

## 2018 MMA Open Issues Forum – Background Information

### Submitted Issues:

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### Issue Details:

Issue #	Topic	Submitter's Name (Society, if applicable)
1	Direct primary care	Robert Koshnick, MD (Heart of the Lakes)

### Submitter's Request of MMA:

MMA and the AMA should ask the government to give a medical tax credit for U.S. citizens to buy direct primary care to transform American medical care into a more efficient primary care based personal health care system.

### Submitter's Rationale/Background:

We need to change our health care system to a primary care-based system rather than specialty or hospital-based system. We need to support the idea that (1) we need to change to a primary care-based system for many reason; (2) the government needs to jump start this change; and (3) direct primary care is a way to get the government and insurance companies out of health care.

### MMA Staff-Identified Background Information:

According to the American Academy of Family Physicians (AAFP), direct primary care (DPC) is:

“a subset model of the retainer-based practice framework for primary care practices. There is not a single DPC practice model; rather the model represents a broad array of practice arrangements that share a common set of characteristics. Perhaps the defining characteristic of DPC practices is that they offer patients the full range of comprehensive primary services, including routine care, regular checkups, preventive care, and care coordination in exchange for a flat, recurring retainer fee that is typically billed to patients on a monthly basis. DPC practices are distinguished from other retainer-based care models, such as concierge care, by lower retainer fees, which cover at least a portion of primary care services provided in the DPC practice.”

One of the main advantages of participating in direct primary care, according to AAFP, is that physician practices can reduce their overhead costs associated with claims filing, as many direct primary care practices do not maintain contracts with insurers. A smaller patient base has also been noted, allowing longer patient visits, which may be advantageous to physician practices but may pose challenges for patients seeking access to primary care.

Patients choosing to participate in direct primary care practices generally need to add additional insurance coverage, such as a catastrophic plan, to cover care that falls outside of the scope of services covered by the direct primary care monthly fee. Although the covered services can vary, insurance is often needed to cover prescription drugs, inpatient care, complex imaging or laboratory services, and most specialty care. Some self-insured employers have also showed interest in direct primary care.

An online search of direct primary care practices in Minnesota found approximately a dozen primary care practices, and about three specialty practices (ophthalmology, ENT, Physicians' Diagnostics & Rehabilitation clinics) associated with PrimaCare Direct. PrimaCare Direct describes itself as, "a cooperative of clinics in Minnesota that want to lower the cost of health care to the patient, while focusing on providing exceptional care centered on wellness."<sup>1</sup>

Provisions of the Affordable Care Act, and some state laws, specifically exclude direct primary care from the definition of "insurance," but some practical barriers remain. The exclusion from the definition of insurance is important, proponents argue, as insurance products are subject to state regulation, including capital requirements. Nevertheless, the Internal Revenue Service considers direct primary care a "gap" insurance product, which means that an individual cannot use or contribute to a health savings account because the addition of the "gap" product means that the individual no longer has a qualifying high deductible health plan (which is required in order to be eligible for an HSA). In addition, there is uncertainty whether the monthly fees that patients pay to direct primary care practices can be recognized as "qualified medical expenses" for purposes of tax deductibility, or for purposes of flexible spending account expenses.

Direct primary care must also navigate the complex Medicare regulations. Medicare does not cover retainer fees. In addition, physicians who accept Medicare assignment cannot charge patients extra fees for Medicare-covered services, which means any direct primary care fees charged to Medicare patients cannot include services that Medicare usually covers.

**Current MMA Policy:**

None

**Current AMA Policy:**

**Direct Primary Care H-385.912**

Our AMA supports: (1) inclusion of Direct Primary Care as a qualified medical expense by the Internal Revenue Service; and (2) efforts to ensure that patients in Direct Primary Care practices have access to specialty care, including efforts to oppose payer policies that prevent referrals to in-network specialists. (Res. 103, A-16 Appended: Res. 246, A-18 Reaffirmation: A-18)

**Opinion 11.2.5 Retainer Practices**

Physicians are free to enter into contracts to provide special non-medical services and amenities with individual patients who are willing and able to pay additional costs out of pocket for such services. While such retainer contracts are one among many diverse models for delivering and paying for health care, they can also raise ethical concerns about access, quality, and continuity of care.

Regardless of the model within which they practice, physicians must uphold their primary professional obligation of fidelity and their responsibility to treat all patients with courtesy and respect for patients' rights and dignity, and ensure that all patients in the physicians practice receive the same quality of medical care, regardless of contractual arrangements for special, non-medical services and amenities.

Physicians who enter into retainer contracts with patients must:

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<sup>1</sup> PrimaCare Direct company information. Available at: <http://www.primacaredirect.com/our-company>

- (a) Present the terms of the retainer arrangement clearly to patients, including implications for the patients' current health care insurance, if known, and take care not to imply that more or better medical services will be provided under a retainer contract.
- (b) Ensure that patient decisions to accept retainer contracts are voluntary and that patients are free to opt-out of entering into a retainer agreement.
- (c) Facilitate transfer of care for any patient who chooses not to participate in a retainer practice. If it is not feasible to transfer a patients care to another local physician, the physician should continue to provide care under the terms of the patients existing health care insurance until other appropriate arrangements for ongoing care can be made.
- (d) Ensure that treatment recommendations for all patients are based on scientific evidence, relevant professional guidelines, sound professional judgment, and prudent stewardship.
- (e) Uphold standards of honesty and transparency in billing and clearly distinguish charges for special services or amenities provided under a retainer contract from medical services reimbursable by the patients' health care insurance or third-party payer.
- (f) Uphold professional obligations to promote access to health care and to provide care to those in need regardless of ability to pay, in keeping with ethics guidance. (AMA Principles of Medical Ethics: I,II,VI,VIII,IX). *The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.*

Issue #	Topic	Submitter's Name (Society, if applicable)
2	Removing non-medical exemptions for vaccinations for those attending public school.	Jeremy Peterson, MD

**Submitter's Request of MMA:**

MMA should take a policy position to support legislation to remove non-medical exemptions for vaccinations for children attending any public/charter schools. This would include undergraduate institutions such as the University of Minnesota system and State Colleges/Universities.

**Submitter's Rationale/Background:**

States that have adopted legislation to not allow non-medical exemptions for vaccinations have an overall higher rate of vaccinated children. This is evident in the statistics linked to California's adoption of such law after the measles epidemic a few years ago.

**MMA Staff-Identified Background Information:**

Three states (CA, MS, WV) preclude immunizations for only medical contraindication, while the remaining 47 states allow for either or both religious beliefs or "conscientiously held beliefs." Current law in Minnesota allows parents and guardians to opt their school-age children out of immunizations required for elementary and primary school attendance for three reasons: medical contraindication, religious beliefs, or "conscientiously held beliefs." Minnesota allows more robust exemptions than the majority of other states. The MMA, alongside allies such as the Minnesota Chapter of the American Academy of Pediatrics (MAFP), the Minnesota Academy of Family Physicians, Mayo Clinic, Children's Hospitals & Clinics, and other vaccine-advocacy groups have long sought to strengthen Minnesota's law by repealing all exemptions save for medical contraindication, though anti-vaccine legislators in the Legislature has blocked progress.

Current law also requires college-bound students to receive immunizations against measles, rubella, and mumps, as well as diphtheria and tetanus within ten years of enrollment. The same exemptions noted above (medical contraindication, religious or conscientiously held beliefs) are available to college students. Of note, students who have graduated from high school later than 1997 are largely exempt from these requirements, as they will have already met the immunization requirements.

In addition, all public and private postsecondary institution are required to provide information on the transmission, treatment, and prevention of hepatitis A, B, and C, and the risks of meningococcal disease and on the availability and effectiveness of any vaccine to all persons who are first-time enrollees.

**Current MMA Policy:**

**110.2795 Vaccine Exemptions**

The MMA supports repeal of the “conscientiously held beliefs” exemption currently available in Minnesota’s school and childcare facility immunization law. Exemptions from vaccines should be limited to medical contraindications only. (BT 11-15)

Issue #	Topic	Submitter’s Name (Society, if applicable)
3	Preferred options	Patrick Zook, MD (Stearns Benton Medical Society)

**Submitter’s Request of MMA:**

If an insurance company refuses to pay for a more expensive but equivalent option, then they should pay an amount equal to their option's cost toward payment of the patient/physician-preferred option. Encourage Minnesota health plans to change to this policy for all covered products or services.

**Submitter’s Rationale/Background:**

Insurance companies are practicing medicine without a license if they force use of an option not recommended by the physician.

Even if there is a “tiering” of what drug an insurance company will pay for, there exists a virtual denial of payment if a patient is confronted with an unaffordable “co-pay” for choosing a doctor’s or patient’s preference med. It could just be that the patient cannot swallow (literally) the cheaper and larger pill of say potassium, but can swallow the smaller and more expensive version of the same drug. In this case, the patient will then have to pay the entire cost of the more expensive, but swallowable pill, instead of just paying the difference in price. Many patients have side effects from a certain med in a class of say blood pressure pills, but do tolerate a more expensive drug of the same class. Instead of just paying the difference in cost, patients are forced to pay the full “cash price” of their preferred version. Thus, I claim that the insurance company and the pharmacy benefit managers are practicing medicine without being licensed to do so.

**MMA Staff-Identified Background Information:**

Patients are permitted to request exceptions to denials in insurance coverage and appeal subsequent adverse coverage decisions. Health plans typically agree to cover medications and procedures that are documented by the treating physician as medically necessary and for which an equivalent medication or procedure is contraindicated. During this process, health plans may – but are not required – agree to partially cover the requested therapy for which the patient would be required to pay the difference in the cost of therapy. Partial coverage agreements are particularly common for procedures utilizing new technologies. Federal or state law neither require nor prohibit a health plan from providing partial coverage for a preferred option that otherwise fails the health plan’s appeal process.

**Current MMA Policy:**

None

Issue #	Topic	Submitter’s Name (Society, if applicable)
4	Carbon fee and dividend policy	Karen Lucas, MD

**Submitter’s Request of MMA:**

Take a policy position supporting carbon fee and dividend to slow or stop climate change.

**Submitter’s Rationale/Background:**

Consider climate change and its impact on public health. Air and water quality with contamination of watersheds and deregulation.

Climate change will cause suffering by extreme weather events, sea level rise causing flooding, drought causing crop and livestock production failures, political instability and poverty and refugee crisis that leads to destabilization of international order. Water scarcity stresses with the near collapse of 21 out of 37 of the worlds aquifers leading to drought (July 20, 2018 NYT article). Deregulation on use of fossil fuels and worsening air quality.

**MMA Staff-Identified Background Information:**

According to Citizen’s Climate Lobby, carbon fee is a fee based on the amount of carbon in a fossil fuel.<sup>2</sup> Carbon is found in fossil fuels such as oil, natural gas and coal. When you burn these fuels, they release carbon dioxide into the atmosphere. The carbon fee is based “on the metric tons of carbon dioxide the fuel would generate, and it would be assessed at the earliest point of sale into the economy — as close as possible to the well, mine, or port. The fee would start out low — \$15 per metric ton — and increase by \$10 each year.”<sup>3</sup>

Furthermore, the carbon dividend is defined as “the quantity of revenue to be rebated to American households. In this case, the total carbon fees collected minus administrative costs are divided up and given back to all households every month on an equal per-person basis.”<sup>4</sup>

Some ask the question of how is the carbon dividend different from a carbon tax?<sup>5</sup> Economists have concluded that when you tax carbon, this gives industry and households a strong incentive to use less fossil-fuel based energy. On the contrary, the carbon dividend puts the revenue from the tax directly to work for the public.<sup>6</sup>

**Current MMA Policy:**

None specific to carbon fee and dividend, but the following on climate change:

**230.26 Climate Change as a Health Concern**

The MMA concurs with the scientific consensus that climate change is causing adverse global climate change and that anthropogenic contributions are significant. These climate changes will create conditions that affect public health, with disproportionate impacts on vulnerable populations, including children, the elderly, and the poor. The MMA recognizes the importance of physician involvement in public policymaking to search for novel, comprehensive, and economically sensitive approaches to mitigating climate change to protect the health of the public; and notes that whatever the etiology of global climate change, policymakers should work to reduce human contributions to such changes. The MMA supports the work of Minnesota’s state and local health departments to strengthen the public health infrastructure to ensure that the global health effects of climate

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<sup>2</sup> Citizens’ Climate Lobby, Carbon Fee and Dividend Policy and FAQs, *available at:*

<https://citizensclimatelobby.org/carbon-fee-and-dividend/>

<sup>3</sup> *Id.*

<sup>4</sup> *Id.*

<sup>5</sup> Washington Post, A Carbon Dividend Really Can Slow Fossil Fuel Use — Under These Conditions, *available at:*

[https://www.washingtonpost.com/news/monkey-cage/wp/2017/03/13/a-carbon-dividend-really-can-slow-fossil-fuel-use-under-these-conditions/?noredirect=on&utm\\_term=.a09ceaea03c3](https://www.washingtonpost.com/news/monkey-cage/wp/2017/03/13/a-carbon-dividend-really-can-slow-fossil-fuel-use-under-these-conditions/?noredirect=on&utm_term=.a09ceaea03c3)

<sup>6</sup> *Id.*

change can be anticipated and responded to more efficiently. The MMA will work to inform and educate Minnesota physicians and communities at large regarding the health consequences of climate change. (BT 11-14)

Issue #	Topic	Submitter's Name (Society, if applicable)
5	Health care reform/Universal health care	Mark Brakke, MD

**Submitter's Request of MMA:**

Support national and state healthcare reform to get us "affordable, high quality, universal health care."

**Submitter's Rationale/Background:**

US health care costs are out of control high. US health care taking 40 to 50% more of our GDP than healthcare in other countries. ....and not everyone is covered.

**MMA Staff-Identified Background Information:**

This open issue submission addresses health reform designed to achieve affordable, universal coverage. The current MMA policy was adopted as part of the MMA's "Physicians' Plan for a Healthy Minnesota." That report focused on achieving the goals of affordable care, universal coverage, and health care access, without focusing on one type of payment method or another.

**Current MMA Policy:**

**290.2483 Physicians' Plan for a Healthy Minnesota**

The Minnesota Medical Association (MMA) adopts the following health care reform policy statements (developed by the Health Care Reform Task Force):

I. MMA Vision for Health Care Reform

The MMA vision for health care reform is as follows: A) The MMA envisions a health care system in which all Minnesotans have affordable coverage for essential health benefits that allows them to get needed care and preventive services in a timely and effective manner. B) Strong patient/physician relationships, unimpeded by third parties, will restore citizen trust in the system and professional satisfaction with the practice of medicine. C) Affordability for individuals, employers, and society will be improved by a renewed commitment by physicians to deliver high-quality effective and efficient care, patient responsibility for personal health behaviors and cost conscious choices, and incentives that reward all parties for a greater focus on prevention and enhanced health. D) The ideal health system will deliver significantly greater returns in improved health status for the dollars invested and will deliver equity for all in access, treatment quality, and outcomes. E) Whatever the design of the system, the funding provided to the public health and health care delivery systems must be broad-based, stable, and adequate to meet the health needs of the state. F) In order to achieve this higher-performing system, we need a fundamental change in the financing approach and market dynamics of health care. The MMA believes that the uncontrolled growth in health care costs can best be mitigated by replacing the current price and volume incentives that result from a system in which payers artificially control prices, with a patient-centered market in which incentives are aligned to encourage the use of preventive services and effective care without subsidizing the consumption of services of minimal clinical value. In the current system, large purchasers and health plans have the ability to impose prices and shift costs to smaller purchasers or individuals because they control the flow of patients. In the new system, the price of care will be determined by patients' determination of the value they receive from the services provided.

II. Stakeholder Responsibilities in Health Care Reform

The MMA anticipates that the roles of all stakeholders will change in a reformed health care system, including new or renewed levels of responsibility. Those expectations are as follows: A) The community has a responsibility 1. To ensure affordable access to basic care; 2. To broadly share the risk and cost of medical needs; 3. To assist the population in using health care resources wisely; 4. To provide the conditions and environment in which people can be healthy and make healthy choices; 5. To maximize the proportion of health spending that goes to effective

care for all who need it; 6. To secure the future capacity of the health care system to provide sustained high quality and affordable health care, through investments in prevention, medical education, medical research, and improvements in the system's infrastructure. B) Individuals have a responsibility to the community 1. To participate financially in sharing the cost of the system that benefits all; 2. To use the system wisely and draw on collective resources judiciously; 3. To take personal responsibility for their own health behaviors and reduce their own health risks; 4. To become more health literate (e.g., educated about prevention, selection of plans/providers, wise use of resources, and the clinical decision making process). C) Physicians and other clinicians have responsibilities to individual patients and to the broader community 1. To accurately assess patient needs and recommend appropriate and effective care; 2. To advocate honestly for needed and effective care for their patients; 3. To help individuals achieve measurable improvements in health; 4. To exercise stewardship over collective health care resources; 5. To participate in care management as members of an effective multidisciplinary health care team; 6. To foster health literacy among patients and the broader population; 7. To create and foster continuous learning environments in the organizations in which they practice. D) Group purchasers (private-sector employers and government) have responsibilities as members of the community 1. To set expectations for health plans to focus on the delivery of efficient care and health improvement by engaging patients and supporting providers; 2. To emphasize prevention strategies (including those with longer-term payoff) in benefits design; 3. To share in the needed investments in improvements to the infrastructure of the health system; 4. To move the health care system toward affordable, universal coverage for all, not just people employed by large companies or covered through publicly sponsored health care funds. E) Health plans/insurers have responsibilities as members of the community 1. To create payment systems that foster care efficiency and health improvement; 2. To coordinate care management systems with physicians and care teams and to provide the needed information and infrastructure supports for high-quality programs; 3. To correct business practices that lead to health care fragmentation, such as carved-out behavioral health benefits; 4. To minimize the complexity of the system and the costs of administration, and to assist patients/members in navigating the system; 5. To share in the needed investments in prevention strategies and infrastructure improvement; 6. To provide tools and resources and foster an environment to help beneficiaries achieve and physicians deliver desirable results; 7. To create and foster continuous learning environments for the improvement of health care administration and delivery.

### III. The MMA Model for Health Care Reform

The MMA model for health care reform includes four interconnected features: 1) A strong public health system; 2) A reformed insurance market that delivers universal coverage; 3) A reformed health care delivery market that creates incentives for increasing value; and, 4) Systems that fully support the delivery of high quality care.

#### IV. A Strong Public Health System

##### A. Public Health Leadership

To strengthen the public health system, the MMA will provide greater leadership in making public health more prominent by linking its public health policies to broader health care reform and cost containment efforts.

##### B. Coordinated Action to Improve Health

To improve the health of individuals and the population of Minnesota, the MMA urges the creation of a statewide, coordinated and strategic action agenda to address the leading modifiable risk factors for disease.

#### V. A Reformed Insurance Market

##### A. Universal Insurance Coverage

The MMA supports universal insurance coverage to be achieved through a requirement that all individuals have coverage for an essential set of benefits that provides for the protection of individuals and public health. The MMA believes that behavioral health services should be covered on the same basis as any other clinical service. Affordability of coverage shall be ensured through financial subsidies to those individual with limited financial means.

##### B. Fairness in Insurance Risk

The MMA supports a fairer system of spreading insurance risk and sharing the cost of health care to be achieved, in part, through the establishment of statewide community rating and guaranteed issuance of an essential benefit set.

## VI. A Reformed Delivery Market

### A. Value, Not Volume

The MMA supports reforms in the health care delivery market that will replace the current incentives for volume with incentives for value.

### B. Patient Engagement

To transform changes in the delivery of care, the MMA supports efforts to more effectively engage patients in making value-based health care decisions – for both the choice of physician/provider and the options for treatment. Patients can make better health care decisions if they have access to valid and useful information about the cost and quality of care.

### C. Cost-Shifting

The MMA urges the elimination of cost-shifting by all payers, particularly government payers, that only serves to distort the cost of health care.

## VII. Systems to Support High-Quality Care

### A. Increase the Delivery of Effective Care

While recognizing the high quality care delivered in Minnesota, which is among the best in the nation, the MMA strongly supports efforts to increase further the amount of effective care that is provided to Minnesota patients. Several immediate efforts that the MMA supports to expand quality care are the following: 1. Appropriate Use of Evidence-Based, Physician-Developed Guidelines – The MMA supports the appropriate use of evidence-based, physician-developed clinical guidelines as an important tool for clinical and shared decision-making. The MMA believes that guidelines must be developed in an open, multi-specialty process and that closed, proprietary development models are unsupportable. 2. Expansion of the Information Infrastructure – The MMA urges statewide implementation of electronic health records that provide, at a minimum, for the exchange of summary report information that can be used for treatment decisions. 3. A Medical Home for Every Minnesotan – To promote continuous healing relationships and to better coordinate care, the MMA urges the establishment of a "medical home" for every Minnesotan. In an effort to increase the likelihood that patients can identify and sustain a relationship with their medical home, the MMA will encourage employers and public and private payers to adopt supportive payment and enrollment policies. 4. Chronic Disease and Cost Control – Recognizing the disproportionate consumption of health care resources by a small percentage of the population, the MMA will urge employers and health plans to support efforts to improve care delivery for patients with chronic disease through refinements in payment policies and by eliminating barriers to primary and secondary prevention.

### B. Transparent Quality Measurement and Reporting

The MMA supports transparent measurement and public reporting of changes and improvements in various dimensions of the health system's performance in order to improve the quality of care, to improve information available to both patients and physicians, and to improve the function of the health care marketplace. The MMA supports performance measurement at the medical group and hospital/facility level. Given the need for statistical validity and the limitations of current measurement techniques, the MMA does not support clinical performance measurement at the individual physician level. The quality of health care is multi-dimensional and it must be measured comprehensively. The MMA supports approaching performance measurement using the six aims defined by the Institute of Medicine (IOM) – safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity. The MMA recognizes that the implications for physicians of performance measurement and public reporting can be significant in terms of both business/economic impact and professional reputation. The selection of appropriate measures is, therefore, critical. The MMA supports, at a minimum, clinical performance measures that are statistically valid, evidence-based, clinically important, cost-effective, and prospectively defined. The MMA recognizes two primary types of measures to evaluate the clinical quality of care delivered – process and outcome. 1) Process measures measure some aspect of the process of care that was performed (e.g., proportion of heart attack patients given aspirin); 2) Outcome measures measure a result or experience of care (e.g., proportion

of treated patients with pressures below 140/90; proportion of hypertensive patients who have heart attacks). While the MMA believes that performance measures that publicly report health outcomes are the ideal, real and significant barriers to adequately measuring health outcomes require that their use be limited. Among the barriers to using outcomes measures are the low frequency of many clinical events, the probability associated with outcomes/the need for large numbers, and the often limited (or unknown) amount of the variance in outcome that is actually controlled by the subject of the measurement. Given current methodological limitations, the MMA believes that in most circumstances process measures that are linked to meaningful differences in outcomes are the most viable metrics for evaluating the quality of clinical care. The MMA will take a leadership role in working with stakeholders to identify, collect, and report appropriate measures that can be used for system improvement and to aid in improved decision making by all stakeholders. The MMA supports the following minimum parameters to guide its involvement in this area:

- Consumers should help to articulate what their information needs are. There should be public reporting of appropriate measures that consumers would find useful to help them make better decisions;
- Measures useful to provider systems for purposes of quality improvement should be fully disclosed and reported back to them;
- Organized medicine and individual medical groups should be consulted in the development of measures for accountability and improvement;
- The role of government should be to partner with the private sector in the use of measurement for purchasing and to support measurement at a communitywide level through incentives and regulation; and,
- Criteria to be used for selection of measures should include whether good evidence exists, and whether an opportunity for savings or other societal benefit exists if performance improves on a measure.

#### C. Simplified Measurement and Reporting Transactions.

The MMA will work to eliminate duplicative quality measurement and reporting efforts. Data should be collected only once in the process of clinical care, measurement, and reporting. A single, common data set for quality measurement should be adopted. The MMA will explore opportunities to facilitate the transition from manual to electronic chart abstracting.

#### D. Payment Systems to Support Quality Practice

The MMA will advocate for the adoption and expansion of payment policies by public and private payers (sometimes referred to as "pay for use") that will financially reward physician actions to improve their capacity and ability to deliver more efficient, effective care (e.g., the installation of electronic health records, computerized pharmacy-order entry systems, clinical decision-support systems, disease and case management, team-based care, etc.). The MMA recognizes that significant national and local attention is being paid to the notion of "pay-for-performance" with little or no existing evidence to indicate that it will achieve the desired improvements in quality or cost reduction that many seek to achieve. Under the MMA model for a reformed health care system, the concept of pay-for-performance becomes moot, because patients will decide for themselves about the value offered in terms of performance and cost. In the short-term, however, the MMA will support payment models that link payment with process measures, but will oppose pay-for-performance models that link payment with outcomes measures. (BT-07/2005) Reaffirmed, in part (VII(D)), HD-SR203-2006. (Retained BT 07-16)

### **290.67 MMA Principles for Health Care Reform**

1. Insurance coverage for all Minnesotans
  - Individual mandate for essential health benefits
  - Fair spreading of risk (guaranteed issue, community rating)
  - Subsidies/tax incentives
2. Preserve patient-physician relationship
  - Guard the trust and ethical foundations of the physician-patient relationship
  - Recognize need for patient and public accountability
  - Oppose third-party interference in personal care decisions
3. Ensure access to appropriate care for all Minnesotans

– Insurance coverage, alone, does not guarantee that patients will have access to physicians and other providers of care that they need

– Reasonable payment rates are necessary to ensure access to care and viability of physician practices

– Invest in health care workforce – education and training

4. Improved affordability of care

– Support evidence-based, effective care

– Promote continuous healing relationships and a "medical home" for every Minnesotan

– Work to reduce administrative waste and low-value or unnecessary care

– Changes to the ACA must strive to improve affordability and should not result in greater financial barriers to care and coverage.

5. Invest in public health and prevention

– Recognize the significant influence of social determinants of health on health care costs and utilization

– Support payment and coverage policies that can limit development/exacerbation of chronic conditions

– Preventive care must continue to be covered as part of any insurance coverage

6. Health equity

– Recognize that structural and institutional racism that exists in hospitals and health care systems in Minnesota has contributed to current racial and ethnic health disparities

– Support policies that will improve health for all Minnesotans, acknowledging the impact of housing, transportation, education, economic opportunity and criminal justice policies in pursuit of that goal

7. Support innovation in care delivery and payment

– Recognize challenges and limitations of a predominantly fee-for-service based payment system

– Support experimentation with value-based payment models – no one-size-fits-all method is appropriate

8. Broad-based, stable and adequate financing

– Ensure adequate investment in system

– Financing systems should reflect broad social benefit of care

Confirmed by BT 01-17

Issue #	Topic	Submitter's Name (Society, if applicable)
6	Health care reform options	Abby Solom (University of Minnesota Medical School - medical student) (MMA-MSS)

**Submitter's Request of MMA:**

The MMA to adopt formal policy that:

- Supports taking the best aspects of each type of healthcare payment model and using them to innovate (see draft language below).
- Opposes discounting outright any one payment model, as it prohibits productive conversation and innovation.

**Proposed draft policy language:**

*"The MMA acknowledges that, in order to devise innovative solutions to our state's healthcare problems and meet the needs of our patients, we cannot exclude outright any one payment model. Each model has something to offer, each model has strengths and weaknesses, and we need to take the best of what each model has to offer and combine it into flexible systems that will work for the providers, patients, and communities of Minnesota.*

*By incorporating ideas from different payment models, we can continue to work toward a healthcare system that provides coverage for everyone in our state and ensures high-quality care in an equitable fashion."*

### **Submitter's Rationale/Background:**

The AMA-MSS has proposed a change in AMA policy to eliminate anti-single-payer language. We would like to see official MMA policy to support this change. We think this is something most Minnesota doctors would support.

### **MMA Staff-Identified Background Information:**

This open issue submission addresses health reforms designed to achieve affordable, universal coverage. The current MMA policy was adopted as part of the MMA's "Physicians' Plan for a Healthy Minnesota." That report focused on achieving the goals of affordable care, universal coverage, and health care access, without focusing on one type of payment method or another.

This submission arises out of attempts to eliminate AMA policy that strongly opposes a single-payer model of health care payment. Here are the AMA policies that include that opposition.

### ***Educating the American People About Health System Reform H-165.844***

*Our AMA reaffirms support of pluralism, freedom of enterprise and strong opposition to a single payer system. (Res. 717, I-07 Reaffirmation A-09)*

### ***Evaluating Health System Reform Proposals H-165.888***

*Year Last Modified: 2017*

*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.

### **Opposition to Nationalized Health Care H-165.985**

Year Last Modified: 2014

Our AMA reaffirms the following statement of principles as a positive articulation of the Association's opposition to socialized or nationalized health care:

(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, and not determined by preferential federal subsidy, regulations or promotion.

(2) Freedom of patients to select and to change their physician or medical care plan, including those patients whose care is financed through Medicaid or other tax-supported programs, recognizing that in the choice of some plans the patient is accepting limitations in the free choice of medical services.

(3) Full and clear information to consumers on the provisions and benefits offered by alternative medical care and health benefit plans, so that the choice of a source of medical care delivery is an informed one.

(4) 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, to participate or not participate in a particular insurance plan or method of payment, and to accept or decline a third party allowance as payment in full for a service.

(5) Inclusion in all methods of medical care payment of mechanisms to foster increased cost awareness by both providers and recipients of service, which could include patient cost sharing in an amount which does not preclude access to needed care, deferral by physicians of a specified portion of fee income, and voluntary professionally directed peer review.

(6) The use of tax incentives to encourage provision of specified adequate benefits, including catastrophic expense protection, in health benefit plans.

(7) The expansion of adequate health insurance coverage to the presently uninsured, through formation of insurance risk pools in each state, sliding-scale vouchers to help those with marginal incomes purchase pool coverage, development of state funds for reimbursing providers of uncompensated care, and reform of the Medicaid program to provide uniform adequate benefits to all persons with incomes below the poverty level.

(8) Development of improved methods of financing long-term care expense through a combination of private and public resources, including encouragement of privately prefunded long-term care financing to the extent that personal income permits, assurance of access to needed services when personal resources are inadequate to finance needed care, and promotion of family caregiving.

### **Current MMA Policy:**

#### **290.2483 Physicians' Plan for a Healthy Minnesota**

The Minnesota Medical Association (MMA) adopts the following health care reform policy statements (developed by the Health Care Reform Task Force):

##### **I. MMA Vision for Health Care Reform**

The MMA vision for health care reform is as follows: A) The MMA envisions a health care system in which all Minnesotans have affordable coverage for essential health benefits that allows them to get needed care and preventive services in a timely and effective manner. B) Strong patient/physician relationships, unimpeded by third parties, will restore citizen trust in the system and professional satisfaction with the practice of medicine. C) Affordability for individuals, employers, and society will be improved by a renewed commitment by physicians to deliver high-quality effective and efficient care, patient responsibility for personal health behaviors and cost conscious choices, and incentives that reward all parties for a greater focus on prevention and enhanced health. D) The ideal health system will deliver significantly greater returns in improved health status for the

dollars invested and will deliver equity for all in access, treatment quality, and outcomes. E) Whatever the design of the system, the funding provided to the public health and health care delivery systems must be broad-based, stable, and adequate to meet the health needs of the state. F) In order to achieve this higher-performing system, we need a fundamental change in the financing approach and market dynamics of health care. The MMA believes that the uncontrolled growth in health care costs can best be mitigated by replacing the current price and volume incentives that result from a system in which payers artificially control prices, with a patient-centered market in which incentives are aligned to encourage the use of preventive services and effective care without subsidizing the consumption of services of minimal clinical value. In the current system, large purchasers and health plans have the ability to impose prices and shift costs to smaller purchasers or individuals because they control the flow of patients. In the new system, the price of care will be determined by patients' determination of the value they receive from the services provided.

## II. Stakeholder Responsibilities in Health Care Reform

The MMA anticipates that the roles of all stakeholders will change in a reformed health care system, including new or renewed levels of responsibility. Those expectations are as follows: A) The community has a responsibility 1. To ensure affordable access to basic care; 2. To broadly share the risk and cost of medical needs; 3. To assist the population in using health care resources wisely; 4. To provide the conditions and environment in which people can be healthy and make healthy choices; 5. To maximize the proportion of health spending that goes to effective care for all who need it; 6. To secure the future capacity of the health care system to provide sustained high quality and affordable health care, through investments in prevention, medical education, medical research, and improvements in the system's infrastructure. B) Individuals have a responsibility to the community 1. To participate financially in sharing the cost of the system that benefits all; 2. To use the system wisely and draw on collective resources judiciously; 3. To take personal responsibility for their own health behaviors and reduce their own health risks; 4. To become more health literate (e.g., educated about prevention, selection of plans/providers, wise use of resources, and the clinical decision making process). C) Physicians and other clinicians have responsibilities to individual patients and to the broader community 1. To accurately assess patient needs and recommend appropriate and effective care; 2. To advocate honestly for needed and effective care for their patients; 3. To help individuals achieve measurable improvements in health; 4. To exercise stewardship over collective health care resources; 5. To participate in care management as members of an effective multidisciplinary health care team; 6. To foster health literacy among patients and the broader population; 7. To create and foster continuous learning environments in the organizations in which they practice. D) Group purchasers (private-sector employers and government) have responsibilities as members of the community 1. To set expectations for health plans to focus on the delivery of efficient care and health improvement by engaging patients and supporting providers; 2. To emphasize prevention strategies (including those with longer-term payoff) in benefits design; 3. To share in the needed investments in improvements to the infrastructure of the health system; 4. To move the health care system toward affordable, universal coverage for all, not just people employed by large companies or covered through publicly sponsored health care funds. E) Health plans/insurers have responsibilities as members of the community 1. To create payment systems that foster care efficiency and health improvement; 2. To coordinate care management systems with physicians and care teams and to provide the needed information and infrastructure supports for high-quality programs; 3. To correct business practices that lead to health care fragmentation, such as carved-out behavioral health benefits; 4. To minimize the complexity of the system and the costs of administration, and to assist patients/members in navigating the system; 5. To share in the needed investments in prevention strategies and infrastructure improvement; 6. To provide tools and resources and foster an environment to help beneficiaries achieve and physicians deliver desirable results; 7. To create and foster continuous learning environments for the improvement of health care administration and delivery.

## III. The MMA Model for Health Care Reform

The MMA model for health care reform includes four interconnected features: 1) A strong public health system; 2) A reformed insurance market that delivers universal coverage; 3) A reformed health care delivery market that creates incentives for increasing value; and, 4) Systems that fully support the delivery of high quality care.

#### IV. A Strong Public Health System

##### A. Public Health Leadership

To strengthen the public health system, the MMA will provide greater leadership in making public health more prominent by linking its public health policies to broader health care reform and cost containment efforts.

##### B. Coordinated Action to Improve Health

To improve the health of individuals and the population of Minnesota, the MMA urges the creation of a statewide, coordinated and strategic action agenda to address the leading modifiable risk factors for disease.

#### V. A Reformed Insurance Market

##### A. Universal Insurance Coverage

The MMA supports universal insurance coverage to be achieved through a requirement that all individuals have coverage for an essential set of benefits that provides for the protection of individuals and public health. The MMA believes that behavioral health services should be covered on the same basis as any other clinical service. Affordability of coverage shall be ensured through financial subsidies to those individual with limited financial means.

##### B. Fairness in Insurance Risk

The MMA supports a fairer system of spreading insurance risk and sharing the cost of health care to be achieved, in part, through the establishment of statewide community rating and guaranteed issuance of an essential benefit set.

#### VI. A Reformed Delivery Market

##### A. Value, Not Volume

The MMA supports reforms in the health care delivery market that will replace the current incentives for volume with incentives for value.

##### B. Patient Engagement

To transform changes in the delivery of care, the MMA supports efforts to more effectively engage patients in making value-based health care decisions – for both the choice of physician/provider and the options for treatment. Patients can make better health care decisions if they have access to valid and useful information about the cost and quality of care.

##### C. Cost-Shifting

The MMA urges the elimination of cost-shifting by all payers, particularly government payers, that only serves to distort the cost of health care.

#### VII. Systems to Support High-Quality Care

##### A. Increase the Delivery of Effective Care

While recognizing the high quality care delivered in Minnesota, which is among the best in the nation, the MMA strongly supports efforts to increase further the amount of effective care that is provided to Minnesota patients. Several immediate efforts that the MMA supports to expand quality care are the following: 1. Appropriate Use of Evidence-Based, Physician-Developed Guidelines – The MMA supports the appropriate use of evidence-based, physician-developed clinical guidelines as an important tool for clinical and shared decision-making. The MMA believes that guidelines must be developed in an open, multi-specialty process and that closed, proprietary development models are unsupportable. 2. Expansion of the Information Infrastructure – The MMA urges statewide implementation of electronic health records that provide, at a minimum, for the exchange of summary report information that can be used for treatment decisions. 3. A Medical Home for Every Minnesotan – To promote continuous healing relationships and to better coordinate care, the MMA urges the establishment of a "medical home" for every Minnesotan. In an effort to increase the likelihood that patients can identify and sustain a relationship with their medical home, the MMA will encourage employers and public and private payers to adopt supportive payment and enrollment policies. 4. Chronic Disease and Cost Control – Recognizing the disproportionate consumption of health care resources by a small percentage of the population, the MMA will urge employers and health plans to support efforts to improve care delivery for patients with chronic disease through refinements in payment policies and by eliminating barriers to primary and secondary prevention.

##### B. Transparent Quality Measurement and Reporting

The MMA supports transparent measurement and public reporting of changes and improvements in various dimensions of the health system's performance in order to improve the quality of care, to improve information available to both patients and physicians, and to improve the function of the health care marketplace. The MMA supports performance measurement at the medical group and hospital/facility level. Given the need for statistical validity and the limitations of current measurement techniques, the MMA does not support clinical performance measurement at the individual physician level. The quality of health care is multi-dimensional and it must be measured comprehensively. The MMA supports approaching performance measurement using the six aims defined by the Institute of Medicine (IOM) – safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity. The MMA recognizes that the implications for physicians of performance measurement and public reporting can be significant in terms of both business/economic impact and professional reputation. The selection of appropriate measures is, therefore, critical. The MMA supports, at a minimum, clinical performance measures that are statistically valid, evidence-based, clinically important, cost-effective, and prospectively defined. The MMA recognizes two primary types of measures to evaluate the clinical quality of care delivered – process and outcome. 1) Process measures measure some aspect of the process of care that was performed (e.g., proportion of heart attack patients given aspirin); 2) Outcome measures measure a result or experience of care (e.g., proportion of treated patients with pressures below 140/90; proportion of hypertensive patients who have heart attacks). While the MMA believes that performance measures that publicly report health outcomes are the ideal, real and significant barriers to adequately measuring health outcomes require that their use be limited. Among the barriers to using outcomes measures are the low frequency of many clinical events, the probability associated with outcomes/the need for large numbers, and the often limited (or unknown) amount of the variance in outcome that is actually controlled by the subject of the measurement. Given current methodological limitations, the MMA believes that in most circumstances process measures that are linked to meaningful differences in outcomes are the most viable metrics for evaluating the quality of clinical care. The MMA will take a leadership role in working with stakeholders to identify, collect, and report appropriate measures that can be used for system improvement and to aid in improved decision making by all stakeholders. The MMA supports the following minimum parameters to guide its involvement in this area:

- Consumers should help to articulate what their information needs are. There should be public reporting of appropriate measures that consumers would find useful to help them make better decisions;
- Measures useful to provider systems for purposes of quality improvement should be fully disclosed and reported back to them;
- Organized medicine and individual medical groups should be consulted in the development of measures for accountability and improvement;
- The role of government should be to partner with the private sector in the use of measurement for purchasing and to support measurement at a communitywide level through incentives and regulation; and,
- Criteria to be used for selection of measures should include whether good evidence exists, and whether an opportunity for savings or other societal benefit exists if performance improves on a measure.

#### C. Simplified Measurement and Reporting Transactions.

The MMA will work to eliminate duplicative quality measurement and reporting efforts. Data should be collected only once in the process of clinical care, measurement, and reporting. A single, common data set for quality measurement should be adopted. The MMA will explore opportunities to facilitate the transition from manual to electronic chart abstracting.

#### D. Payment Systems to Support Quality Practice

The MMA will advocate for the adoption and expansion of payment policies by public and private payers (sometimes referred to as "pay for use") that will financially reward physician actions to improve their capacity and ability to deliver more efficient, effective care (e.g., the installation of electronic health records, computerized pharmacy-order entry systems, clinical decision-support systems, disease and case management, team-based care, etc.). The MMA recognizes that significant national and local attention is being paid to the notion of "pay-for-performance" with little or no existing evidence to indicate that it will achieve the desired improvements in quality or cost reduction that many seek to achieve. Under the MMA model for a reformed health care system,

the concept of pay-for-performance becomes moot, because patients will decide for themselves about the value offered in terms of performance and cost. In the short-term, however, the MMA will support payment models that link payment with process measures, but will oppose pay-for-performance models that link payment with outcomes measures. (BT-07/2005) Reaffirmed, in part (VII(D)), HD-SR203-2006. (Retained BT 07-16)

### **290.67 MMA Principles for Health Care Reform**

1. Insurance coverage for all Minnesotans
    - Individual mandate for essential health benefits
    - Fair spreading of risk (guaranteed issue, community rating)
    - Subsidies/tax incentives
  2. Preserve patient-physician relationship
    - Guard the trust and ethical foundations of the physician-patient relationship
    - Recognize need for patient and public accountability
    - Oppose third-party interference in personal care decisions
  3. Ensure access to appropriate care for all Minnesotans
    - Insurance coverage, alone, does not guarantee that patients will have access to physicians and other providers of care that they need
    - Reasonable payment rates are necessary to ensure access to care and viability of physician practices
    - Invest in health care workforce – education and training
  4. Improved affordability of care
    - Support evidence-based, effective care
    - Promote continuous healing relationships and a "medical home" for every Minnesotan
    - Work to reduce administrative waste and low-value or unnecessary care
    - Changes to the ACA must strive to improve affordability and should not result in greater financial barriers to care and coverage.
  5. Invest in public health and prevention
    - Recognize the significant influence of social determinants of health on health care costs and utilization
    - Support payment and coverage policies that can limit development/exacerbation of chronic conditions
    - Preventive care must continue to be covered as part of any insurance coverage
  6. Health equity
    - Recognize that structural and institutional racism that exists in hospitals and health care systems in Minnesota has contributed to current racial and ethnic health disparities
    - Support policies that will improve health for all Minnesotans, acknowledging the impact of housing, transportation, education, economic opportunity and criminal justice policies in pursuit of that goal
  7. Support innovation in care delivery and payment
    - Recognize challenges and limitations of a predominantly fee-for-service based payment system
    - Support experimentation with value-based payment models – no one-size-fits-all method is appropriate
  8. Broad-based, stable and adequate financing
    - Ensure adequate investment in system
    - Financing systems should reflect broad social benefit of care
- Confirmed by BT 01-17

### **Current AMA Policy:**

#### **Achieving Health Care Coverage for All D-165.974**

Achieving Health Care Coverage for All -- Our American Medical Association joins with interested medical specialty societies and state medical societies to advocate for enactment of a bipartisan resolution in the US Congress establishing the goal of achieving health care coverage through a pluralistic system for all persons in the United States consistent with relevant AMA policy.

Citation: (Res. 733, I-02; Modified: CCB/CLRPD Rep. 4, A-12)

### **Educating the American People About Health System Reform H-165.844**

Our AMA reaffirms support of pluralism, freedom of enterprise and strong opposition to a single payer system.  
Citation: (Res. 717, I-07; Reaffirmation A-09)

### **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)

<b>Issue #</b>	<b>Topic</b>	<b>Submitter's Name (Society, if applicable)</b>
7	Advocating for schools as gun-free zones	Lisa Erickson, MD (TCMS)

#### **Submitter's Request of MMA:**

The MMA should adopt the same position on gun safety regarding schools as the AMA: Our AMA: (1) encourages states to adopt legislation enabling schools to limit and control the possession and storage of weapons or potential weapons on school property; (2) advocates for schools to remain gun-free zones except for school-sanctioned activities and professional law enforcement officers; and (3) opposes requirements or incentives of teachers to carry weapons.

#### **Submitter's Rationale/Background:**

The AMA adopted several new policies on gun violence at its June 2018 meeting. None of these are current MMA policy and we hope to adopt the AMA's position.

#### **MMA Staff-Identified Background Information:**

As noted above by the author of the submission, the AMA adopted policy in June 2018 that states: "The AMA will advocate for schools to remain gun-free zones—with the exception of school-sanctioned activities and professional law enforcement officials. The AMA also opposes requirements or incentives for teachers to carry weapons in schools." The MMA does not have a similar policy statement.

Minnesota law generally prohibits any person from knowingly possessing, storing, or keeping a firearm on school property, including in any school building, bus, or facility temporarily under the exclusive control of a school, where signs give actual notice. This law defines school to mean any public or private elementary, middle, or secondary school building or its improved grounds, whether owned or leased by the school. The law also prohibits firearms possessions in a licensed child care center during the time that children are present. A violation of any of these prohibitions is a felony. Current Minnesota law also allows businesses, and other private establishments to preclude the carrying of a firearm onto their property.

#### **Current MMA Policy:**

The MMA has extensive policy on firearms, including provisions related to safe storage, waiting periods, prohibition on the sale of certain types of firearms and high-capacity magazines, local ordinance preemption, and others, though there is no specific policy related to gun-free zones. Several policies are related, including:

## 260.12 Gun Control

The MMA reaffirms its support for stricter enforcement of existing firearm laws and advocates for tighter handgun control laws. HD-R38-1995 (Retained 2005) (Retained BT 07-16)

### Current AMA Policy:

#### **School Violence H-145.983**

Our AMA: (1) encourages states to adopt legislation enabling schools to limit and control the possession and storage of weapons or potential weapons on school property; (2) advocates for schools to remain gun-free zones except for school-sanctioned activities and professional law enforcement officers; and (3) opposes requirements or incentives of teachers to carry weapons. (Sub. Res. 402, I-95 Reaffirmed: CSA Rep. 8, A-05 Reaffirmed: CSAPH Rep. 1, A-15 Appended: Res. 402, A-18)

Issue #	Topic	Submitter's Name (Society, if applicable)
8	Firearms and high-risk individuals	Lisa Erickson, MD (TCMS)

### Submitter's Request of MMA:

We want the MMA to adopt the AMA policy on gun safety laws and high-risk individuals. This is an urgent health care issue.

### Submitter's Rationale/Background:

The AMA adopted several new policies on gun violence at its June meeting. None of these are current MMA policy, but should be so considering the current concerns regarding gun safety. AMA policy is as follows:

#### **Firearms and High-Risk Individuals**

Our AMA supports: (1) the establishment of laws allowing family members, intimate partners, household members, and law enforcement personnel to petition a court for the removal of a firearm when there is a high or imminent risk for violence; (2) prohibiting persons who are under domestic violence restraining orders, convicted of misdemeanor domestic violence crimes or stalking, from possessing or purchasing firearms; (3) expanding domestic violence restraining orders to include dating partners; (4) requiring states to have protocols or processes in place for requiring the removal of firearms by prohibited persons; (5) requiring domestic violence restraining orders and gun violence restraining orders to be entered into the National Instant Criminal Background Check System; and (6) efforts to ensure the public is aware of the existence of laws that allow for the removal of firearms from high-risk individuals.

### MMA Staff-Identified Background Information:

During the June 2018 meeting of the AMA, delegates voted to support "gun violence restraining orders that would allow family members, intimate partners, household members, and law enforcement personnel to petition a court to remove firearms from individuals who pose a high or imminent risk for violence. The new policy also requires states to have protocols or processes in place for requiring the removal of firearms by prohibited people and requiring gun violence restraining orders to be entered into the National Instant Criminal Background Check System."<sup>7</sup>

According to research conducted at the Johns Hopkins Center for Gun Policy and Research at the Johns Hopkins Bloomberg School of Public Health and the University of California, Davis, "a review of 28 published studies

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<sup>7</sup> AMA Recommends New, Common-sense Policies to Prevent Gun Violence, June 12, 2018, *available at*: <https://www.ama-assn.org/ama-recommends-new-common-sense-policies-prevent-gun-violence>

examining U.S. gun policy found that laws and regulations designed to keep firearms from people at risk of committing violence, such as felons and those under restraining orders, are effective and, in some instances, reduce lethal violence.”<sup>8</sup> In addition, the research found that “certain laws, including rigorous permit-to-purchase laws which require a permit to be issued before completing a handgun sale and comprehensive background checks, are associated with keeping guns out of the hands of criminals.”<sup>9</sup>

**Current MMA Policy:**

None

**Current AMA Policy:**

**Firearms and High-Risk Individuals H-145.972**

Our AMA supports: (1) the establishment of laws allowing family members, intimate partners, household members, and law enforcement personnel to petition a court for the removal of a firearm when there is a high or imminent risk for violence; (2) prohibiting persons who are under domestic violence restraining orders, convicted of misdemeanor domestic violence crimes or stalking, from possessing or purchasing firearms; (3) expanding domestic violence restraining orders to include dating partners; (4) requiring states to have protocols or processes in place for requiring the removal of firearms by prohibited persons; (5) requiring domestic violence restraining orders and gun violence restraining orders to be entered into the National Instant Criminal Background Check System; and (6) efforts to ensure the public is aware of the existence of laws that allow for the removal of firearms from high-risk individuals. (CSAPH Rep. 04, A-18)

Issue #	Topic	Submitter’s Name (Society, if applicable)
9	Gun Safety	Lisa Erickson, MD (TCMS)

**Submitter’s Request of MMA:**

We want the MMA to adopt the AMA policy on gun safety. This is an urgent health care issue.

It is the policy of the AMA to support (a) mandatory inclusion of safety devices on all firearms, whether manufactured or imported into the United States, including built-in locks, loading indicators, safety locks on triggers, and increases in the minimum pressure required to pull triggers; (b) bans on the possession and use of firearms and ammunition by unsupervised youths under the age of 21; (c) bans of sales of firearms and ammunition from licensed and unlicensed dealers to those under the age of 21 (excluding certain categories of individuals, such as military and law enforcement personnel).

**Submitter’s Rationale/Background:**

The AMA adopted several new policies on gun violence at its June meeting. None of these are current MMA policy but should be so considering the current urgent concerns regarding gun safety.

**MMA Staff-Identified Background Information:**

According to the Giffords Law Center, “federal law imposes no design safety standards on domestically produced firearms.”<sup>10</sup> The reason for this is that firearms and ammunition are exempted from the health and safety standards set by the Consumer Product Safety Act, unlike other products produced in the U.S. The

<sup>8</sup> Daniel W. Webster and Garen J. Wintemute, Effects of Policies Designed to Keep Firearms from High-Risk Individuals, Annual Review of Public Health 2015, Vol. 36:21-37, March 2015, available at: <https://www.annualreviews.org/doi/abs/10.1146/annurev-publhealth-031914-122516>

<sup>9</sup> *Id*

<sup>10</sup> Giffords Law Center, Design Safety Standards, available at: <http://lawcenter.giffords.org/gun-laws/policy-areas/child-consumer-safety/design-safety-standards/>

Giffords Law Center further states that “as a result, many firearms are manufactured and sold in the U.S. without undergoing appropriate safety testing and without including basic safety features. Poorly constructed firearms play a significant role in unintentional shootings and are disproportionately associated with criminal misuse, especially by juveniles and young adults.”<sup>11</sup>

According to the Johns Hopkins Center for Gun Policy and Research, youth 18-20 years of age have “some of the highest rates of homicide offending.”<sup>12</sup> Furthermore, “age-specific homicide offending rates rise sharply in the late teens and peak at age 20.”<sup>13</sup> In states with the weakest standards for legal firearm ownership, the largest segment of offenders who would have been prohibited in other states that had stricter standards were those between 18 and 20 years of age.<sup>14</sup>

**Current MMA Policy**

**260.18 Firearm Safety**

The MMA will promote conversations between providers and patients on responsible firearm ownership and safe storage in the home (much like current conversations on the use of child-restraint systems in the car).

The MMA supports the growing movement for common-sense changes to gun laws to promote responsible gun ownership and support efforts in Minnesota to require criminal background checks on all purchases and transfers/exchanges of firearms, with reasonable exceptions for immediate family and law enforcement and military acting in an official capacity.

The MMA urges elected leaders to ensure that law enforcement officials have adequate resources to enforce the laws that hold sellers accountable when they sell firearms to prohibited purchasers.

The MMA supports state investment in Minnesota’s firearm surveillance system to improve data collection, analysis, and research on firearm injury prevention.

The MMA supports the renewal and strengthening of the assault weapons ban, including banning high-capacity magazines. BT 11-16 (Retained as edited EC 03-18)

Issue #	Topic	Submitter’s Name (Society, if applicable)
10	Oppose federal concealed carry reciprocity	Lisa Erickson, MD (TCMS)

**Submitter’s Request of MMA:**

We want the MMA to adopt the AMA policy opposing federal concealed carry reciprocity. This is an urgent health care issue and we need a policy position so that we can be proactive when legislation occurs in Minnesota.

It is the policy of the AMA to oppose “concealed carry reciprocity” federal legislation that would require all states to recognize concealed carry firearm permits granted by other states and that would allow citizens with concealed gun carry permits in one state to carry guns across state lines into states that have stricter laws. The AMA supports the right of local jurisdictions to enact firearm regulations that are stricter than those that exist in state statutes and encourages state and local medical societies to evaluate and support local efforts to enact useful controls.

<sup>11</sup> *Id.*

<sup>12</sup> Johns Hopkins Center for Gun Policy and Research, Johns Hopkins Bloomberg School of Public Health, The Case for Gun Policy Reforms in America, October 2012, available at: [https://www.jhsph.edu/research/centers-and-institutes/johns-hopkins-center-for-gun-policy-and-research/publications/WhitePaper020514\\_CaseforGunPolicyReforms.pdf](https://www.jhsph.edu/research/centers-and-institutes/johns-hopkins-center-for-gun-policy-and-research/publications/WhitePaper020514_CaseforGunPolicyReforms.pdf)

<sup>13</sup> *Id.*

<sup>14</sup> *Id.*

**Submitter’s Rationale/Background:**

The AMA adopted several new policies on gun violence at its June meeting. None of these are current MMA policy but should be so considering the current urgent concerns regarding gun safety.

**MMA Staff-Identified Background Information:**

During the 2018 meeting of the AMA, delegates voted to oppose federal legislation permitting “concealed carry reciprocity” across state lines.<sup>15</sup> According to the AMA, “such a law would require all states to recognize concealed carry permits granted by other states and allow citizens with concealed carry permits in one state to carry guns into states that have stricter laws. The law could endanger law enforcement agents, victims of domestic violence, and the public. AMA has supported the right of local jurisdictions to enact firearm regulations that are stricter than those that exist in state statutes, but concealed carry laws lower standards to the lowest common denominator.”<sup>16</sup>

According to *Everytown for Gun Safety*, “state concealed carry permitting systems vary dramatically.”<sup>17</sup> States set their own requirements for carrying concealed, loaded guns in public – and thus you will find firearms training varies across states.<sup>18</sup> In addition, some states issue permits to individuals with felonies, while 12 states do not require permits to carry concealed.<sup>19</sup> In addition, someone who was denied a permit in their home state could get a permit out of state, and then come back to their home state and carry.<sup>20</sup>

**Current MMA Policy**

**260.13 Permit to Carry a Concealed Weapon**

The MMA supports that issuing permits to carry concealed weapons should remain at the discretion of local law enforcement. HD-R38-1996 (Retained 2006) (Retained as edited BT 07-16)

Issue #	Topic	Submitter’s Name (Society, if applicable)
11	Conversion therapy	James Pathoulas and Kevin O’Donnell (University of Minnesota Medical School – medical students) (MMA-MSS)

**Submitter’s Request of MMA:**

The MMA should draft, advocate, and endorse legislation that broadly: (1) prohibits licensed mental health and medical professionals from providing, referring, or billing medical assistance for conversion therapy on children, adolescents, or vulnerable adults in Minnesota (2) sanctions offending licensed mental health and medical professionals, requiring disciplinary action determined by a state licensing board or other agency.

**Submitter’s Rationale/Background:**

The practice of conversion therapy by licensed healthcare providers occurs in Minnesota at well-known clinics described in the local news media. Minnesota is among 36 states in the U.S. where conversion therapy of minors by licensed professionals is lawful. The Williams Institute of UCLA School of Law estimates 698,000 people in the U.S. have received conversion therapy, 350,000 of whom experienced conversion therapy as children or

<sup>15</sup> AMA Recommends New, Common-sense Policies to Prevent Gun Violence, June 12, 2018, *available at*: <https://www.ama-assn.org/ama-recommends-new-common-sense-policies-prevent-gun-violence>

<sup>16</sup> *Id.*

<sup>17</sup> Everytown for Gun Safety, Concealed Carry Reciprocity: Overriding State Public Safety Laws, *available at*: <https://everytownresearch.org/concealed-carry-reciprocity-overriding-state-public-safety-laws/>

<sup>18</sup> *Id.*

<sup>19</sup> *Id.*

<sup>20</sup> *Id.*

adolescents. In the U.S., 20,000 of Lesbian, gay, bisexual, and transgender (LGBT) youth ages 13-17 will receive conversion therapy from a licensed health care professional before they reach the age of 18.

Conversion therapy is an illegitimate and fraudulent practice detrimental to children, adolescents, and vulnerable adults. The Minnesota Medical Association (MMA) should adopt policy opposing licensed mental health and medical professionals from practicing, referring, or billing medical assistance for conversion therapy on children, adolescents, or vulnerable adults in Minnesota, as MMA has a vested interest in the professional conduct of Minnesota’s healthcare providers and the health and wellbeing of all Minnesotans.

**MMA Staff-Identified Background Information:**

Fourteen states (WA, OR, CA, NV, NM, IL, MD, DE, NJ, CT, RI, VT, NH) and the District of Columbia prohibit the use of conversion therapy for minors. Cities in five additional states (AZ, FL, NY, OH, PA WI) have banned the use of conversion therapy for minors within their municipalities. Bills to ban conversion therapy for minors have been introduced but not enacted by the federal House of Representatives and in five states and one territory (IA, MI, MN, OH, PA, PR). The use of conversion therapy is opposed by the following professional organizations: American Academy of Child and Adolescent Psychiatry, American Academy of Pediatrics, American Association for Marriage and Family Therapy, American College of Physicians, American Counseling Association, American Medical Association, American Psychiatric Association, American Psychoanalytic Association, American Psychological Association, American School Counselor Association, American School Health Association, and the National Association of Social Workers. Opponents to conversion therapy bans have challenged these laws on First Amendment speech and religious liberty grounds.

**Current MMA Policy**

None

Issue #	Topic	Submitter’s Name (Society, if applicable)
12	Improving outcomes for those with maternal opioid use disorder	Cresta Jones, MD, FACOG (MNACOG)

**Submitter’s Request of MMA:**

We want the MMA to support appropriate efforts to improve outcomes with maternal opioid use disorder:

- Promote public health efforts to reduce maternal opioid use disorder and neonatal abstinence syndrome (NAS).
- Oppose punitive legislation against women with opioid use disorder and babies born with NAS.
- Support implementation of laws to ensure access to appropriate care for women with opioid use disorder and babies born with NAS.
- Protect against mandatory testing and reporting to law enforcement or child protective services; maintain protections for women undergoing medically assisted treatment (MAT).

**Submitter’s Rationale/Background:**

Pregnancy provides an important opportunity to identify and treat women with substance use disorders. Identifying patients with substance use disorders using validated screening tools, offering brief interventions (such as engaging a patient in a short conversation, providing feedback and advice), and referring for specialized care, as needed, are essential elements of care. Additionally, it is important to advocate for this often-marginalized group of patients, particularly in terms of working to improve availability of treatment and to ensure that pregnant women with opioid use disorder who seek prenatal care are not criminalized. Finally, obstetric care providers have an ethical responsibility to their pregnant and parenting patients with substance use disorder to discourage the separation of parents from their children solely based on substance use disorder, either suspected or confirmed. In states that mandate reporting, policy makers, legislators, and physicians should work

together to retract punitive legislation and identify and implement evidence-based strategies outside the legal system to address the needs of women with addictions.

**MMA Staff-Identified Background Information:**

According to the American College of Obstetricians and Gynecologists (ACOG), “opioid use in pregnancy has escalated dramatically in recent years, paralleling the epidemic observed in the general population.”<sup>21</sup> In 2012, more than 259 million prescriptions for opioids were written by health care providers in the U.S. That number is twice as many as were written in 1998. In addition, rates of admission to treatment programs for misuse of prescription opioids more than quadrupled between 2002 and 2012. Death rates associated with opioids rose nearly 400% between 2000 and 2014. Furthermore, heroin use has also increased, with overdose deaths attributable to heroin increasing more than 300% in less than 5 years.

In addition, according to ACOG<sup>22</sup>, 22.8% of women enrolled in Medicaid programs in 46 states filled a prescription for opioids during pregnancy. Opioid use in pregnancy has led to an increase in neonatal abstinence syndrome.<sup>23</sup> According to the National Institute on Drug Abuse, every 25 minutes, a baby is born suffering from opioid withdrawal.<sup>24</sup> In states conducting maternal mortality reviews, substance use has been identified as a major risk factor for pregnancy-associated deaths.<sup>25</sup>

ACOG also notes that pregnancy provides an opportunity to identify substance use disorder in women, and an opportunity to work towards treating them. It is important that obstetric care providers are aware of the medical, social and legal consequences that come with opioid use in pregnant women – and that they advocate for these women, so that they seek the care they need and are not criminalized. ACOG believes that where mandatory reporting exists, policy makers and physicians should work to remove legislation that is punitive and implement evidence-based strategies for pregnant women with opioid use disorder.<sup>26</sup>

Finally, a public health approach to substance use disorder is an effective way to improve outcomes for pregnant women – when already faced with the negative consequences of their substance use.<sup>27</sup> Providing pregnant women with effective treatment can lay the groundwork for these women and their infants to have better health. On the contrary, punitive approaches (*e.g.*, charging women with child abuse for using substances while pregnant, removing children from their mothers, etc.) has the potential to create trauma and stress, two factors that will serve as barriers to these women seeking health care services – both for their substance use, and during and after their pregnancy.

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<sup>21</sup> American College of Obstetricians and Gynecologists, ACOG Committee Opinion, Number 711, August 2017, available at: <https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Opioid-Use-and-Opioid-Use-Disorder-in-Pregnancy>

<sup>22</sup> *Id.*

<sup>23</sup> *Id.*

<sup>24</sup> National Institute on Drug Abuse, Dramatic Increases in Maternal Opioid Use and Neonatal Abstinence Syndrome, available at: <https://www.drugabuse.gov/related-topics/trends-statistics/infographics/dramatic-increases-in-maternal-opioid-use-neonatal-abstinence-syndrome>

<sup>25</sup> *Id.*

<sup>26</sup> ACOG Committee Opinion, Number 711, August 2017, available at: <https://www.acog.org/-/media/Committee-Opinions/Committee-on-Obstetric-Practice/co711.pdf?dmc=1>

<sup>27</sup> Jacobs Institute of Women’s Health, The George Washington University, Pregnant Women and Substance Use – Overview of Research & Policy in the United States, February 2017, available at: [https://publichealth.gwu.edu/sites/default/files/downloads/JIWH/Pregnant\\_Women\\_and\\_Substance\\_Use\\_update\\_d.pdf](https://publichealth.gwu.edu/sites/default/files/downloads/JIWH/Pregnant_Women_and_Substance_Use_update_d.pdf)

**Current MMA Policy**

**50.33 Harm Reduction for Opioid Dependence through Evidence-Based Approaches to Addiction Treatment**

The Minnesota Medical Association will support efforts to ensure the availability of effective and evidence-based addiction treatment options for individuals with opioid dependence, and will provide resources and information regarding these harm reduction options for physicians. (BT 01-15)