OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 18 – 2025

Introduced by: Medical Student Section

Subject: Support for Statewide Tracking of and Control Mechanisms for Health Care Expenditure Growth that Promote Primary Care

Referred to: Resolutions Committee No. 1

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WHEREAS, the United States spent at minimum $4,506 per capita more than other developed nations in 2022 on healthcare, yet lags behind in key health outcomes such as life expectancy, infant mortality, and maternal mortality[1]; and

WHEREAS, as a state, Ohio has one of the highest spending rates per capita, ranking 34 of 50 from lowest spending to highest spending, yet remains in the bottom quartile (43 of 50) for population health, which takes into account, health behaviors, chronic disease, life expectancy, and infant mortality[2]; and

WHEREAS, by type of service, most US healthcare dollars (30%) are spent on hospital services, suggesting an emphasis on chronic disease treatment and management with less focus on preventative services; broken down by type of spending, 30% of dollars are spent on administrative costs, suggesting inefficiencies in healthcare spending and delivery[3-4]; and

WHEREAS, the high cost of health care in the US and in Ohio has many implications including but not limited to delays in care, foregoing care, and increased medical debt, all of which disproportionately impact persons of color and low income families and further exacerbate social determinants of health[5-8]; and

WHEREAS, tracking healthcare spending can provide insight to where overinflated health costs are most prominent, as Ohioans have had a dramatic increase in personal Health Expenditures in the past two decades, with an average of spending of $2,669/person/year in 1991 to $10,478/person/year in 2020 with an average increase in personal spending of 4.8% per year[9]; and

WHEREAS, primary care represents over half of patient visits in the U.S. but accounts for less than 6% of healthcare spending and only 0.4% of NIH research funding, despite its critical role in improving outcomes[10-15]; and

WHEREAS, states such as California and Oregon, have used their tracking of healthcare spending to improve primary care and behavioral health spending and adopt alternative payment models that reward quality outcomes[16-17]; and

WHEREAS, Rhode Island's 2010 affordability standards imposed price controls by implementing inflation caps and diagnosis-based payments on contracts between commercial insurers and hospitals and clinics and required commercial insurers to increase their spending on primary care and care coordination services, which decreased quarterly fee-for-service spending by $76 per enrollee, or a decrease of 8.1%, without changing quality measures between 2007-2016[18]; and

WHEREAS, Rhode Island now requires insurers to invest at least 10.7% of their total medical expenses in primary care[19]; and

WHEREAS, Delaware has a similar target of 11.5% of spending into primary care by 2025 while mandating insurers reimburse at least at Medicare rates[20]; and

WHEREAS, Colorado require insurers increase their primary care investment by 2% from 2021-2023 while prohibiting insurers from raising their premiums to offset the cost[21]; and

WHEREAS, OSMA has policies which necessitate knowing healthcare spending dollars, aim to make healthcare more affordable [Policy 18-2016, 18-2019, 18-2021, 20-2022, 27-2023, 6-2023], and promote primary care [Policy 30-1994, 8-2013]; and

WHEREAS, AMA policies advocate for expanding Medicaid eligibility and enhancing premium tax credits to cover uninsured populations, thereby addressing the affordability and accessibility gaps in the current healthcare system [Policy H-165.824]; and therefore be it

RESOLVED, that our OSMA advocates for statewide tracking of healthcare expenses and establish a maximum growth rate for total healthcare costs to curb rising expenses; and be it further

RESOLVED, that our OSMA advocate for inflation caps and diagnosis-based payments in contracts between insurers and providers to manage healthcare costs; and; and be it further

RESOLVED, that our OSMA advocates for state targets for commercial insurers to increase their total health expenses percentage in primary care and care coordination as a strategy to control healthcare spending.

Fiscal Note: **$50,000 (Sponsor)**
$50,000 (Staff)

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RELEVANT OSMA POLICY

Policy 18 – 2016 – Site of Service Charges

1. The OSMA requests that the American Medical Association continue to address the current inequity of "site of service" charges being used by hospitals and Medicare.

Policy 18 – 2019 – Practice Overhead Expense and the Site-of-Service Differential

1. The OSMA will appeal to the Ohio congressional delegation for legislation to direct CMS to eliminate any site-of-service differential payments to hospitals for the same service that can safely be performed in a doctor's office.
2. The OSMA will appeal to the Ohio congressional delegation for legislation to direct CMS in regards to any savings to Part B Medicare, through elimination of the site-of-service differential payments to hospitals, (for the same service that

can safely be performed in a doctor's office), be distributed to all physicians who participate in Part B Medicare, by means of improved payments for office-based Evaluation and Management Codes, so as to immediately redress underpayment to physicians in regards to overhead expense.

3. The OSMA will appeal to the Ohio congressional delegation for legislation to direct CMS to make Medicare payments for the same service routinely and safely provided in multiple outpatient settings (e.g., physician offices, HOPDs and ASCs) that are based on sufficient and accurate data regarding the actual costs of providing the service in each setting.
4. This policy on practice overhead expense and site-of-service differential be forwarded to our AMA for consideration at the Annual HOD Meeting in June 2019.

Policy 18 – 2021 – Differential Payment

1. The OSMA reaffirms existing policies 18-2016, site of service charges, and 18-2019, practice overhead expense and the site-of-service differential.

Policy 20 – 2022 – Appropriate Physician Reimbursement to Cover Rising Expenses of Office Practice

1. The Ohio State Medical Association (OSMA) advocates that physician reimbursement for all activities be increased to cover the expenses of running an office practice.
2. The OSMA will work with our Ohio State Legislature and Ohio Congressional delegation to improve physician reimbursement.
3. The OSMA Delegation to the American Medical Association (AMA) shall take this resolution regarding improved physician reimbursement to the AMA House of Delegates for action.

Policy 27 – 2023 -- Decrease Costs for Ohio Patients with Diabetes with Commercial Insurance

1. The OSMA will: (1) encourage the Ohio Department of Insurance to investigate insulin pricing and market competition and take enforcement actions as appropriate; (2) support initiatives that provide physician education regarding the cost-effectiveness of insulin therapies; and (3) support state efforts to limit the ultimate expenses incurred by commercially insured patients for prescribed insulin and diabetic equipment and supplies.

Policy 6 – 2023 -- Increased Access to Health Care

1. The OSMA continues to express its support for increased access to comprehensive, affordable, high-quality health care.
2. The OSMA rescinds current Policy 11 – 2010 – Promoting Free Market-Based Solutions to Health Care Reform.

Policy 30 – 1994 – Increase in Number of Primary Care Physicians

1. The OSMA supports positive incentives such as shifting of more subsidies to primary care medical education programs, increasing reimbursement levels, tax

abatements and loan repayment programs to attract greater numbers of primary care and rural physicians.

2. The OSMA discourages the enactment of restrictive measures such as licensure limitations, quotas in medical education programs, or compulsory measures which are intended to influence the numbers of primary care physicians in Ohio.

Policy 08 – 2013 – Support for More Primary Care Physicians

1. The OSMA shall take steps to increase the number of medical students and residents going into primary care by calling for an increase in the number of residency positions in primary care.

RELEVANT AMA POLICY

Policy H-165.824: Improving Affordability in the Health Insurance Exchanges

1. Our American Medical Association will:
    a. support adequate funding for and expansion of outreach efforts to increase public awareness of advance premium tax credits.
    b. support expanding eligibility for premium tax credits up to 500 percent of the federal poverty level.
    c. support providing young adults with enhanced premium tax credits while maintaining the current premium tax credit structure which is inversely related to income.
    d. encourage state innovation, including considering state-level individual mandates, auto-enrollment and/or reinsurance, to maximize the number of individuals covered and stabilize health insurance premiums without undercutting any existing patient protections.
2. Our AMA supports:
    a. eliminating the subsidy "cliff", thereby expanding eligibility for premium tax credits beyond 400 percent of the federal poverty level (FPL).
    b. increasing the generosity of premium tax credits.
    c. expanding eligibility for cost-sharing reductions.
    d. increasing the size of cost-sharing reductions.

Policy H-165.888: Evaluating Health System Reform Proposals

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.

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.