OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 51 – 2025

Introduced by: Medical Student Section

Subject: Support of Comprehensive Healthcare Reform Through Exploration of Other Models

Referred to: Resolutions Committee No. 2

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WHEREAS, the U.S. consistently ranks last amongst other high-income nations on domains of health care access, including overall health care system ranking, health outcomes, access to care, health equity, and administrative efficiency[1]; and

WHEREAS, the U.S. spent $4.9 trillion on health care in 2023, 17.6% of its GDP, and has nearly twice the average per capita spending on health care than comparably wealthy nations[2-3]; and

WHEREAS, 26.4 million Americans lacked health insurance in 2023, a number that has remained relatively unchanged since 2015[4]; and

WHEREAS, insurance status, or lack thereof, has been correlated with health outcomes in the United States, as evidenced by lower rates of vaccination, less laboratory testing, decreased medication receipt and greater mortality rate for the uninsured during the COVID Pandemic[5-12]; and

WHEREAS, in 2024, Ohio was ranked by the Health Policy Institute of Ohio at 44 out of 51 states for health value, with Ohio remaining in the bottom quartile on important health measures such as number of primary care physicians, life expectancy, premature death, total Medicare spending, and hospital adjusted expenses per day[13]; and

WHEREAS, employer-sponsored health plans in the US are increasingly unaffordable for workers, with 85% of these plans including an annual deductible averaging $1,787 for a single person plan 2024, with the growth in family premiums outpacing the growth in income by nearly double in 2024[14]; and

WHEREAS, after weighting for family distribution, Ohioans had a combined average premium plus deductible cost of $7,344 in 2020 - about 10.9% of Ohio's median household income[15-16]; and

WHEREAS, 28% of Americans in 2022 reported avoiding mental, dental, and/or medical health care due to cost, with significant disparities seen amongst those under 200% of the federal poverty rate, uninsured, or of Hispanic descent[17]; and

WHEREAS, efforts to improve healthcare coverage and reduce medical debt, such as the Affordable Care Act, have had minimal effect on rates of debt, with 41% of families reporting a significant medical debt in 2022 and medical debt attributable 66% of bankruptcies attributable to medical debt[18-19]; and

WHEREAS, the administrative overhead of private insurance operations averages 20-25% of total medical expenses, much greater than the administrative overhead of Medicare which was just 1.16% of medical costs of 2021[20-21]; and

WHEREAS, expansion of public options like Medicaid through the ACA improved access to health care for disenfranchised groups such as Black Americans, Hispanics and those in poverty, both nationally and in Ohio[13,21]; and

WHEREAS, public insurance systems such as Medicare and Medicaid spent $89.12 billion less in administrative costs in 2022 than private health insurance entities[2]; and

WHEREAS, the U.S. could save over $600 billion annually on administrative costs with a single-payer system and over $14 billion annually if it were paying government negotiated prescription drug prices[23-24]; and

WHEREAS, overbilling by Medicare Advantage organizations and outside agencies costs the US government upwards of $25 billion in excess each year[25]; and

WHEREAS, a single-payer system would reduce fraudulent, wasteful spending through a singular billing system which would log all interactions and services[26]; and

WHEREAS, an increased emphasis on financing and complex incentives requires physicians to spend two thirds of clinic time on administrative tasks, significantly contributing to rising rates of burnout, which would be alleviated under single payer[28-29]; and

WHEREAS, the Congressional Budget Office (CBO) estimates that a public option with universal healthcare coverage such as single-payer would increase physician income by as much as 9% through increased health care utilization with secured reimbursement and reduced administrative costs for health care delivery[29-30]; and

WHEREAS, through a single payer system, a single healthcare EMR would be created, providing a secure, centralized database of health records, reducing medical errors due to incomplete or inaccurate histories, eliminating care redundancies and delays for medical record requests, and expanding opportunities for retrospective chart reviews[31-33]; and

WHEREAS, several medical societies including the American College of Physicians, Hawaii Medical Association, New Hampshire Medical Society, Vermont

Medical Society, and Washington State Medical Association have passed resolutions endorsing single payer health care[34]; and

WHEREAS, local governments in Ohio such as Toledo, Lucas County, Lakewood, Newburgh Heights, Cleveland Heights, Kent, Cincinnati, and Dayton have passed resolutions calling upon Congress to enact a single payer system[35]; and

WHEREAS, single-payer systems, such as those implemented in Canada, have demonstrated cost efficiency, reducing administrative overhead to less than 2%[36-37]; and

WHEREAS, public option systems, like those seen in Australia, provide a government-managed insurance plan competing alongside private insurance, increasing accessibility and affordability for underserved populations[38]; and

WHEREAS, direct primary care models have gained traction in the U.S., offering affordable flat-fee subscription plans for patients, resulting in improved patient satisfaction and reduced emergency department visits[38]; and

WHEREAS, the Bismarck model, implemented in Germany, successfully uses employer-funded insurance schemes combined with government oversight to achieve universal coverage and lower healthcare costs[39]; and

WHEREAS, combining aspects of these models, such as single-payer's administrative efficiency, public option's competitive structure, direct primary care's affordability, and the Bismarck model's universal employer-funded approach, offers a viable path toward comprehensive reform[40-41]; and

WHEREAS, universal health coverage systems can leverage economies of scale to negotiate lower prescription drug prices, as evidenced by the Veterans Affairs system in the United States[42]; and

WHEREAS, integrated healthcare delivery models, such as those in the Netherlands, combine public and private insurance with comprehensive primary care networks to achieve high patient satisfaction and cost efficiency[43]; and

WHEREAS, innovative pilot programs within the U.S., such as Accountable Care Organizations (ACOs), demonstrate the feasibility of aligning incentives to improve health outcomes and reduce costs, providing a framework that could complement broader healthcare reforms[44]; and therefore be it

RESOLVED, that the Ohio State Medical Association supports universal healthcare reform that explores elements of single-payer efficiency, public option accessibility, and direct primary care affordability to maximize healthcare equity and cost-effectiveness; and be it further

RESOLVED, that the Ohio State Medical Association supports existing and pilot programs integrating these elements to evaluate their feasibility and scalability in addressing healthcare disparities within the United States.

Fiscal Note: $ (Sponsor)
$ 500+(Staff)

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Relevant OSMA Policy:

Policy 11 – 2010 - Promoting Free Market-Based Solutions to Health Care Reform

1. The OSMA promotes free market based solutions to improve access and cost effectiveness of health care delivery in the United States.

Policy 05 – 2011 - Universal Health Insurance Coverage

1. The OSMA reaffirms support for universal health insurance access for all Americans through market based initiatives to create incentives for the purchase of coverage.
2. OSMA and AMA will pursue legislative and regulatory reform to achieve universal health insurance access through free market solutions.

Relevant AMA Policy:

N/A