AMERICAN ACADEMY OF INSURANCE MEDICINE

AAIM Delegate to the AMA Report

1992 Annual Meeting of the House of Delegates, American Medical Association

Introduction

- There were 435 delegates seated initially, which included the return of the American College of Surgeons. The House voted to seat a delegate from the American Fertility Society, bringing the total to 436. One organization, the American Society of Clinical Pharmacology and Therapeutics, failed to meet the criteria for continued representation and will be dropped from the roster of voting delegates.

- The delegates' agenda contained 104 reports and 311 resolutions making this the largest agenda in the history of the AMA House of Delegates.

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

Medicare Physician Payment Reform (RBRVS)

The board of Trustees submitted an informational report detailing AMA's response to the Medicare Physician Payment Reform. The report's conclusion:

- recognizes that for many physicians, the new Medicare physician payment system has brought steep payment reductions and the need to adapt to new payment and coding policies,
- emphasized the importance to physicians of membership in organized medicine and reported that 82% of the Congress gave support for restoration of $10 billion to the Medicare budget which resulted from the 1991 campaign by organized medicine to reverse the proposed conversion factor.

The House received ten resolutions and adopted the following policy statement to guide the AMA's future actions:

RESOLVED, That the AMA take all necessary legal, legislative, and other action to redress the inequities in the implementation of the RBRVS, including, but not limited to:

1. Reduction of allowances for new physicians.
2. The non-payment of EKG interpretations.
3. Defects in the Geographic Practice Cost Indices and area designations.
4. Inappropriate Resource-Based Relative Value Units.
5. The deteriorating economic condition of physicians' practices disproportionately affected by the Medicare payment system.
6. The need for restoration of the RBRVS conversion factor to levels consistent with the statutory requirement for budget neutrality.
7. The inadequacy of payment for services of assistant surgeons.
8. Loss of surgical tray benefit for many outpatient surgical procedures; and be it further

RESOLVED, That the AMA seek an evaluation of (1) stress factors (i.e., intensity values) as they affect the calculation of the Medicare Payment Schedule, seeking appropriate, reasonable, and equitable adjustments; and (2) descriptors (i.e., vignettes) and other examples of services used to determine RBRVS values and payment levels and seek adjustments so that the resulting values and payment levels appropriately pertain to the elderly and often infirm patients; and be it further

RESOLVED, That the AMA evaluate the use of the RBRVS on the calculation of the work component of the Medicare Payment Schedule and ascertain that the concept for the work component continues to be an appropriate part of the resource-based relative value system; and be it further

RESOLVED, That the AMA seek to assure that all modifiers, including global descriptors, are well publicized and include adequate descriptors; and be it further

RESOLVED, That the AMA seek the establishment of a reasonable and consistent interpretation of global fees, dealing specifically with pre-operative office visits, concomitant office procedures, and/or future procedures; and be it further
RESOLVED, That the AMA take steps to assure that relative value units in the Medicare payment schedule, such as nursing home visits, are adjusted to account for increased resources needed to deliver care and comply with federal and state regulatory programs that disproportionately affect these services and that the Medicare conversion factor be adjusted and updated to reflect these increased overall costs; and be it further

RESOLVED, That the AMA support the concepts of HR 4393 (the Medicare Geographic Data Accuracy Act of 1992), S 2680 (the Medicare Geographic Data Accuracy Act of 1992), and S 2683 (Medicare Geographic Data Accuracy Act) for improving the accuracy of the Medicare geographic costs indices (GPCIs) and that it work with HCFA and the Congress to assure that GPCIs are updated in as timely a manner as feasible and reflect actual physician costs, including gross receipt taxes; and be it further

RESOLVED, That the AMA request that HCFA refine relative values for particular services on the basis of valid and reliable data and that it rely upon the work of the AMA/Specialty Society RVS Updating Committee (RUC) for assignment of relative work values to new or revised CPT codes and any other tasks for which the RUC can provide credible recommendations; and be it further

RESOLVED, That the AMA take steps to assure all relative value units contained in the Medicare Payment Schedule are adjusted as needed to comply with ever increasing state and federal regulatory requirements; and be it further

RESOLVED, That the American Medical Association oppose application and expansion of the current Medicare RBRVS to private sector payors.

Confidential Care for Minors

The Council on Ethical and Judicial Affairs submitted a report that stimulated a great deal of press coverage around the nation regarding providing confidential care for minors. The House approved the Council's recommendations which read as follows:

1. Physicians who treat minors have an ethical duty to promote the autonomy of minor patients by involving them in the medical decision-making process to a degree commensurate with their abilities.

2. When minors request confidential services, physicians should encourage them to involve their parents. This includes making efforts to obtain the minors' reasons for not involving their parents and correcting misconceptions that may be motivating their objections.

3. Where the law does not require otherwise:

   a. Physicians should permit competent minors to consent to medical care and should not notify parents without the patients' consent. Depending on the seriousness of the decision, competence may be evaluated by physicians for most minors. When necessary, experts in adolescent medicine or child psychological development should be consulted. Use of the courts for competence determinations should be made only as a last resort.

   b. When an immature minor requests contraceptive services, pregnancy-related care (including pregnancy testing, pre-natal and postnatal care, and delivery services), or treatment for sexually transmitted disease, drug and alcohol abuse or mental illness, physicians must recognize that requiring parental involvement may be counterproductive to the health of the patient. Physicians should encourage parental involvement in these situations. However, if the minor continues to object, his or her wishes ordinarily should be respected. If the physician is uncomfortable with providing services without parental involvement, and alternative confidential services are available, the minor may be referred to those services. In cases when the physician believes that without parental involvement and guidance, the minor will face a serious health threat, and there is reason to believe that the parents will be helpful and understanding, disclosing the problems to the parents is ethically justified. When the physician does breach confidentiality to the parents, he or she must discuss the reasons for the breach with the minor prior to the disclosure.

   c. For minors who are mature enough to be unaccompanied by their parents for their examination, confidentiality of information disclosed during an exam, interview, or in counselling should be maintained. Such information may be disclosed to parents when the patient consents to disclosure. Confidentiality may be justifiably breached in situations for which confidentiality for adults may be breached. In addition, confidentiality for immature minors may be ethically breached when necessary to enable the parent to make an informed decision about treat-
4. When laws violate these ethical standards, physicians should fulfill their legal requirements. However, such laws should be altered to conform with these guidelines. Physicians should play an active role in changing laws that are not in conformity with these standards.

Self-referral

Another ethical issue pertaining to self-referral also received wide press coverage. The House adopted a resolution that "softened" AMA's previous stand:

RESOLVED, That the American Medical Association adopt the policy that medically necessary referrals by a physician to an off-site facility in which he/she has a financial interest is ethical if the patient is fully informed of the ownership interest and the existence of any available alternate facilities.

HIV Infections and Physicians

The Board of Trustees submitted a comprehensive report on the subject that will serve as the basis for a future white paper outlining and tying together AMA policy of HIV/AIDS. The House adopted a series of positions on a wide variety of related issues surrounding the AIDS epidemic:

Look-back Program Update

- That a panel of experts should be assembled to translate available look-back information into a meaningful statement on the estimated true risk of transmission and the need, if any, for additional studies.

Routine HIV Testing

- Explicit consent should not always be required prior to HIV testing. However, pretest counselling must be conducted for patients receiving routine HIV testing. Post-test information in the form of a simple verbal or written report and interpretation must be given for negative results. Pretest and post-test counselling must be conducted for patients when HIV is the focus of the medical attention or when a history of high risk behavior is present; full post-test counselling is always required when test results are positive. Physicians must be aware that most states have enacted laws requiring informed consent before HIV testing.

Monitoring HIV-Infected Physicians

- Any HIV-infected physician should disclose his/her serostatus to a state public health official or local review committee. Ideally, membership on the review committee should be flexible to meet various needs. It should include the patient's physician, an infectious disease specialist not involved in the care of the patient, an epidemiologist, and others as appropriate. Committee members should be unbiased, and at least some of the members should be familiar with the performance of the infected physician. This review committee may recommend to the appropriate authority restrictions upon the physician's practice, if they believe there is a significant risk to patients' welfare. The review committee is also responsible for monitoring adherence to universal precautions and must also monitor the physician's clinical competency. Those who do not abide by imposed restrictions should be reported to appropriate authorities such as the state licensure board.

- Any physician who performs patient care procedures that pose a significant risk of transmission of HIV infection should voluntarily determine his/her serostatus at intervals appropriate to risk.

- AMA reaffirms its previous policy and remains opposed to mandatory testing.

- AMA reaffirms its previous policy and remains opposed to HIV testing as a condition of medical staff privileges.

Liability Insurance

- That the AMA continue the dialogue with liability insurance companies to monitor issues surrounding liability coverage for HIV-infected physicians and will establish guidelines for any collection or use of HIV serostatus data by professional liability carriers. Serostatus information should be treated with strict privacy and nondisclosure assurances.

Social Security Listing of Disabilities

- That the AMA continue its efforts with the Social Security Administration and should explore ways of educating physicians on the disability evaluation of patients.

Underground Manufacture and Sale of Drugs

- That physicians be urged to inquire of a patient with HIV infection whether the patient is taking unprescribed medications or drugs manufactured by
a pharmaceutical company with an unfamiliar name. Appropriate action should be based on the circumstances, but the patient should be made aware of the possible ineffectiveness and complications of such medications.

Health Care Workers' Safety

- Employees of the health care system who might be at risk of contacts with infected blood or other body fluids must be afforded all available and practical protection to assure a low level of personal risk of occupational infection. Universal precautions and all other applicable infection control measures must be understood and consistently used to safeguard the health of all personnel. Physicians should be aware of the legal requirement to adhere to the new OSHA regulations on blood borne diseases.

- Because health care workers (HCW) who are immunocompromised due to HIV infection or other causes are especially susceptible to active M. tuberculosis infection, HIV-infected HCWs and their physicians should be aware of the findings in Report 00 (Multiple Drug Resistant Tuberculosis: A Multifaceted Problem) of the Board of Trustees, and the preventive diagnostic and therapeutic recommendations in that report.

- AMA reaffirms its previous policy and explores the feasibility of developing a voluntary office visitation program to assess the policies, procedures and education programs that are in place concerning prevention of HIV/ HBV transmission. This effort would include exploring the feasibility of developing minimal guidelines for physician offices.

Organized Medicine's Role in Health Care Policy Development and Implementation

Several resolutions were submitted dealing with the ability of physicians to act collectively and to negotiate. After much debate, the House adopted the following substitute resolution:

RESOLVED, That in order to maintain the role of physicians as patient advocates, there should be appropriate legislative, regulatory, and judicial action providing for formal physician organization involvement in all areas of public and private sector health care policy development and implementation. This shall include, but not be limited to: review of quality and appropriateness of care, appropriateness of payments and fees, negotiation of reimbursement, and predictability of health care costs; and shall not exclude any other areas of legislative or regulatory activities affecting physicians; and be it further

RESOLVED, That the AMA continue to seek, as the highest of priorities, the necessary changes in the antitrust laws to permit involvement of organized medicine in the negotiating process, which is inherent in the development and implementation of all areas of health policy; and be it further

RESOLVED, To reaffirm present policy of the House of Delegates, that the American Medical Association shall not endorse or advocate price fixing in any form, or budget predictability achieved by expenditure targets, budget caps or global budget limits; and be it further

RESOLVED, That the Board of Trustees establish an Ad Hoc Technical Advisory Committee to help explore and define the options and activities necessary to achieve the policies set forth by the establishment of formal physician organization involvement in the development and implementation of health care policy and to include options outlining alternative approaches and innovative concepts (such as mandatory membership in state or national medical societies) that may be necessary to allow the voice of medicine to speak with maximum authority.

The Board is expected to report back to the House at the 1992 Interim Meeting on the activities and progress made relating to the provisions of this Resolution.

Peer Review Organizations

The Board of Trustees and the Council on Medical Service each submitted a report that presented a status report on the Peer Review Organization program and address physicians' concerns regarding the Uniform Clinical Data Set.

Health Access America and the "Play-or-Pay" Approach to Health System Reform

The Board submitted two reports and the House received twelve resolutions on issues surrounding the provision of access to health care and recent proposals described as "play or pay."

The Board concluded that Health Access America has enabled the Association to provide a leadership role and to be at the forefront of health care reform efforts in this country. The Board presented several recommendations designed to strengthen the AMA's House Access America proposal, which were amended, then adopted by the House. They read as follows:
The Board of Trustees recommends that:

1. The AMA seek to have discussions with the American Hospital Association, the Pharmaceutical Manufacturers Association, and other relevant national organizations regarding development of guidelines for the release of price information on hospital charges, drugs, and medical devices to physicians and the public.

2. The AMA analyze the impact of marketing new technologies before adequate clinical trials on overall health care expenditure growth and develop recommendations, as appropriate, to address the effect of such marketing activities on rising health expenditures.

3. The AMA adopt the following policy modifications to Health Access America:
   a. Employer Required Insurance
      Employers who fail to provide the required coverage shall be subject to a penalty and to payment for eligible health care costs incurred by an employee or dependent.
   b. Health IRA/Tax-Preferred Plans
      When employers and employees reach a voluntary agreement to increase the deductible beyond the AMA minimum benefits plan, tax incentives should be provided to encourage contributions to Health IRAs or similar tax-preferred plans.
   c. Special Assistance to Small Employers
      Small employers shall receive a refundable tax credit for premium amounts for the required minimum benefits policy which exceed a designated percentage of payroll/wages and before-tax income.
   d. Uniform Electronic Billing
      Health insurers and physicians shall be provided incentives to switch to uniform electronic billing in a uniform format within a designated period of time. No physicians should ever be penalized for not adopting electronic billing systems.
   e. Managed Care
      Physician-based managed care is an option some purchasers may choose. It should be one choice in a pluralistic system and should comport to the following key principles, which are intended to supplement existing AMA policy on managed care:
      1) Managed care programs should compete openly and equally in the health care market with other delivery systems. Individual preferences should be the sole determinants of growth in any mode of delivery (i.e., managed care vs. any other mode of delivery). Public policy should be neutral.
      2) Reimbursement under managed care programs should be easy to administer, promote quality health care, occur in a timely fashion, and be viewed as fair by all concerned parties.
   3) Managed care programs should disclose, in simple and understandable terms, the nature of any cost control mechanisms and other review procedures and policies to actual or potential beneficiaries.
   4) Patient access to necessary medical care should not be limited by financial incentives to physicians or others.
   5) Utilization review under managed care programs should be based on open and consistent review criteria that are acceptable to, and have been developed in concert with, the medical profession. Physicians (with background appropriate to the care under review) should have the ultimate responsibility for determining the necessity and quality of care. Physicians should be licensed in the state in which the services that they are reviewing are performed. Professional review by a physician should be readily and promptly available. Doctor-to-doctor communications should be encouraged.
   6) Legislation should be enacted relative to managed care programs that would allow broader physician negotiation regarding quality of care, adequacy of payment rates, and other appropriate provisions of managed care programs.
   7) Standardization and methods of accreditation for man-
aged care programs should be pursued.

8) In public programs and any others where the administrative costs of managing care is not included in the premium, there should be frequent cost/benefit analyses of the programs' review techniques.

9) In all programs, there should be biennial assessments, which are made public, of the effect of managed care on quality of care.

f. Part-time Workers

All employers shall be required to provide their part-time workers with an insurance voucher, equal to a designated percentage of the worker's gross pay. The voucher would be redeemable toward the purchase of a private sector health insurance policy, meeting the standards of the AMA minimum benefit plan, for the worker and his/her family.

The Board of Trustees continues to analyze additional cost containment options for possible inclusion in Health Access America as appropriate.

National Practitioner Data Bank

A report of the Board described the political and practical implications of the policy to seek to abolish the data bank and requested deferral of action on this policy at this time. This controversial issue has been before the House on several occasions and the delegates again grappled with determining the best course of action.

With over 400 items of business, it is impossible to cover every issue in this short report. In other actions the House of Delegates voted policies to guide the American Medical Association Future activities:

Concurrent Care

RESOLVED, That the American Medical Association seek enactment of federal legislation and/or a change in HCFA policy to establish more equitable standards for fair and prompt payment for concurrent care for both primary care and specialist physicians; and be it further

RESOLVED, That the American Medical Association seek uniformity among Medicare carriers and other third party payers in application of concurrent care policies and seek to allow physicians to be identified by their specialty and subspecialty as reported to the carrier, rather than by an arbitrary carrier definition for such policies, and that medical subspecialties not be included in the broad category "internal medicine"; and be it further

RESOLVED, That the American Medical Association request that HCFA appropriately reimburse primary care physicians (MD/DO) for medically necessary documented services such as counselling and coordination of care in the surgical patient; and be it further

RESOLVED, That the American Medical Association communicate to HCFA the importance of carrier understanding that more than one physician can be involved in a case and that the carrier or insurance company not expect a physician to manage a medical problem outside his/her area of expertise or specialty, and that both the primary care physician or other specialist be reimbursed for this care in accordance with their responsibilities; and be it further

RESOLVED, That the American Medical Association use all appropriate means to have HCFA and/or its carriers not routinely deny all but the first claim received for services rendered to the same patient on the same day for the same diagnosis and that the AMA urge that carrier systems not automatically reject such claims.

Current Procedural Terminology

RESOLVED, That the American Medical Association continue to work to improve the CPT process by encouraging specialty societies to participate fully in the CPT process; to continue to enhance communications with specialty societies concerning the CPT process and subsequent appeals process; and to assist specialty societies, as requested, in the education of their members concerning CPT coding issues.

Clinical Laboratory Improvement Act of 1988 (CLIA '88)

RESOLVED, That the American Medical Association continue to vigorously pursue legislative, legal or consultative action to ensure more appropriate placement of tests into a broadened waived category under the Clinical Laboratory Improvement Amendments of 1988 (CLIA '88) to not further impede the timely provision of quality care; and be it further

RESOLVED, That the AMA monitor potential effects that CLIA '88 will have on the quality and cost of health care; and be it further

RESOLVED, That the AMA aggressively pursue appropriate action so
that physicians will pay only a proportionate share of the costs of implementing CLIA '88, commensurate with the volume of testing they perform; and be it further

RESOLVED, That the AMA, with state medical and national medical specialty societies, publicize information about Commission on Office Laboratory Accreditation (COLA) and encourage that all physicians seek clinical laboratory accreditation through COLA in lieu of federal or other government certification.

Tobacco

Advertising Aimed at Children

RESOLVED, That the American Medical Association call on the R.J. Reynolds Tobacco Company and other tobacco companies to refrain from engaging in advertising practices which either intentionally or inadvertently target children; and be it further

RESOLVED, That the American Medical Association support the concept of free-of-charge advertising space for anti-tobacco public service advertisements.

In the Workplace

RESOLVED, That the American Medical Association use active political means to encourage the Secretary of Labor to swiftly promulgate an Occupational Safety and Health Administration (OSHA) standard to protect American workers from the toxic effects of environmental tobacco smoke in the workplace, preferably by banning smoking in the workplace.

On International Flights

RESOLVED, That the American Medical Association join with other concerned organizations to seek a Federal Aviation Administration ban on smoking on all flights originating from or destined to the United States; and be it further

RESOLVED, That the AMA, the World Health Organization, and the World Medical Association work with the medical department of the International Civil Organization (ICAO) to ban smoking on all international flights.

Conclusion

AMA House meetings provide a unique educational opportunity and we would encourage you to attend and participate. Any member of the Association may present testimony at the Reference Committee hearings and, of course, corridor discussions on the issues provide ample opportunities to get your views across.

The item of greatest concern to the insurance industry was Report E of the Council on Ethical and Judicial Affairs, entitled "Predictive Medical Testing by Health Insurance Companies," which recommended in part,...people should not be denied health insurance, or have their premiums raised, because they have an elevated risk for developing disease. Medical tests to predict a person's predisposition for disease should therefore not be used by health insurance companies in the underwriting process. As a corollary, health insurance companies should not obtain results of predictive medical tests that have been performed by the applicant's physician." Your delegates were able to obtain advance copies and mount a successful campaign in defeat of this report by highlighting serious flaws in the body of the report. AAIM's alternate delegate Bob Davies was particularly eloquent in testifying before the reference committee.

If you can't come to the meeting, you can still be represented through your delegate. Let your delegate know your opinions. You can also prepare a resolution and request that it be submitted to the House.

Respectfully submitted,

Franklin A. Smith, MD
AAIM Delegate
House of Delegates, AMA