AMERICAN ACADEMY OF INSURANCE MEDICINE

AAIM Delegate to the AMA Report

1993 Annual Meeting of the House of Delegates, American Medical Association

Introduction

- There were 435 delegates seated, representing state medical associations, national medical specialty societies, AMA Sections, the Armed Forces, and the U.S. Public Health Service.
- The House agenda contained 117 reports and 229 resolutions.
- The First Lady, Hillary Rodham Clinton, addressed an overflow audience at the Opening Session, receiving much applause from the delegates as she spoke to many of the major concerns of physicians, e.g. CLIA regulations, third party interference, professional liability reform, and quality of care. Over 200 reporters covered her address, and the AMA received extensive press that was generally favorable to the AMA and American medicine.

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

Harnessing Market Forces in Medical Pricing

The House considered a major report of the Board and four resolutions pertaining to physician payment under Medicare RBRVS. The House took the following actions to guide the Association in the coming months:

1. That the AMA continue its policy of non-endorsement of the Medicare RBRVS-based physician payment system until such time as it is adequately corrected and refined.
2. That the AMA call for HCFA to conduct a study and collect cost data necessary for development of a resource-based approach to practice expenses for the Medicare RBRVS with all deliberate speed. In addition, that the AMA advocate that HCFA be given the authority to immediately correct identified anomalies in the current RBRVS practice expense relative value units. All applications of these methods should refrain from reductions in payments for services without complementary increases in services that this method identifies as "undervalued."
3. That the AMA advocate the following principles for physician payment under Health Access America and any other relevant health system reform proposal:
   A. A resource-based relative value scale (RBRVS) that is annually updated and rigorously validated could be a basis for non-Medicare physician fee and payment schedules.
   B. Payors could make their fee-for-service payments with a payment schedule based on the national standard RBRVS.
   C. Physicians could likewise base their fees on the national standard RBRVS. Fees would be based upon a physician conversion factor determined by physicians' assessment of their overhead and the market value of their services.
   D. All third party payors using this method would provide their enrolled beneficiaries with: a copy of the current national standard RBRVS; the plan's current conversion factor; and any plan RBRVS adjusters.
   E. In managed care plans, government plans, and health plans as feasible, payor conversion factors should be negotiated between individual health plans and the affected physicians.
4. That the AMA Board of Trustees provide assistance and guidance to state medical associations, national medical specialty societies, physician practices, and public and private third party payors to help ensure that any potential non-Medicare use of an RBRVS reflects the most current and accurate data and implementation methods.
5. That the AMA actively support the position that the RBRVS should not be implemented by private payors as a cost containment device; savings from payment reductions should be used
for the purpose of increasing payments for undervalued services.

6. That the AMA reaffirm policies which hold that a relative value scale, a tool for use by physicians and/or payors, if not, in and of itself, a fee schedule, and that the AMA continue its strong opposition to implementation of any mandatory fee schedule.

7. That the AMA reaffirm the policy which, as part of Health Access America, calls for employers to make available to their employees a triple option in health plans: a benefit payment schedule, a UCR plan, and a pre-paid plan.

Health System Reform

The House considered three reports and three resolutions on health system reform under consideration by the Clinton Administration. The House voted to:

1. Continue to provide action oriented assistance to the states on all aspects of health system reform, including assistance on the individually mandated health insurance reform option.

2. Reaffirm policy supporting the continuation of AMA activities to reform sensibly the Medicare program in a manner that will:

A. Examine the long-term care needs of the Medicare eligible population.

B. Address the health care needs of the next generation of Medicare beneficiaries.

C. Reduce hassles imposed on physicians, hospitals, other providers of health care service and beneficiaries.

D. Recognize the economic status of program beneficiaries.

E. Address pressing funding needs.

F. Address the issue of the crisis developing over rising health care costs.

3. Support a blend of private and public responsibilities as the best position for the AMA.

4. Call for a Council on Medical Service report to the House on the following issues: (1) the extent to which a system of individually-selected and owned health insurance should be the long range goal of the AMA; (2) the feasibility of mandatory employer responsibility for ensuring that employees choose and own their own health insurance; and (3) discussions with large and small employers to determine their views and obtain their suggestions on this issue.

5. Reaffirm opposition to global budgeting, expenditure targets, price controls, and similar methods of limiting health care expenditures, yet acknowledge that some state medical associations are in favor of a budgeting process that incorporates the ability for physician groups to bargain collectively on state-level budgets and supports these state medical associations in their negotiations and development of budgeting process.

6. That the AMA reaffirm its strong opposition to implementation of any mandatory fee schedule.

In a related action the House directed that the Board of Trustees:

- make certain that the preventive, diagnostic and therapeutic services in the required benefits package are scientifically valid,

- develop an actuarially validated cost estimate of the plan based upon implementation in different geographic and population areas of the country, under a variety of cost sharing provisions and under a variety of health care delivery models, i.e. HMO, PPO, benefit payment schedule, etc.,

- study the fiscal impact of said benefit plan on individuals, the business community and the government if said benefit plan would be required for all citizens of the country.

The House approved the recommended benefits package proposed by the council and asked the AMA to advocate the proposal within the context of AMA's Health Access America. The House also adopted a recommendation that units of the Federation considering the need for further modification of this required package use the same process used by the Council. The House approved the recommendation that the AMA continue to encourage and support outcome studies, development of additional practice parameters based on these studies, and further refinement of the required benefits package based on such studies.
Repeal of CLIA

The inordinate regulatory burden imposed by CLIA engendered much debate. The Board of Trustees submitted a report detailing an impressive progress report on efforts to alleviate the CLIA regulatory burden and also reported that more substantial relief is imminent.

In a related action the House voted: "That the AMA continue to support eliminating the full weight of regulatory requirements through the development of an expanded and modified free-standing physician testing category that would allow physician-supervised personnel to perform tests necessary for the treatment of the physician's patients." 

Enterprise Liability

"Enterprise" or "organizational" liability is a concept widely reported to be under consideration by the White House Task Force on Health Care Reform. All medical liability exposure would be transferred away from individual physicians to the "Accountable Health Plan" (AHP) or hospital institution, which would then become the single defendant in a medical malpractice lawsuit. The AHP or hospital would be empowered to implement and enforce effective patient safety/risk management education and regulation of its medical staff.

Testimony before the Reference Committee was consistent in pointing out that enterprise liability threatens physician autonomy and would likely increase the costs of liability due to the fact that so-called enterprises will be perceived as having deeper pockets than physicians, and also they will be viewed as faceless entities that will not be harmed by lawsuit.

The House adopted the recommendations contained in Board of Trustees report that called on the AMA:

1. To affirm its position that effective medical liability reform based on California's MICRA model is integral to health system reform, and must be included in any comprehensive health system reform proposal that hopes to be effective in containing costs, providing access to health care services and promoting the quality and safety of health care services,

2. To continue to support strong patient safety initiatives and the investigation of alternative dispute resolution models, appropriate uses of practice parameters in medical liability litigation and other reform ideas that have the potential to decrease defensive medicine costs and more fairly and cost-effectively compensate persons injured in the course of receiving health care services.

AMA Dues

Noting that the dues levels have remained unchanged for the past five years and that a small increase in dues is necessary to continue the AMA's advocacy activities on behalf of physicians, the House approved a recommendation to increase the dues by $20 for 1994.

AMA's National Campaign Against Family Violence

The House approved a series of policy statements related to AMA's National Campaign Against Family Violence in the areas of (1) recognition, safety, and treatment; (2) coordination of efforts of violence control and prevention activities; (3) primary prevention; and (4) called for a study of the problem of domestic violence in doctor's families and make recommendations concerning approaches to recognition and treatment.

These policies call for the provision of educational and training programs for physicians in diagnosing, treating, and referring cases of abuse constituting family violence and working with local medical societies, governmental and community groups in the development of violence control and prevention activities, and support the establishment of violence prevention committees made up of physicians and members of the AMA Alliance. Also, physicians should be encouraged to routinely screen for the effects of violence and abuse in all patients.

Thermography Update

The Council on Scientific Affairs submitted an update on its report on thermography which was first submitted in 1987. The House approved as amended the Council's recommendations as follows:

1. That, in view of the lack of sufficient proof of effectiveness, it is the policy of the AMA that the use of thermography for diagnostic purposes cannot be recommended at this time. It should be noted that research protocols using thermography are continuing and data derived from these studies will require careful evaluation.

2. That the AMA continue to monitor the published literature on thermography, with periodic reports as appropriate.

3. That the AMA affirm the principle that proponents of a test, procedure, or treatment should bear the burden of proving that it is safe and effective for the proposed purpose through well-designed and well-controlled clinical trials. The results of these trials should
be critically reviewed, preferably through reports submitted to peer-reviewed journals.

Election Results

President-Elect
Robert E. McAfee, MD (Maine)

Speaker, House of Delegates
Daniel H. Johnson, Jr., MD (Louisiana)

Vice Speaker, House of Delegates
Richard E. Corlin, MD (California)

Board of Trustees
Palma E. Formica, MD (New Jersey)
Donald "Ted" Lewers, MD (Maryland)
P. John Seward, MD (Illinois)
Frank B. Walker, MD (Michigan)
Michael S. Goldrich, MD (Resident)

Council on Constitution and Bylaws
Jack T. Chisolm, MD (Texas)
Ronald J. Clearfield, MD (Pennsylvania)

Council on Medical Education
William E. Golden, MD (Arkansas)
Thomas S. Harle, MD (Texas)
Richard J. D. Pan, MD (Resident)

Council on Medical Service
Herman I. Abromowitz, MD (Ohio)
William A. Fogarty, MD (Wyoming)
T. Reginald Harris, MD (North Carolina)
John A. Knote, MD (Indiana)

Council on Scientific Affairs
Ronald M. Davis, MD (Michigan)
John P. Howe, III, MD (Texas)
Patricia Joy Numann, MD (New York)
W. Douglas Skelton, MD (Georgia)

Conclusion
AMA House meetings provide a unique educational opportunity and I would encourage you to attend and participate. Any member of the American Medical 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.

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. AAIM's alternate delegate, Dr. Bob Davies of Nationwide, or I would be pleased to receive your input or to help you arrange attendance at an upcoming House of Delegates meeting, if you would like.

Franklin A. Smith, MD
Delegate

A. Robert Davies, MD
Alternate Delegate