ASSOCIATION OF LIFE INSURANCE MEDICAL DIRECTORS OF AMERICA

ALIMDA DELEGATE TO THE AMA

Report

1991 ANNUAL MEETING OF THE HOUSE OF DELEGATES, AMERICAN MEDICAL ASSOCIATION

Introduction

- There were 438 delegates seated initially and the House voted to seat the following four additional specialty societies, bringing the total voting delegates to 442.

1. American Medical Directors Association
2. Society of Cardiovascular and Interventional Radiology
3. Society of Critical Care Medicine
4. American Orthopaedic Foot and Ankle Society
- This brings voting specialty societies to 81, with ALIMDA being one.
- The delegates agenda contained 106 reports and 263 resolutions.
- The annual elections for AMA officers, trustees, and council members were held (results are attached).

A wide variety of issues were considered in socio-economics, science, and public health. Following are the major issues considered at the meeting:

The New Medicare Physician Payment System (RBRVS)

The beginning of the transition to a new Medicare payment system will culminate nearly a decade of efforts to reform Medicare's physician payment system. From the start, the AMA has played a leadership role. The AMA has viewed Medicare adoption of a payment schedule based upon a Resource-Based Relative Value Scale (RBRVS) as a means of preserving fee-for-service as a viable Medicare option, and has used its support for such a system to defeat proposals for physician DRGs or widespread capitation for Medicare, as well as to fend off even more severe proposed budget cuts than those actually enacted since 1984.

AMA support was also a major factor in the adoption of key elements of the 1989 payment reform provisions. The AMA played a leadership role in the design of the new system, and has continued this role by developing workable approaches to many implementation issues, advocating adoption of policies that serve the best interests of the entire medical profession, and opposing those that would harm physicians or patients. This report clearly establishes the AMA's intention to maintain its leadership position throughout the implementation process.

The AMA is optimistic that, with the active support of the Federation, the proposed conversion factor cut can be reversed. If it is, as a result of the RBRVS and geographic adjustments, Medicare payments will increase for many physicians. For others, these changes, as well as new limiting charges, will produce payment decreases. Current projections suggest, however, that, if the proposed reduction in the monetary conversion factor can be overcome, most physicians will either benefit from or be relatively unaffected by these changes. In addition, the move to a more standardized payment system, in and of itself, with limits on geographic variation and no specialty differentials, will play a major role in determining the impact on individual physicians.

All physicians will benefit from the simplicity and standardization of the new system and, regardless of how remaining policy issues are resolved, it is clear that RBRVS-based payment schedule continues to be the best Medicare payment alternative of those proposed. To strengthen AMA's advocacy efforts and maintain the Association's leadership role in payment reform, the House adopted the following policies:

1. That the AMA reaffirm its policies in support of an RBRVS-based Medicare indemnity payment schedule (95.021 and 95.016). However, failing appropriate adjustments in the RBRVS payment methodologies for Medicare, the AMA Board of Trustees be given the authority to withdraw AMA support of implementation of the RBRVS.

2. That the AMA strongly oppose reductions in the payment schedule conversion factor due to volume offset assumptions and spending increases resulting from the transition formula.

3. That the American Medical Association carefully evaluate and use caution in support for any wider program use of either the RBRVS or the new Medicare physician payment system until the conversion factor reductions are reversed and until there is an acceptable level of Medicare experience with this new system; and that the AMA produce a current evaluation of RBRVS and the new Medicare physician payment system to ensure that reimbursements for physicians are equitable, appropriate, and adequate, with a report back at the 1991 Interim Meeting.

4. That the AMA oppose any further public program use of either the RBRVS or the new Medicare physician payment system until the conversion factor reductions are reversed and until there is an acceptable level of Medicare experience with this new system.

5. That the AMA continue to work productively with HCFA on such issues as revision of visit and consultation codes, RVS updating, and other elements of the pending Medicare physician payment system.
6. That the AMA embark on a major campaign (the Payment Reform Education Project) to educate physicians and their organizations about the new Medicare payment system, and that the Board report back to the House on its status at the 1991 Interim Meeting.

7. That the AMA monitor the transition to the new system and report back at each Interim and Annual Meeting of the House during the transition.

HIV Testing

The issue of testing for AIDS occupied a major portion of the delegates debate and received widespread attention from the public media.

The House adopted important policy positions regarding routine HIV testing, testing for health care workers and patients, and testing for prisoners:

- Hospitals, clinics and physicians may adopt routine HIV testing based on their local circumstances. Such a program is not a substitute for universal precautions. Local considerations may include:
  - likelihood that knowledge of a patient's serostatus will improve patient care and reduce HIV transmission risk;
  - prevalence of HIV in patients undergoing invasive procedures;
  - costs, liabilities, and benefits;
  - alternative methods of patient care and staff protection available to the patient.

- Routine HIV testing should include appropriately modified informed consent and modified pre-test and post-test counseling procedures. The Board of Trustees will develop a simplified, modified informed consent form by I-91. Informed consent should include the following information:
  - patient option to receive more information and/or counseling before deciding whether or not to be tested;
  - patient should not be denied treatment if he or she refuses HIV testing, unless knowledge of HIV status is vital to provide appropriate treatment; in this instance, the physician may refer the patient to another physician for care.

- All negative test results should be provided in a confidential manner accompanied by information on the meaning of these results and the offer, directly or by referral, of appropriate counseling.

- All positive HIV results should be provided in a confidential face-to-face session by a professional properly trained in HIV post-test counseling and with sufficient time to address the patient's concerns about medical, social, and other consequences of HIV infection.

- When an individual presents to a physician with concerns about possible exposure to HIV or when a history of high-risk behavior exists, full pretest and post-test counseling procedures should be utilized.

- State medical associations should be encouraged to review and seek modification of state laws that restrict the ability of hospitals and other medical facilities to initiate routine HIV testing programs.

HIV Testing for Health Care Workers and Patients

RESOLVED, That the American Medical Association support HIV testing of physicians, healthcare workers, and students in appropriate situations; and be it further

RESOLVED, That the AMA study the issues related to such testing, including specifying situations in which testing should be performed, the frequency of testing, and the relationship of such testing to licensure, professional liability insurance, granting of privileges, or any credentialing process with report back at I-91; and be it further

RESOLVED, That the AMA supports the position that HIV testing be done on physicians, other health care workers, and patients consistent with testing for other infections and communicable diseases; and be it further

RESOLVED, That the AMA encourage education of patients and the public about the limited risks of iatrogenic HIV infection.

In other actions, the House of Delegates voted policies to guide the American Medical Association's future activities:

Assistants at Surgery

- That the American Medical Association oppose any effort by Medicare or any other third-party payer to limit payment for medically necessary care, especially in the area of assistants at surgery;

- That the AMA support and participate in as appropriate, the efforts of state and specialty societies to develop guidelines for appropriate use of physicians as assistants at surgery;

- That the AMA continue to oppose and seek regulatory and/or legislative relief from the discriminatory down-grading or elimination of Medicare payments for assistants at surgery.

Bush Administration Professional Liability Proposal

- That the American Medical Association commend the Bush Administration for its legislative efforts designed to achieve medical liability reform;

- That the AMA support the elements of legislative proposals introduced in the 102nd Congress which are consistent with Association policy, including: (1) limitations of $250,000 or lower on recovery of noneconomic damages; (2) the mandatory offset of collateral sources of plaintiff compensation; (3) a decreasing, sliding scale regulation of attorney contingency fees; (4) periodic payment of future awards of damages; and (5) a limitation on the period for suspending the application of state statutes of limitations for minors to no more than six years after birth.

National Practitioner Data Bank

- That the American Medical Association urge the Department of Health and Human Services to retain an independent consultant (1) to evaluate the utility and effectiveness of the National Practitioner Data Bank, (2) to evaluate the confidentiality and security of the reporting, processing, and distribution of Data Bank information, and (3) to provide the findings and recommendations to the
National Practitioner Data Bank Executive Committee and the General Accounting Office;

- That the AMA take appropriate steps to have Congress repeal Section 4752(f) of the Omnibus Budget Reconciliation Act of 1990 requiring peer review organizations and private accreditation entities to report any negative action or finding to the Data Bank;

- That the AMA oppose any legislative or administrative efforts to expand the Data Bank reporting requirements for physicians, such as the reporting of a physician who is dismissed from a malpractice suit without any payment made on his or her behalf, or to expand the entities permitted to query the Data Bank such as public and private third party payors for purposes of credentialing for reimbursement;

- That the AMA seek to amend the Health Care Quality Improvement Act of 1986 to allow a physician, at the time the physician notifies the Data Bank of a dispute, to attach an explanation or statement to the disputed report;

- That the AMA urge HHS to analyze malpractice data gathered by the Physician Insurance Association of America and recommend to Congress that a threshold of at least $30,000 for the reporting of malpractice payments be established as soon as possible;

- That the AMA continue to work with HHS to allow physicians an expanded time period to verify the accuracy of information reported to the Data Bank prior to its release in response to queries;

- That the AMA continue to work with HHS to improve its mechanism to distribute revisions and clarifications of Data Bank policy and procedures;

- That the AMA review questions regarding reportability to the Data Bank and that periodic updates on reportability issues be provided to the AMA House of Delegates.

Biomedical Research and Criminal Activism

- That the American Medical Association work with Congress to establish a uniform method to assure a prompt, unbiased review by scientific peers of federally funded research projects before grant or contract monies can be withheld from any investigator or institution;

- That the American Medical Association work through Congress to oppose legislation which inappropriately restricts the choice of scientific animal models used in research;

- That the American Medical Association support the Facilities Protection Act (S-544 and HR-2407) which makes it a federal crime and similar legislation at state levels to make it a felony to trespass and/or destroy laboratory areas where biomedical research is conducted;

- That the American Medical Association emphasize to Congress and the American public the need for research on trauma that affects Americans of all ages.

Conclusion

AMA House of Delegates meetings provide a unique educational opportunity and I would encourage you to attend and participate. Any member of the Association may present testimony at the Reference Committee hearings and discussions on the issues provide ample opportunities to get your views across. If you can't come to the meeting you can still be represented through your delegate. Let your delegation know your opinions. You can also prepare a resolution and request that it be submitted to the House. Many AMA policies began with an individual physician who had a good idea and coaxed it through the democratic process.

Roger H. Butz, MD
Delegate
Franklin A. Smith, MD
Alternate Delegate

ATTACHMENT

1991 AMA ANNUAL MEETING ELECTION RESULTS

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