must be higher than prevailing Medicare rates and at rates sufficient to sustain the costs of medical practice.
   d. Physicians have the freedom to choose whether to participate in the public option. Public option proposals should not require provider participation and/or tie physician participation in Medicare, Medicaid and/or any commercial product to participation in the public option.
   e. The public option is financially self-sustaining and has uniform solvency requirements.
   f. The public option does not receive advantageous government subsidies in comparison to those provided to other health plans.
   g. The public option shall be made available to uninsured individuals who fall into the “coverage gap” in states that do not expand Medicaid — having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credits — at no or nominal cost. (Modify Current HOD Policy)

Fiscal Note: Not yet determined

Received: 10/04/22

References:

RELEVANT AMA POLICY

Options to Maximize Coverage under the AMA Proposal for Reform H-165.823

1. Our AMA will advocate that any public option to expand health insurance coverage must meet the following standards:
   a. The primary goals of establishing a public option are to maximize patient choice of health plan and maximize health plan marketplace competition.
   b. Eligibility for premium tax credit and cost-sharing assistance to purchase the public option is restricted to individuals without access to affordable employer-sponsored coverage that meets standards for minimum value of benefits.
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   e. The public option is financially self-sustaining and has uniform solvency requirements.
   f. The public option does not receive advantageous government subsidies in comparison to those provided to other health plans.
   g. The public option shall be made available to uninsured individuals who fall into the “coverage gap” in states that do not expand Medicaid – having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credits – at no or nominal cost.

2. Our AMA supports states and/or the federal government pursuing auto-enrollment in health insurance coverage that meets the following standards:
   a. Individuals must provide consent to the applicable state and/or federal entities to share their health insurance status and tax data with the entity with the authority to make coverage determinations.
   b. Individuals should only be auto-enrolled in health insurance coverage if they are eligible for coverage options that would be of no cost to them after the application of any subsidies. Candidates for auto-enrollment would, therefore, include individuals eligible for Medicaid/Children’s Health Insurance Program (CHIP) or zero-premium marketplace coverage.
   c. Individuals should have the opportunity to opt out from health insurance coverage into which they are auto-enrolled.
   d. Individuals should not be penalized if they are auto-enrolled into coverage for which they are not eligible or remain uninsured despite believing they were enrolled in health insurance coverage via auto-enrollment.
   e. Individuals eligible for zero-premium marketplace coverage should be randomly assigned among the zero-premium plans with the highest actuarial values.
   f. Health plans should be incentivized to offer pre-deductible coverage including physician services in their bronze and silver plans, to maximize the value of zero-premium plans to plan enrollees.
   g. Individuals enrolled in a zero-premium bronze plan who are eligible for cost-sharing reductions should be notified of the cost-sharing advantages of enrolling in silver plans.
   h. There should be targeted outreach and streamlined enrollment mechanisms promoting health insurance enrollment, which could include raising awareness of the availability of premium tax credits and cost-sharing reductions and establishing a special enrollment period.

3. Our AMA: (a) will advocate that any federal approach to cover uninsured individuals who fall into the “coverage gap” in states that do not expand Medicaid—having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credit eligibility—make health insurance coverage available to uninsured individuals who fall into the coverage gap at no or nominal cost, with significant cost-sharing protections; (b) will advocate that any federal approach to cover uninsured individuals who fall into the coverage gap provide states that have already implemented Medicaid expansions with additional incentives to maintain their expansions; (c) supports extending eligibility to purchase Affordable Care Act (ACA) marketplace coverage to undocumented immigrants and Deferred Action for Childhood Arrivals (DACA) recipients, with the guarantee that health plans and ACA marketplaces will not collect and/or report data regarding enrollee immigration status; and (d) recognizes the potential for state and local initiatives to provide coverage to immigrants without regard to immigration status.

Universal Health Coverage H-165.904
Our AMA: (1) seeks to ensure that federal health system reform include payment for the urgent and emergent treatment of illnesses and injuries of indigent, non-U.S. citizens in the U.S. or its territories; (2) seeks federal legislation that would require the federal government to provide financial support to any individuals, organizations, and institutions providing legally-mandated health care services to foreign nationals and other persons not covered under health system reform; and (3) continues to assign a high priority to the problem of the medically uninsured and underinsured and continues to work toward national consensus on providing access to adequate health care coverage for all Americans.

Citation: Sub. Res. 138, A-94; Appended: Sub. Res. 109, I-98; Reaffirmation A-02; Reaffirmation A-07; Reaffirmation I-07; Reaffirmed: Res. 239, A-12; Reaffirmed: CMS Rep. 1, A-22

Evaluating Health System Reform Proposals H-165.888
1. Our AMA will continue its efforts to ensure that health system reform proposals adhere to the following principles:
A. Physicians maintain primary ethical responsibility to advocate for their patients' interests and needs.
B. Unfair concentration of market power of payers is detrimental to patients and physicians, if patient freedom of choice or physician ability to select mode of practice is limited or denied. Single-payer systems clearly fall within such a definition and, consequently, should continue to be opposed by the AMA. Reform proposals should balance fairly the market power between payers and physicians or be opposed.
C. All health system reform proposals should include a valid estimate of implementation cost, based on all health care expenditures to be included in the reform; and supports the concept that all health system reform proposals should identify specifically what means of funding (including employer-mandated funding, general taxation, payroll or value-added taxation) will be used to pay for the reform proposal and what the impact will be.
D. All physicians participating in managed care plans and medical delivery systems must be able without threat of punitive action to comment on and present their positions on the plan's policies and procedures for medical review, quality assurance, grievance procedures, credentialing criteria, and other financial and administrative matters, including physician representation on the governing board and key committees of the plan.
E. Any national legislation for health system reform should include sufficient and continuing financial support for inner-city and rural hospitals, community health centers, clinics, special programs for special populations and other essential public health facilities that serve underserved populations that otherwise lack the financial means to pay for their health care.
F. Health system reform proposals and ultimate legislation should result in adequate resources to enable medical schools and residency programs to produce an adequate supply and appropriate generalist/specialist mix of physicians to deliver patient care in a reformed health care system.
G. All civilian federal government employees, including Congress and the Administration, should be covered by any health care delivery system passed by Congress and signed by the President.
H. True health reform is impossible without true tort reform.
2. Our AMA supports health care reform that meets the needs of all Americans including people with injuries, congenital or acquired disabilities, and chronic conditions, and as such values function and its improvement as key outcomes to be specifically included in national health care reform legislation.
3. Our AMA supports health care reform that meets the needs of all Americans including people with mental illness and substance use / addiction disorders and will advocate for the inclusion of full parity for the treatment of mental illness and substance use / addiction disorders in all national health care reform legislation.
4. Our AMA supports health system reform alternatives that are consistent with AMA principles of pluralism, freedom of choice, freedom of practice, and universal access for patients.

Health System Reform Legislation H-165.838

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

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

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

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

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

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

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

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

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

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

11. AMA policy is that national health system reform must include replacing the sustainable growth rate (SGR) with a Medicare physician payment system that automatically keeps pace with the cost of running a practice and is backed by a fair, stable funding formula, and that the AMA initiate a "call to action" with the Federation to advance this goal.
12. AMA policy is that creation of a new single payer, government-run health care system is not in the best interest of the country and must not be part of national health system reform.

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