REPORT 2 OF THE COUNCIL ON MEDICAL SERVICE (I-24)
Unified Financing Health Care System
(Resolution 818-I-23, Second Resolve)
(Reference Committee J)

EXECUTIVE SUMMARY

At the 2023 Interim Meeting, the House of Delegates referred the second resolve clause of Resolution 818, which asked the American Medical Association (AMA) to support a national unified financing health care system that meets the principles of choice, freedom and sustainability of practice, and universal access to quality care for patients. Because there has been no serious movement toward unified financing at the federal level in the United States (U.S.), this report describes efforts in California to pursue a unified financing system; outlines the model's potential benefits and challenges; summarizes AMA policy on health system reform policy and the AMA's plan to cover the uninsured; and presents policy recommendations. For the purposes of this report, unified financing is defined as a health care delivery system that pools funding sources to pay for universal coverage of a standard benefits package that is made available to everyone, regardless of age, employment status, and income. A potential role for health plans or other intermediaries distinguishes unified financing from single payer systems, which are a type of unified financing.

Discussions of unified financing at the state level are still in the early stages in this country, with California taking the lead and exploring the pursuit of federal waivers that would permit the state to pool and redistribute federal Medicaid, Medicare, and Affordable Care Act (ACA) funds under a unified financing system. Among its benefits, unified financing has the potential to reduce health system fragmentation, improve health equity, and eliminate insurance churn. However, the Council on Medical Service is strongly concerned that, under this model, patients and physicians would have less choice and physician payments would be reduced. The report cautions that payment cuts under unified financing could negatively impact physician supply and patient access to care, especially given ongoing threats to practice sustainability stemming from Medicare and Medicaid payment inadequacies.

Moreover, many uncertainties about the model's design remain, including how such a system would be funded and what new taxes might be needed; the mechanisms through which and the levels at which physicians and hospitals would be paid; and the role (if any) of private health plans. Without such details and lacking sufficient analyses in the literature on the impact of unified financing on physicians and patients in the U.S., the Council believes it would be premature to comment on the model's advisability. Instead, this report recommends that our AMA continue to monitor federal and state health reform proposals, including the development of state plans and/or waiver applications seeking program approval for unified financing.

Additionally, two policies are recommended for reaffirmation: Policy D-165.942, which advocates that state governments be given the freedom to develop and test different models for covering the uninsured, provided certain standards are met; and Policy H-165.838, which upholds the AMA's commitment to achieving health system reforms that include health insurance for all Americans, expand choice of affordable coverage, assure that health care decisions remain in the hands of patients and their physicians, and are consistent with pluralism, freedom of choice, freedom of practice, and universal access.

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REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 2-I-24

Subject: Unified Financing Health Care System
(Resolution 818-I-23, Second Resolve)

Presented by: Stephen Epstein, MD, MPP, Chair

Referred to: Reference Committee J

At the 2023 Interim Meeting, the House of Delegates (HOD) referred the second resolve clause of Resolution 818 and asked the American Medical Association (AMA) to "support a national unified financing health care system that meets the principles of choice, freedom and sustainability of practice, and universal access to quality care for patients." The Board of Trustees assigned this item to the Council on Medical Service for a report back to the HOD at the 2024 Interim Meeting. Relatedly, the HOD voted to not adopt the first resolve clause of Resolution 818-I-23, which would have directed our AMA to remove opposition to single payer health care delivery systems from its policy, and instead evaluate all health care system reform proposals based on our stated principles as in AMA policy.

BACKGROUND

Resolution 818-I-23 defines unified financing as "any system of health care financing that provides uniform and universal access to health care coverage that is high quality and affordable, which can include single payer or multi-payer systems based on managed competition between private insurers and does not necessarily mean government run." Supplemental information provided by the sponsors describes unified financing as a system where all health care financing is managed, to varying levels, through a single integrated mechanism with the aim of streamlining health care funding, reducing fragmentation, enhancing efficiency, and improving access to health services. Analyses of health systems specifically labeled as unified financing models are scant in the health care literature aside from a handful of papers on Brazil's health system and a treatise exploring state-level transformational health reform by the Healthy California for All Commission. This Commission was established by a 2019 state law and charged with developing a plan for achieving a unified financing system in California that could include, among other options, a single payer system. The Commission's deliverable, Key Design Considerations for a Unified Health Care Financing System in California, explains unified financing as a "statewide system to arrange, pay for, and assure health care in which all Californians will be entitled to receive a standard package of health care services; entitlement will not vary by age, employment status, disability status, income, immigration status, or other characteristics; and distinctions among Medicare, Medi-Cal, employer-sponsored insurance, and individual market coverage will be eliminated."[1] A *Health Affairs* paper authored by two California Commission members describes unified financing as a type of single payer system "that pools all sources of financing, public and private, into one source to finance a unified benefit package for everyone."[2] For the purposes of this report, the Council defines unified financing as a health care delivery system that pools funding sources to pay for universal coverage of a standard benefits package that is made available to everyone, regardless of age, employment status, and income. A potential role for health plans or other intermediaries

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distinguishes unified financing from single payer systems, which are usually government-run; however, single payer is a type of unified financing. Unified financing also includes multi-payer systems in which a single fund coordinates contributions from various sources while maintaining a standardized approach to benefits and coverage. Interestingly, unified financing can co-exist with supplemental insurance markets or private markets that operate independently, just as substitutive or supplemental private health insurance is available in many countries with unified financing—including single payer—systems. In this country, there has been no serious movement toward unified financing at the federal level and consideration of Medicare-for-All-type proposals has largely stalled; accordingly, this report focuses primarily on California's efforts to implement unified financing reforms.

Because the path towards unified financing in California is still in its early stages, uncertainties about its potential design and implementation remain, including the mechanisms through which or the levels at which physicians, hospitals, and other providers would be paid for their services; the sources of funding that will finance the system; the role (if any) of private health plans; and methods for controlling health care spending, which would be integral to the model's sustainability. According to the Commission, "a threshold issue for California involves securing federal permissions to redirect and consolidate existing federal funding for Medicaid, Medicare, and Affordable Care Act (ACA) advance premium tax credits within a state unified financing system."[3] Furthermore, the reform's sustainability would largely depend on the ability of the state to maintain adequate funding levels and could potentially necessitate new or higher taxes.[4] In October 2023, the California state legislature enacted SB 770, which endorsed the Commission's recommendations for a unified financing system and directed the Secretary of the California Health and Human Services agency to "pursue waiver discussions with the federal government with the objective of a unified health care financing system that incorporates specified features and objectives, including, among others, a comprehensive package of medical, behavioral health, pharmaceutical, dental, and vision benefits, and the absence of cost sharing for essential services and treatments."[5] Updates regarding the need for specific waivers or a timeline for formal waiver applications had not been published at the time this report was written.

At the federal level, unified financing could be implemented through a Medicare-for-All approach, in which eligibility for Medicare is extended to all Americans in a single payer system that replaces employer-sponsored insurance, individual market coverage, and most existing public programs, including Medicaid and Children's Health Insurance Program (CHIP). The Medicare-for-All approach was addressed by the Council in Council Report 2-A-19 and in other reports supporting improvements to the ACA and policies targeting the remaining uninsured. Longstanding AMA policy opposing single-payer systems has been periodically considered by the HOD and was kept in place most recently just a year ago. As the Council has consistently noted, focusing AMA efforts on improving the ACA instead of abandoning it helps promote physician practice viability by maintaining a robust payer mix. Additional concerns about a Medicare-for-All approach include the enormous cost related to implementing such a system and how possible pay-fors would impact patients and physicians.

Some proponents of unified financing also maintain that the model could be implemented by merging employer-sponsored and individual insurance markets and harmonizing their subsidy systems. A Council report presented at the 2024 Annual Meeting addressed this issue and recommended incrementally lowering the ACA affordability firewall so that more workers who have access to employer-sponsored insurance would be eligible to purchase subsidized ACA plans. However, the HOD referred this report back to the Council for further study, in part because of concerns about its potential impact on payer mix and physician practice sustainability. An updated report will be presented by the Council at the 2025 Annual Meeting.

International Unified Financing Models

As noted in Key Design Considerations for a Unified Health Care Financing System in California, a range of unified financing approaches—including single payer systems and mixed models—have been used internationally to achieve universal coverage and access to a standardized set of health services. Under Canada's single payer system, there is no national standardized benefits package; instead, Canadian provinces and territories make most public coverage decisions and administer universal health insurance programs within their jurisdictions. As a result, coverage for services that are not federally mandated (e.g., outpatient prescription drugs and mental health, dental, and vision services) may vary across provinces and territories, most of which provide some level of prescription drug coverage for individuals lacking supplemental private coverage.[6] Two-thirds of Canadians have supplemental private insurance—paid for mostly by employers—that covers vision and dental care, outpatient prescription drugs, private hospital rooms, and other services not covered by the publicly-funded plan.[7]

In addition to Australia's public system, which is funded by general taxation and an income-based tax and covers most hospital and physician services at no cost, patients can purchase private health insurance that facilitates access—at a cost—to private hospitals and specialists and other services not covered by the public system.[8]

Brazil's health system, known as SUS (Sistema Único de Saúde), is decentralized such that the administration and delivery of care is managed at the municipal or state level. Under SUS, which is financed by taxes and contributions from federal, state, and municipal governments, all residents and visitors can access primary, specialty, mental health, and hospital services free of charge and without cost-sharing. Almost a quarter of the population also enrolls in private plans, some of which have their own health facilities, to circumvent delays in accessing care under SUS.[9]

The United Kingdom's (UK) health care system is more centralized; the government-administered National Health Service (NHS), which is funded by general taxation, provides mostly free health care to its residents. NHS owns public hospitals in the UK and pays the salaries of most physicians, nurses, and other care providers and, notably, NHS physicians report high levels of stress and burnout due to staffing shortages and dissatisfaction with pay.[10] As in other countries, more than 10 percent of people in the UK also have private health insurance policies that they either purchase or obtain through an employer. This private coverage provides quicker access to care, greater choice of specialists and hospitals, and amenities for elective hospital procedures but does not include general, emergency, maternity, or mental health care services which are provided by the NHS.[11]

Government plays a lesser role in Germany's universal multi-payer health system, where health insurance is mandatory and provided through either statutory health insurance—administered by competing nonprofit plans known as sickness funds—or substitutive private coverage that individuals can opt into if they make more than €69,300 per year. Health care is financed by mandatory contributions (from employers and workers) imposed as a percentage of wages, which are pooled into a central health fund and reallocated to the sickness funds. Individuals purchasing substitutive private coverage pay risk-adjusted premiums that are determined at the time of enrollment. Although government subsidies are not available to purchase substitutive insurance, these private plans remain attractive, especially to young people, because they may include a broader range of services and lower premiums.[12]

In the Netherlands, all residents must purchase statutory insurance from private health insurers and most people (84 percent) also purchase supplementary insurance that covers dental and vision care and other services not covered by the statutory plan. Statutory insurance is financed through a

combination of a nationally defined income tax, government grants for those under 18 years of age, and community-rated premiums set by each insurer. Such contributions are collected centrally and allocated to insurers according to a risk-based capitation formula. Because supplemental private insurance premiums are not regulated, plans can screen for risks. Interestingly, almost all individuals purchase voluntary supplemental coverage from the same insurer that provides their statutory health insurance.[13]

In its 2017 report on health care financing models around the world, the Council identified both advantages and disadvantages of each of the models studied. In that report, the Council found that the diversity of health care financing models represented different country-to-country priorities, societal beliefs, and acceptable trade-offs related to the level of coverage achieved by the financing model; individual tax burdens; and levels of government regulation, including of health care prices. The Council further found that some financing models were tied to increased government regulation of prices and budgets across the health system, which was perceived as undermining the free market principles long supported by the AMA, and that countries with such systems, including single payer models, tend to have higher rates of taxation and social insurance contributions.

The U.S. is unique among high-income countries in that it lacks a publicly financed system of universal health care. Instead, our pluralistic system incorporates multiple financing models that include a mix of public (e.g., Medicare, financed by federal taxes, a mandatory payroll tax, and individual premiums; and Medicaid and CHIP, jointly financed by federal and state tax revenues) and private (e.g. employment-based insurance, paid for by employers and employees; or plans purchased by individuals, often federally subsidized, on an ACA exchange) options. Although patients enrolled in publicly financed health systems like Medicaid may incur fewer cost-sharing expenses, they may also experience access challenges, lengthier wait times, and/or delayed or lack of access to costly innovative services and therapeutics. The private insurance system in this country reflects free market principles and embraces choice but may be more costly for some patients (and employers), thereby raising equity concerns.[14]

As stated in Council Report 2-A-17, approaches to paying physicians and other providers vary by country and are not wholly dependent on a country's health care financing model. Physicians can be salaried or be paid via fee-for-service or capitation, with fee schedules set by national, regional, or local health authorities, negotiated between national medical societies or trade unions and the government, or negotiated/set by sickness funds or health plans. Hospital financing can vary but generally depends on whether hospitals are public, private, nonprofit, or for-profit. Public hospitals may operate under a global budget determined by the responsible health authority, or receive a majority of their funding from national, regional, or local governments.

While the U.S. surpasses other countries when it comes to health spending, it underperforms on some metrics related to health outcomes. Americans tend to be greater consumers of medical technology and pharmaceuticals and often pay more for care in our market-based system. As noted in Council Report 2-A-17, although many governments across the world finance universal health care, there may be lengthy wait times to see physicians in some countries or an inability to access procedures or innovative therapies that can be obtained in the U.S.

Potential Benefits of Unified Financing

The California Commission's report, Key Design Considerations for a Unified Health Care Financing System in California, outlines many potential benefits of unified financing systems. The report notes that the existing fragmented financing system is administratively burdensome; lacks accountability for quality, costs, and equity; and can lead to coverage gaps for people experiencing job or life changes. According to the report, unified financing would allow the state to achieve notable health goals related to:

- Universality, since unified financing creates universal coverage;
- Improved equity, by eliminating differences in coverage between employer-sponsored insurance, Medicare, Medicaid, nongroup marketplace plans, and the uninsured;
- Affordability, since monthly premiums would no longer be paid, and long-term services and supports and dental services would be covered;
- Access, since uninsurance and underinsurance would be eliminated, and
- Quality, due to the new system being more uniform, which would facilitate quality improvements.[15]

Although it is possible to dispute the report's assertions that unified financing will improve health care quality and access (especially if physician and other provider payments are decreased), unified financing could streamline health care funding and lessen the fragmentation of the existing system, thereby potentially giving rise to a range of benefits, including increased equity and transparency as well as decreased administrative burdens related to the standardization of billing, prior authorization, and other insurance-related expenses, which could produce cost savings for physicians. Additional administrative costs, related to brokers, pharmacy benefit managers, and other middlemen, could also be reduced or eliminated under unified financing.[16] Reduced fragmentation should theoretically result in a system that is less administratively complex for patients to navigate, and if all physicians and hospitals are covered under unified financing, provider networks would be eliminated. Importantly, a unified financing health system would also eliminate insurance churn and reduce gaps in coverage that often occur when individuals, for a variety of reasons, switch coverage types (for example between Medicaid and ESI or ESI and ACA marketplace plans). In principle, universal coverage of standardized benefits should increase access to care, especially among people with lower incomes, and improved access may lead to improved health outcomes.[17]

In terms of design options, the Commission's report analyzed the costs of implementing unified financing under different scenarios that, for example, make direct payments to providers or use a health plan to do so; require zero cost-sharing or income-related cost-sharing; or include long term services and supports (LTSS) as it exists today or expanded LTSS services. According to the report, if federal and state funding streams remain consistent with current levels, and a payroll tax (or combination of other progressive taxes) is used to replace employer-sponsored insurance, a unified financing system would lower health care costs in year one and produce savings over time, primarily because the various scenarios assume significant savings will be incurred from decreases in drug prices as well as provider and payer administrative costs. SB 770 asserts that a unified financing system would save California more than $500 billion over 10 years.

Potential Challenges of Unified Financing

Unifying public and private payers into a single pooled fund would be immensely challenging in this country. Key Design Considerations for a Unified Health Care Financing System in California

recognizes that transitioning to a unified financing system would completely upend health care financing and coverage as it exists today. As such, it is important to consider the feasibility of some of the assumptions delineated above, such as the payroll tax, which—the report states—will produce "winners and losers," since some employers will be required to pay more than others. Additionally, the report assumes that the U.S. Department of Health and Human Services (HHS) will agree to consolidate and redirect current levels of federal Medicaid, ACA, and Medicare funds to the state's new health authority that provides all Californians with the same benefits package, regardless of a person's age, income, or disability. For that to happen, all statutory and regulatory requirements stipulating that certain benefits be provided to particular populations would need to be waived and, moreover, some benefits enshrined in statute may need to be reduced or eliminated. The California Commission acknowledges that a waiver of this magnitude would be unprecedented and controversial, and that it is possible that HHS may not be authorized to approve such a model without new federal authorizing legislation.[18]

Both a direct payment approach, in which providers would be paid directly by the state authority, and an approach that uses health plans or other nonprofits as intermediaries, were discussed in the California Commission's report. If health plans or health systems are used as intermediaries, they would be required to offer the same benefits and cost-sharing structure, which could be perceived as antithetical to choice, which is embraced in AMA policy. Although it is not clear how physicians and other health care providers would be paid under a unified financing system, the report cites the Maryland Total Cost of Care Model, which sets global budgets for hospitals, as a potential design feature. For physicians and other outpatient providers, the Commission's report states that the "unified financing authority would either set or negotiate fee-for-service based payment rates," and that "aggregate payments to physicians would be equal to the weighted average of current Medi-Cal, Medicare, and ESI payments, minus estimated reductions in costs due to reduced billing and administrative costs." The report further states:

> *One implication of [unified financing] UF is that physicians whose patients are currently primarily covered by private insurance will receive less revenue under UF than they do under the status quo, while physicians whose patients are primarily insured by Medicare and Medi-Cal will receive an increase in revenue. The analysis assumes that, because the UF system will be the only source of third-party payment, all California physicians and other health care providers will participate in the UF system.*

Notably, the latter assumption may violate AMA policy on physician choice of practice (Policy H-385.926) and physician freedom to participate in a particular insurance plan or method of payment (Policy H-165.985). Language in SB 770 specifies that unified financing waivers should incorporate "a rate-setting process that uses Medicare rates as the starting point for the development of final rates that avoid disruptions in the health care system and expand the availability of high quality vital services by sustaining a stable, experienced, and equitably compensated workforce."[19] Still, any cuts to physician, hospital, and other provider payments under unified financing in California or any other state, or federally, could have widespread ramifications on the delivery system, physician supply, and patient access to care. As noted in the previous section, fewer administrative burdens under unified financing could lead to reductions in prior authorization and billing costs incurred by physicians producing some cost savings. However, potential payment impacts are especially concerning given that annual Medicare payment reductions and the lack of an inflationary update already threaten the viability of physician practices, add to physician's considerable burdens, and stifle innovation. Medicaid physician payment rates also remain inadequate in many states which negatively impacts patient access to certain care. At the same time, as evidenced by a 3.6 percent projected increase to the MEI in 2025,

the inflationary costs associated with running a practice continue to rise while physician payments under Medicare and Medicaid are failing to keep up.

With regard to pluralism, unified financing assumes a centralization of financing while garnering potential efficiencies, which could potentially cause benefits and payment levels to coalesce into a single or tightly limited range. If this were to occur, patients and physicians would have little recourse should decisions be made to underpay for certain types of medical care or to deny or modify coverage for certain services. In turn, this could affect the adoption of newer technologies and treatments, which some insurers may cover sooner than others or with fewer or more restrictions. Under the current decentralized (pluralistic) system of competing health plans, some patients and physicians can choose not to purchase a particular insurance product, or to not be in network with those payers; however, this may not be feasible in a more centralized unified financing system. These concerns would be mitigated, however, if supplemental private plans offering different benefits become available on top of the standardized unified financing plan.

Although analyses of California's unified financing approach project cost-savings over time, it is important to point out that single payer systems have been estimated to increase federal health spending by more than 50 percent, which may not be politically palatable.[20] Depending on health system design specifications, a unified financing model could necessitate increases in taxation. Additionally, as evidenced by experiences around the world, political and economic shifts can pose serious risks to the stability of unified financing systems which, if not adequately funded, experience capacity and physician shortages as well as bottlenecks that can delay medically necessary care when fiscal austerity measures are put in place. Finally, transitioning residents into a transformed health system could lead to administrative challenges, especially in the early years, similar to those experienced when the ACA was first implemented.

A Potential Feature of Unified Financing: Hospital Global Budgeting

Hospital global budgeting, which has been implemented in other countries (e.g., Canada and the Netherlands) and in U.S. jurisdictions participating in the Centers for Medicare & Medicaid's (CMS) "state total cost of care" demonstrations, was cited by the California Commission as a potential design feature under unified financing that could help control health care costs. In this country, hospitals implementing global budgeting are generally exempt from Medicare's inpatient and outpatient prospective payment systems and are instead paid predetermined, fixed annual budget amounts based on previous years' Medicare and Medicaid payment levels, adjusted for inflation and population changes. Hospitals operating under global budgeting thus experience more payment stability and predictability, since they know what they will be paid from year to year, enabling more proactive planning.[21] Hospitals can also retain some revenues by managing costs below established payment levels, which may incentivize them to provide value-based care and reduce preventable hospitalizations.

To advance hospital global budgeting in more states, CMS launched a new voluntary state total cost of care model called States Advancing All-Payer Health Equity Approaches and Development (AHEAD) in 2023. At the time this report was written, four states had signed on—Maryland, Vermont, Connecticut, and Hawaii.[22] According to CMS, the AHEAD model aims to drive multi-payer alignment across more states through hospital global budgeting coupled with a primary care component. To address improvements in health equity, adjustments for social risk will be incorporated into hospital global budget payments.[23]

Global budgets are not new and could potentially be implemented as part of California's unified financing system. Although about half of the states attempted to regulate hospital prices in the

1970s, Maryland is the only state that has continuously embraced an all-payer approach and has been partnering with CMS to implement global hospital budgeting since 2014.[24] Vermont has administered an all-payer model for accountable care organizations (ACOs) since 2017,[25] the same year that Pennsylvania began implementing a rural health model that pays participating hospitals a fixed amount prospectively, regardless of patient volume.[26] These states have been able to implement such changes by participating in CMS waiver demonstrations and their experiences contributed to the design of the new AHEAD model.

Maryland's global budget is limited to hospitals; physician services provided in hospital settings and care provided outside of hospital campuses are generally excluded. Annual budgets are established by the Health Services Cost Review Commission for each hospital (excluding federal and children's hospitals, and some specialty hospitals) in the state using the previous year's budget as the base coupled with annual updates reflecting inflation and population growth. This independent state agency also sets all-payer pricing for hospital care units of service, which are used to determine a hospital's global budget amount.[27] Through its federal waivers, Maryland has committed to producing $2 billion in Medicare savings between 2019 and 2026 while improving quality and population health in the state. An evaluation of the program found that, in 2022, 41 hospitals were able to retain $1.1 billion in revenue by reducing volume while 11 hospitals surpassed the volume included in their global budgets, resulting in negative $79 million in revenue.[28] From 2014 through 2018, Maryland's all-payer model resulted in $975 million in Medicare savings while reducing inpatient admissions and potentially avoidable hospitalizations.[29]

AMA POLICY ON HEALTH SYSTEM REFORM

The AMA continues to advocate for policies that allow physicians and patients to be able to choose from a range of public and private coverage options with the goal of providing coverage to all Americans. To achieve universal coverage, the AMA has long advocated for the promotion of individually selected and owned health insurance; the maintenance of the safety net that Medicaid and CHIP provide; and the preservation of employer-based coverage to the extent that the market demands it. Notably, the AMA's proposal for health system reform—which is grounded in AMA policies supporting pluralism, freedom of choice, freedom of practice, and universal access for patients—has been extensively debated by the HOD for more than 25 years. Based principally on recommendations developed by the Council, beginning in 1998, AMA policy has advocated for the promotion of individually selected and owned health insurance using refundable and advanceable tax credits that are inversely related to income so that patients with the lowest incomes receive the largest credits (Policies H-165.920 and H-165.865). Our policy also underscores that, in the absence of private sector reforms that would enable people with lower incomes to purchase health insurance, the AMA supports eligibility expansions of public sector programs, such as Medicaid and CHIP, with the goal of improving access to health coverage to groups that would be otherwise uninsured (Policy H-290.974).

The principles and guidelines embedded throughout the AMA's large compendium of health reform policy, which has been refined over the years as the coverage environment has evolved, form the basis by which the AMA continues to thoughtfully evaluate and engage in advocacy around a broad array of approaches to achieve universal health coverage. Since the ACA was enacted, the HOD has adopted a multitude of policies addressing how to cover the remaining uninsured and improve health care affordability, thereby ensuring that our proposal for reform continues to evolve. For example, Policy H-165.823 was amended in 2021 to address uninsured individuals who fall into the "coverage gap" as well as those ineligible for coverage due to immigration status. Policy H-290.955 was adopted in 2022 and subsequently amended in 2023 to address the unwinding of Medicaid's continuous enrollment requirement, which was the most

1 significant nationwide coverage transition since the ACA and led to improper Medicaid
2 disenrollments of eligible individuals in many states.
3
4 This year, the AMA's plan to cover the uninsured focuses on expanding health insurance coverage
5 to five main population targets, which make up the nonelderly uninsured population: 1) individuals
6 eligible for ACA premium tax credits (35 percent of the uninsured); 2) individuals eligible for
7 Medicaid or CHIP (25 percent of the uninsured); 3) people who are ineligible for ACA premium
8 tax credits due to an offer of "affordable" employer-provided insurance (20 percent of the
9 uninsured); 4) individuals ineligible for coverage due to immigration status (15 percent of the
10 uninsured); and 5) people ineligible for Medicaid because they fall into the "coverage gap" in states
11 that have not expanded Medicaid (6 percent of the uninsured).[30] To maximize coverage and
12 improve affordability, the following policies form the basis of the AMA proposal for reform:
13
14 • Policy H-165.824 supports improving affordability in health insurance exchanges by
15 expanding eligibility of premium tax credits beyond 400 percent of the federal poverty level
16 (FPL); increasing the generosity of premium tax credits; expanding eligibility for cost-sharing
17 reductions; and increasing the size of cost-sharing reductions.
18 • Policy H-290.955, which was adopted in response to the Medicaid unwinding, encourages
19 states to facilitate coverage transitions, including automatic transitions to alternate forms of
20 coverage, including for people no longer eligible for Medicaid who are eligible for ACA
21 marketplace plans. This policy also encourages state Medicaid agencies to implement strategies
22 to reduce inappropriate terminations from Medicaid/CHIP for procedural reasons and provide
23 continuity of care protections to patients transitioning to a new health plan that does not
24 include their treating physicians. Finally, this policy supports additional strategies that respond
25 to improper Medicaid disenrollments.
26 • Policy H-165.828, which is intended to help employees having difficulties affording ESI,
27 supports lowering the threshold used to determine ESI affordability to the level at which
28 premiums are capped for individuals with the highest incomes eligible for subsidized ACA
29 coverage.
30 • Policy D-290.979 advocates that all states expand Medicaid, as authorized by the ACA.
31 • Policy H-165.823 advocates for a pluralistic health care system—which may include a public
32 option—that focuses on increasing equity and access, is cost-conscious, and reduces burden on
33 physicians. This policy establishes standards for supporting a public option and states that it
34 shall be made available to uninsured individuals who fall into the "coverage gap" in states that
35 do not expand Medicaid at no or nominal cost. Policy H-165.823 also directs the AMA to
36 advocate that any federal approach to covering uninsured individuals who fall into the
37 "coverage gap" in non-expansion states makes health insurance coverage available at no or
38 nominal cost, with significant cost-sharing protections. Importantly, this policy supports
39 extending eligibility to purchase ACA marketplace coverage to undocumented immigrants and
40 Deferred Action for Childhood Arrivals recipients. Finally, Policy H-165.823 supports states
41 and/or the federal government pursuing auto-enrollment in health insurance coverage provided
42 it meets certain standards.
43 • Policies H-165.824, H-290.976, H-290.971, H-290.982 and D-290.982 support investments in
44 outreach and enrollment assistance activities to improve coverage rates of individuals eligible
45 for ACA financial assistance or Medicaid/CHIP.
46 • Policy D-165.942 advocates that state governments be given the freedom to develop and test
47 different models for covering the uninsured, provided that their proposed alternatives a) meet
48 or exceed the projected percentage of individuals covered under an individual responsibility
49 requirement while maintaining or improving upon established levels of quality of care, b)

ensure and maximize patient choice of physician and private health plan, and c) include reforms that eliminate denials for pre-existing conditions.

A plethora of health reform principles are also delineated throughout the AMA's health reform policy, including Policies H-165.838, H-165.888, H-165.846, and H-165.985. Policy H-165.838 commits the AMA to achieving health reforms that include the following components:

- Health insurance coverage for all Americans;
- Insurance market reforms that expand choice of affordable coverage and eliminate denials for pre-existing conditions;
- Assurance that health care decisions will remain in the hands of patients and their physicians, not insurance companies or government officials;
- Investments and incentives for quality improvement and prevention and wellness initiatives;
- Repeal of the Medicare physician payment formula that triggers steep cuts and threaten seniors' access to care;
- Implementation of medical liability reforms to reduce the cost of defensive medicine; and
- Streamline and standardize insurance claims processing requirements to eliminate unnecessary costs and administrative burdens.

Policy H-165.888 directs the AMA to continue its efforts to ensure that health system reform proposals adhere to a range of principles regarding choice and include valid estimates of implementation costs and the identification of sources of funding, including specific types of taxation. Policy H-165.846 supports a series of principles to guide in the evaluation of health insurance coverage options, including that provisions must be made to assist individuals with low-incomes or unusually high medical costs in obtaining health insurance coverage and meeting cost-sharing obligations. Policy H-165.985 reaffirms core AMA health reform principles, including free market competition, freedom of patients to select and change physicians or health plans, freedom of physicians to choose whom they will serve, to establish their fees at a level which they believe fairly reflect the value of their services, and to participate or not participate in a particular plan or method of payment.

The AMA also has policy addressing some of the federal waivers that would be needed for California or another state to move forward with implementing a unified financing model, including:

- Policy H-165.826, which supports the criteria outlined in Section 1332 of the ACA for the approval of State Innovation Waivers, including that the waiver must: a) provide coverage to at least a comparable number of the state's residents as would be provided absent the waiver; b) provide coverage and cost-sharing protections against excessive out-of-pocket spending that are at least as affordable for the state's residents as would be provided absent the waiver; c) provide coverage that is at least as comprehensive for the state's residents as would be provided absent the waiver; and d) not increase the federal deficit.
- Policy H-290.987, which supports the provision of state Medicaid waivers, provided they promote improving access to quality medical care; are properly funded; have sufficient physician and other provider payment levels to secure adequate access; and do not coerce physicians into participating.
- Policy H-165.829, which encourages the development of state waivers to develop and test different models for transforming employer-provided health insurance coverage, including giving employees a choice between employer-sponsored coverage and individual coverage

offered through health insurance exchanges, and allowing employers to purchase or subsidize coverage for their employees on the individual exchanges.

After thoroughly reviewing the compilation of AMA health reform policies, the Council also notes that, depending on specific design features, unified financing proposals may be inconsistent with the following AMA policies:

- Policy H-165.838, under which the AMA supports health system reform alternatives that are consistent with AMA policies on pluralism, freedom of choice, and freedom of practice. This policy also states that the 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.
- Policy H-165.920, which affirms AMA support for pluralism of health care delivery systems and financing mechanisms in obtaining universal coverage and access to health care services.
- Policy H-165.888, which states that 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.
- Policy H-165.985, which opposes socialized or nationalized health care and instead supports: 1) free market competition among all modes of health care delivery and financing, with the growth of any one system determined by the number of people who prefer that mode of delivery, 2) freedom of patients to select and change their physician or medical care plan, 3) freedom of physicians to choose whom they will serve, to establish their fees, and to participate in a particular insurance plan or method of payment, and 4) improved methods for financing long-term care through a combination of private and public resources.
- Policy H-165.844, which reaffirms support of pluralism, freedom of enterprise and strong opposition to a single payer system.
- Policy H-285.998, which is one of the AMA's preeminent policies addressing managed care, states that the needs of patients are best served by free market competition and free choice by physicians and patients between alternative delivery and financing systems.

DISCUSSION

Although the Council last presented a comprehensive report on health care financing models in 2017 (Council Report 2-A-17), several reports since then have enhanced AMA policy on health system reform and covering the uninsured, including:

- Council Report 2-A-18, Improving Affordability in the Health Insurance Exchanges;
- Council Report 3-A-18, Ensuring Marketplace Competition and Health Plan Choice;
- Council Report 2-A-19, Covering the Uninsured Under the AMA Proposal for Reform;
- Council Report 1-Nov-20, Options to Maximize Coverage Under the AMA Proposal for Reform;
- Council Report 3-Nov-21, Covering the Remaining Uninsured;
- Council Report 3-A-22, Preventing Coverage Losses After the Public Health Emergency Ends;
- Council Report 6-A-23, Health Care Marketplace Plan Selection; and
- Council Report 5-I-23, Medicaid Unwinding Update.

Together, these reports have established AMA policy that seeks to guarantee affordable health coverage—and timely access to quality care—for every American while embracing the organization's commitment to universal coverage, and to longstanding principles related to pluralism, choice, freedom and sustainability of practice, and universal access to care. The compilation of health reform policy summarized in this report forms the basis by which the AMA

1 continues to evaluate and engage in advocacy around health system reform proposals and efforts to
2 improve the health care system for all patients and physicians. As AMA policy evolves, so too does
3 the AMA's plan to cover the uninsured, which is updated biennially to incorporate current metrics
4 on the uninsured and operationalize AMA priorities for improving affordability and covering the
5 remaining uninsured.
6
7 At the 2023 Interim Meeting, the HOD voted against removing AMA opposition to single payer
8 systems (e.g., Medicare-for-All-type proposals) from its policy while referring the second resolve
9 of Resolution 818-I-23, which led to the Council's unified financing study and the development of
10 this report. The Council's study of unified financing systems was limited in part by the lack of
11 formal analyses on the impact that such models would have on patients, physicians, hospitals,
12 medical practice, and the costs, quality, and timeliness of care in the U.S. consistent with this
13 limitation, the Council found that discussions of this type of reform are still in the preliminary
14 stages in this country, with California taking the lead as it explores pursuing federal waivers that
15 would be required for the state to pool and redistribute Medicaid, Medicare, ACA, and possibly
16 other federal dollars under a unified financing system. Even in California, the Council believes it is
17 unclear how unified financing would work or how physicians and patients would be impacted. As
18 more details regarding the specific features of California's plan are released, the Council will
19 continue to explore the model's pros and cons and consider critical lessons that will be learned
20 from the state's experience. At this time, while the Council generally finds that unified financing
21 has potential to reduce fragmentation in our health care system, improve health equity, and
22 eliminate insurance churn and coverage gaps, we remain strongly concerned that patients and
23 physicians would have less choice under this model, and that physician and hospital payments may
24 be reduced in order to lower health care costs and fund system redesign. As cautioned in this
25 report, the Council believes that any cuts to physician or hospital payments could have widespread
26 ramifications on the delivery system, physician supply, and patient access to care, especially given
27 ongoing threats to practice sustainability due to longstanding inadequacies of Medicare and
28 Medicaid payment rates.
29
30 The Council is intrigued by California's embrace of unified financing and pursuit of
31 transformational health reform; however, we also recognize that the state is likely years away from
32 implementing unified financing and that many uncertainties about its model's design and potential
33 implementation remain, including how such a system would be funded, and what new taxes—
34 payroll or otherwise—might be needed; the mechanisms through which and the levels at which
35 physicians and hospitals would be paid; and the role (if any) of private health plans. Since no state
36 had begun pursuing the necessary waiver applications at the time this report was written, the
37 Council also has lingering questions about the feasibility of unified financing in the U.S., especially
38 since federal waivers, even if approved, can be undone when Administrations change. Furthermore,
39 it is unclear if HHS would even have the statutory authority to consolidate and redirect current
40 levels of federal Medicare, Medicaid, and ACA funds without new federal legislation. As
41 previously noted, there is no significant movement towards unified financing at the federal level
42 and consideration of Medicare-for-All-type proposals has largely stalled.
43
44 Although the Council's study included international examples of unified financing systems, we
45 emphasize that models implemented in other countries are not generalizable to the U.S. because of
46 the existing complexities inherent to our current system. Until the aforementioned implementation
47 issues are resolved, we believe it would be premature to recommend new AMA policy on unified
48 financing, such as principles or guardrails that unified financing systems should incorporate
49 (similar to the public option standards delineated in Policy H-165.823). Instead, this report
50 summarizes the potential benefits and challenges of a unified financing model without commenting
51 on its advisability. In order to keep abreast of new unified financing developments in California or

elsewhere, the Council recommends that our AMA continue to monitor federal and state health reform proposals, including the development of state plans and/or waiver applications seeking program approval for unified financing. Consistent with California's exploration of a unified financing model and potential action in other states, the Council also recommends reaffirming Policy D-165.942, which advocates that state governments be given the freedom to develop and test different models for covering the uninsured provided that certain standards are met (e.g., patient choice of physician and private health plan must be ensured).

The Council continues to stand behind the substantial health reform policies summarized herein, which reflect the organization's commitment to achieving universal coverage by improving the current system and expanding its reach to Americans who fall within its coverage gaps. Instead of upending and fully redesigning the health system, which may be unrealistic, AMA policy builds on the foundation already in place—a pluralistic system that embraces competition and freedom of choice—to achieve the right mix of public and private coverage and expanded Medicaid options in every state. The Council has heard the argument that our policy opposing single payer systems precludes the AMA from engaging in discussions of federal and state health reform proposals. However, we maintain that the AMA stands ready to evaluate any mature reform proposal that is introduced, no matter its structure and scope. Furthermore, the Council did not identify any gaps in existing AMA policy that need to be addressed for the AMA to continue advancing its health reform vision with Congress, the Administration, and states. Even if a moderately detailed unified financing proposal was introduced tomorrow, its provisions could be thoroughly vetted for consistency with the existing health reform policies cited in this report, such as Policy H-165.838, which upholds the AMA's commitment to achieving enactment of health system reforms that include health insurance coverage for all Americans, expand choice of affordable coverage, ensure that health care decisions remain in the hands of patients and their physicians, and are consistent with pluralism, freedom of choice, freedom of practice, and universal access.

RECOMMENDATIONS

The Council on Medical Service recommends that the following recommendations be adopted in lieu of the second resolve clause of Resolution 818-I-23, and that the remainder of the report be filed.

1. That our American Medical Association (AMA) continue monitoring federal and state health reform proposals, including the development of state plans and/or waiver applications seeking program approval for unified financing. (Directive to Take Action)

2. That our AMA reaffirm Policy D-165.942, which advocates that state governments be given the freedom to develop and test different models for covering the uninsured, provided that proposed alternatives a) meet or exceed the projected percentage of individuals covered under an individual responsibility requirement while maintaining or improving upon established levels of quality of care, b) ensure and maximize patient choice of physician and private health plan, and c) include reforms that eliminate denials for pre-existing conditions. (Reaffirm HOD Policy)

3. That our AMA reaffirm Policy H-165.838, which upholds the AMA's commitment to achieving enactment of health system reforms that include health insurance for all Americans, expand choice of affordable coverage, assure that health care decisions remain in the hands of patients and their physicians, and are consistent with pluralism, freedom of choice, freedom of practice, and universal access. (Reaffirm HOD Policy)

Fiscal Note: Less than $500.

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