Association of Life Insurance Medical Directors of America

ALIMDA Delegates' Report
of the 1989 Annual Meeting of the
American Medical Association
House of Delegates

Introduction:
The AMA House of Delegates met in Chicago June 18-22, 1989. There were 435 delegates seated including 347 delegates representing state medical associations, 78 delegates representing national medical specialty societies (including ALIMDA) and 10 section and service delegates representing medical students, medical schools, residents, hospital staff, young physicians, Army, Navy, Air Force, U.S. Public Health Service, and the V.A. The applications of two additional specialty societies were approved by the House for seating at this meeting.

Significant speeches included that of AMA President, James E. Davis, MD. Dr. Davis reiterated his call for physicians to make a commitment to community service, and reviewed the status of American medicine. An address by Louis W. Sullivan, MD, Secretary of the U.S. Department of Health and Human Services and the remarks of James H. Sammons, MD, Executive Vice President of the AMA were also received. There were 94 reports and 269 resolutions concerning AMA policy which were considered during the meeting. Most of these revolved around 16 major issues of which 11 were of immediate interest to the insurance industry.

Expenditure Targets
The U.S. House of Representatives Ways and Means Committee began considering expenditure targets while the House of Delegates was in session in Chicago. Expenditure targets (E.T.) are government established expenditure goals for total physician services under Medicare, Part B. If the targets are exceeded then Medicare physician payment changes would be adjusted downward accordingly across the board.

The purpose of expenditure targets is to reduce the amount of physician services the government pays for. They are justified by the Physician Payment Review Commission and others based upon the need to reduce the federal deficit. The targets are said to take into account increased demand and other factors which would increase costs. The government, not the medical profession, will establish such targets. The government's stated first concern for Medicare is to reduce spending to reduce the deficit.

"Even if the government were committed to fair targets and had a fair process for physician negotiation and input (of which there is none proposed), targets cannot be established scientifically, either before or after the services are provided. There simply is no way to measure or prove appropriate increases in demand or appropriate increases in costs from technological advances. The targets will inevitably be arbitrarily low as health care spending competes with other government priorities. That is the experience in Canada and every other country that has capped or targeted government health care expenditures."

After lengthy discussion, the House of Delegates adopted the following resolution on this issue:

RESOLVED, that the American Medical Association reaffirm its willingness to participate in efforts to control the cost of Medicare in a manner that preserves the quality and availability of health care to Medicare recipients; and be it further

RESOLVED, that the AMA reaffirms its position that the Medicare program establish actuarially sound financing of benefits as stated in Board of Trustees Report MM (A-86); and be it further

RESOLVED, that the AMA urge Congress to incorporate the following considerations when applying budgetary controls to Medicare in place of Expenditure Targets:

(a) Assure a high priority to health care for Medicare patients in relation to other programs when allocating federal funds.

(b) Given Medicare's finite resources, develop a mechanism to channel those resources to those patients with greater financial need and to require a proportionately larger financial contribution by the more affluent towards their own health care.

(c) Reduce the cost of defensive medicine (approximately $20 billion a year) caused by the present tort system.

Covering the Uninsured
The AMA House of Delegates considered a Board report and three resolutions dealing with providing health insurance to the uninsured. After extended debate, the House adopted an amended version of the Board report that recommends that the AMA:

1. Endorse the concept of a phased-in requirement that employers (limited initially to larger employers) provide health insurance coverage within the private sector for all full-time employees, with coverage expanding over several years and with a program of diminishing tax credits or other incentives to avoid adverse effects on employers;

2. Continue to study all approaches to providing health services for the uninsured and work with business groups to develop approaches that are best suited to the needs of small employers and report to the House of Delegates at the 1989 Interim Meeting; and
3. In conjunction with other health organizations begin the development of a package of basic health benefits.

Misleading Explanation of Benefits Language

The House filed a report of the Council on Medical Service which described the efforts of the Council to develop accurate and clear explanation of benefits language for use by third party payors.

The House also adopted the following additional resolutions:

that the AMA continues to seek action which will direct HCFA to provide to both physicians and beneficiaries on all Medicare claims (whether assigned or non-assigned) a copy of the Explanation of Medicare Benefits in language easily understandable to physicians and patients.

that the AMA seek to remove, on the Explanation of Medicare Benefits sent to patients of Medicare non-participating physicians, all statements regarding the participation status of the physician and the alleged benefits associated with the assignment of claims from seeing participating physicians.

Medicare Reimbursement, Geographical Differences

The House adopted, as amended, a Council on Medical Service report that described current AMA activities to improve rural health care and to remedy geographic physician payment inequities under Medicare. The report recommended setting a floor on prevailing charges for all services at 80% of the national prevailing charge for those services.

In related actions, the House called on the AMA to:

support elimination of most Medicare reimbursement differentials between urban and rural medical care and that AMA inform the Congress of the impact of such differentials on the rural population.

reaffirm its policy that geographic variations under a Medicare payment schedule reflect only valid and demonstrable differences in physician practice costs, with further adjustments as needed to remedy demonstrable access problems in specific geographic areas.

Resource-Based Relative Value Scale for Physician Services

The House amended and then adopted a Board report that provides an update on recent events involving the RBRVS and calls on the AMA to:

1. reaffirm its support for an indemnity payment schedule

2. support reasonable attempts to remedy geographic payment inequities that do not conflict with AMA support for an RBRVS-based indemnity system

3. continue to seek implementation of an RBRVS-based indemnity payment system upon the expansion, correction, and refinement of the RBRVS

4. oppose any efforts to link acceptance of an RBRVS with any proposal that is counter to AMA policy, such as expenditure targets and mandatory assignment

5. continue to oppose the arbitrary and unwarranted use of so called “overpriced procedure” reductions as part of the fiscal year 1990 budgetary process, the use of data generated by the yet-to-be-completed Harvard RBRVS study to determine such payment cuts, and especially, the use for this purpose of RBRVS data for specialties whose RBRVS results are being restudied as part of Phase II of the RBRVS study.

In a related action the House also adopted a resolution that called on the AMA:

to develop and aggressively seek Congressional sponsorship and support for federal legislation that would allow AMA and the state medical associations, on behalf of physicians, to negotiate payment schedules on federal and state policies respectively, impacting on physician reimbursement.

Strengthening the U.S. Health Care System

The Board of Trustees announced a major initiative involving the commitment of substantial resources to ensure that the advantages of the U.S. health care system is maintained. The initiative also will include significant resources to see that the public and others are fully aware of the benefits of American medicine.

Key programs include:

Medicaid expansion
coverage for the uninsured
Medicare reform

The Board report indicated that:

it is not an overstatement to emphasize that American medicine is at a crossroads, with one road leading to government controls, rationing of care, and other objectionable results inherent in a nationalized system and the other leading to a strengthened U.S. system preserving the advantages of the American system.

Study of the Canadian Health Care System

The Board presented a brief evaluation of the Canadian health care system. It concluded that:

while the Canadian system has many positive features it may not be best suited to post-industrial societies. It also stated that while costs might be reduced, the centralized controls required would make it an unsatisfactory model to be followed by the United States.
Medicare Denials of Payment for Substandard Care

Ten resolutions were submitted pertaining to the controversial proposed Health Care Financing Administration (HCFA) regulations on “Denial of Payment for Substandard Quality Care and Review of Beneficiary Complaints.”

The House adopted a resolution calling on the AMA to:

1. seek withdrawal of the proposed rule
2. use all available options, including possible legal action, to prevent further implementation until due process considerations are addressed
3. assure that quality of care decisions under these regulations be made by identifiable PRO physician reviewers, based on their clinical experience and judgment rather than reliance on mandated written criteria
4. assure that PRO physician reviewers making a quality denial be required to consult with a physician in the same specialty and practice situation before final action on only quality denial.

National Practitioner Data Bank

Four proposed resolutions addressed a growing concern with the development of the National Practitioner Data Bank project. A resolution was adopted that contained several directives:

1. That the American Medical Association request a modification of the National Practitioner Data Bank requirements so that settlements and judgments of less than $30,000 are not reported or recorded;
2. That reports, other than licensure revocation, in the data bank be purged after five years;
3. That procuring of physicians for the purpose of investigation not be reportable;
4. That physicians not be required to turn over copies of their data bank file to any third party not authorized direct access to the data bank;
5. That the AMA seek to assure that any physician’s statement included in the data bank file automatically accompany any adverse report about that physician in distributions from the data bank;
6. That the AMA, in addition to publishing articles in AMNews, develop additional educational materials as appropriate for physicians to understand the implications of the National Practitioner Data Bank.

Medicare ICD-9-CM Coding

The Catastrophic Coverage Act of 1988 contained a diagnostic coding requirement that carries a civil money penalty provision for failure to utilize ICD-9-CM coding. The House adopted a resolution that calls on the AMA to:

1. support legislation to repeal or substantially ameliorate the threat of federal civil money penalty liability for failure to utilize ICD-9-CM and DSM III coding in filing Medicare claims;
2. seek amendments to the quasi-criminal Medicare civil money penalty process by providing to those charged with civil offenses the same rights now available to defendants in criminal proceedings;
3. make every effort to assure that HCFA’s implementation of the coding requirement be undertaken with a view to minimizing compliance difficulties to physicians and their office staff;
4. review all other Medicare civil monetary penalty provisions, assess the reasonableness of these fines and the process available to physicians to challenge civil fines levied against them, and report its findings and recommendations to the House of Delegates at the 1989 Interim Meeting;
5. request Congress to repeal the ICD-9-CM coding requirement for physician services under Medicare.

AIDS

At the 1987 Annual Meeting the House adopted its landmark AIDS policy that provided physicians with a coherent, comprehensive response to the AIDS epidemic. Given the complexity of the AIDS-related issues, advances in the detection of viral infection, and the changing nature of the AIDS epidemic, the House referred 10 resolutions to the Board of Trustees and asked the Board for an updated policy report on AIDS at the 1989 Interim Meeting (December 1989).

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In addition to these pertinent issues, the House of Delegates established AMA policy calling for restrictions on private ownership of “assault” firearms, supporting a national policy pertaining to adverse health effects of environmental pollution, reaffirming a program to achieve a smoke-free society by the year 2000, and items concerning physician collective negotiation and physician ownership in healthcare facilities.

ALIMDA delegates spoke in Reference Committee and/or the House debate concerning a resolution calling for mandated insurance coverage for all diagnostic and therapeutic services for infertility. This was defeated. We also addressed a report from the Council on Medical Service recommending new definitions for reconstructive and cosmetic surgery which significantly broadened the AMA accepted definition of (medically necessary) reconstructive surgery and further obfuscated the differentiation between this and purely elective beautification. The new definitions were adopted despite our testimony.
Election Results

Annual elections resulted in the following selections for expiring terms of office:

**President-Elect**
C. John Tupper, MD, of California

**Speaker, House of Delegates**
John L. Clowe, MD, of New York

**Vice Speaker, House of Delegates**
Daniel H. Johnson, Jr., MD, of Louisiana

**Board of Trustees**
Nancy W. Dickey, MD, of Texas
William E. Jacott, MD, of Minnesota
John J. Ring, MD, of Illinois
Frank B. Walker, MD, of Michigan
Mary Ann Contogiannis, MD (Resident)

**Council on Constitution and Bylaws**
James F. McDonough, MD, of Massachusetts
Linda D. Warren, MD, of Kansas

**Council on Medical Education**
John E. Chapman, MD, of Tennessee
William E. Golden, MD (term to end in 1990) of Arkansas
J. Lee Dockery, MD, of Florida
George T. Lukemeyer, MD, of Indiana
Charles D. Sherman, MD, of New York

**Council on Medical Service**
H. Christopher Alexander, III, MD, of Virginia
Donald K. Crandall, MD, of Michigan

**Council on Scientific Affairs**
Mitchell S. Karlan, MD, of California
William R. Kennedy, MD, of Minnesota
A. Bradley Eisenbrey, MD (Resident)

**Council on Medical Education**

**Council on Medical Service**

**Council on Scientific Affairs**

**ALIMDA and the House of Delegates**

The AMA House of Delegates has begun periodic review of seated specialty societies with a plan to remove those which fall short of the standards established for entry. ALIMDA will be reviewed in 1990. OUR CONTINUED MEMBERSHIP IN THE HOUSE OF DELEGATES SEEMS ASSURED PROVIDED THAT WE ARE ABLE TO DEMONSTRATE THAT AT LEAST 50% OF ELIGIBLE MEMBERS OF ALIMDA ARE ACTIVE AMA MEMBERS.

IF YOU ARE NOT AN AMA MEMBER, PLEASE RECONSIDER JOINING NOW. Information can be obtained from your local medical society or contact me directly. If membership in county, state and American associations exceeds your budget, consider a separate, direct AMA membership. Please do whatever you can to be certain that ALIMDA continues to retain this representation in the House of Delegates of the American Medical Association.

**Conclusion**

AMA House meetings provide a unique educational opportunity. I would encourage you to attend and participate whenever possible. 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. If you can't come to a 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 for consideration as AMA policy. Many AMA policies began with an individual physician who had a good idea and coaxed it through the democratic process.

Roger H. Butz, MD
ALIMDA Delegate to the AMA