AAIM Delegate to the AMA
Report

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

Introduction

- The House considered 231 resolutions and 90 Board and Council reports on a wide variety of national issues of critical importance to the future practice of medicine and the future health and well-being of the American people.
- There were 436 delegates seated.
- The House composition is:
  - 343 delegates representing state medical associations
  - 83 delegates representing national medical specialty societies
  - 10 delegates representing medical students, resident physicians, hospital medical staffs, medical schools, young physicians, Army, Air Force, Navy, United States Public Health Service, and the Veterans Administration.

Health System Reform

The House of Delegates considered eight reports and a number of resolutions addressing the issues surrounding health system reform. These issues such as managed care, managed competition, negotiations, global budgeting, and refinements to AMA's Health Access America dominated the time and attention of the delegates.

The House adopted a large body of policy decisions designed to guide the AMA's activities in the coming months under the new Clinton Administration.

Regarding organized medicine's role in health care policy development and implementation, the House amended and adopted the following recommendations:

1. That the AMA continue its aggressive leadership campaign for antitrust relief and legal and legislative recognition of physicians' right to negotiate.

2. That the AMA continue to position the Association to provide rapid, judicious, and effective actions and responses regarding negotiating roles that allow physicians to protect the interests of patients and legitimate interests of their own.

3. That the AMA commit itself to the establishment of mechanisms to fulfill essential standards setting roles necessary to assure the quality and cost effectiveness of medical services provided through public and private health plans and, where appropriate, invite other organizations (such as, national medical specialty societies, or provider trade associations, associations of private payers, government agencies or public interest groups) to participate in these mechanisms.

4. That the AMA support the creation of a national health advisory body or task force that will form a public/private partnership with the AMA to formulate policy and implement activities in areas except for global budgets, expenditure targets or payment determination.
5. At a time of the potential for imminent health system reform the House of Delegates empower the Board of Trustees to act on behalf of the Association to promote proactively and negotiate for those elements of health system reform which they feel will best represent the interests of patients and the profession.

Managed Care – Policy and Initiatives

The House considered a major report on managed care that summarized key policy assumptions underlying managed care, presented physician, purchaser, and patient perspectives on managed care, and described the current environment with respect to the inclusion of managed care in health system reform proposals.

The House amended and adopted the following recommendations:

1. That the AMA adopt the policy that all "hold harmless" clauses in managed care contracts should be explicitly identified as such and urge physicians to consult with legal counsel prior to contracting with a managed care entity to prevent the imposition of unfair liability upon the physician and that the AMA develop model state legislation to prohibit "hold harmless" clauses in managed care contracts and encourage state medical societies to pursue such legislation.

2. That the AMA continue to advocate strongly to Congress, the Department of Justice, and the Federal Trade Commission the need for changes in relevant antitrust laws to allow physicians and physician organizations to form bargaining groups to engage in group negotiations with managed care plans.

3. That the AMA adopt the following policy statement on utilization review: "Utilization review under managed care programs shall be based on open and consistent review criteria that are acceptable to and have been developed in concert with the medical profession. Managed care programs shall use actively practicing physicians engaged in direct patient care at least 20 hours per week in the same specialty as that of the physicians under review in any decision to deny or reduce coverage for services based on medical necessity or quality of care determinations. Physicians reviewing the medical necessity and/or appropriateness of services or site of services under managed care programs shall be licensed and engaged in the practice of medicine 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."

4. That the AMA continue to advocate strongly and refine further, as appropriate, the managed care provisions contained in health Access America.

5. That the AMA support, and pursue an active role in, the development of national managed care and utilization review standards.

6. That the AMA support, and pursue an active role in, the creation of a national managed care/utilization review accrediting or certifying process when acceptable national standards are developed.

7. That the AMA extend its policy on managed care programs so that such programs make available to physicians under review the identities and credentials of the physician reviewers.

8. That the AMA study the concept of establishing managed care appeals bodies with the power to suspend a reviewing physicians' right to participate in further review based on a pattern of reversals on appeal.

9. That the AMA reaffirm the portion of its existing model state legislation that calls for certain elements of utilization review to be defined as the practice of medicine.

10. That the AMA reaffirm its policy that payors be liable for harms resulting from the results of any review decisions.

11. That the Council on Medical Service be commended for and requested to expedite its development of guidelines for managed care.

Managed Competition

In related action, the House amended and adopted a number of recommendations addressing a new term "managed competition" that frequently enters the debate on health system reform. The House recommended that:

1. The AMA adopt the following policy position: Health system reform proposals that concentrate unfairly the market power of payors are detrimental to patients and physicians, if patient freedom of choice or physician ability to select mode of practice is limited or denied. Single-payor 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 payors and physicians or be opposed.

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2. The AMA continue to support a pluralistic health care system, with no preferential treatment by government that gives a competitive advantage to any form of health insurance/health care delivery organization. In particular, integrated systems, as defined in the report, should be given no competitive advantage.

3. The AMA propose and support legislative or regulatory action requiring employers to offer a benefit payment schedule plan, in addition to other plans.

4. The AMA continue to advocate strongly to Congress, the Department of Justice, and the Federal Trade Commission, the need for changes in relevant antitrust laws to allow physicians and physician organizations to engage in group negotiations with collective purchasers, managed care plans, insurers and other payors.

5. The AMA make support for any "managed competition" proposal contingent, in part, on:
   - relief from existing antitrust laws with respect to the right of physicians and physician organizations to engage in group negotiations with collective purchasers, managed care plans, insurers and other payors.
   - modifications to ERISA to ensure that any rules and negotiation requirements apply equally to self-insured and insured health benefit plans.

6. That the AMA study appropriate means of risk indexing and adjusting premiums used under any "managed competition" proposals.

Negotiations Issue - Current Activities

In responding to a resolution at the 1992 Annual Meeting, the Board of Trustees reviewed three initiatives recommended by the Board to:
1. That the AMA continue to pursue enhanced involvement in the development of health care policy and regulations by the federal Medicare program and Medicaid programs, including the use of mechanisms established by the AMA and the national medical specialty societies, with participation by other provider and trade associations in the health care industry and representatives of the federal government, for the purpose of developing Medicare and Medicaid medical review criteria.

2. That the AMA continue to pursue enhanced roles for physicians in private sector health plans, including lobbying for appropriate modification of the antitrust laws to facilitate physician negotiation with managed care plans and for legislation requiring managed care plans to allow participating physicians to organize for the purpose of commenting on medical review criteria, and including the development of an AMA team to develop the information and networks of consultants necessary to assist physicians in their interactions with managed care plans.

3. That the AMA continue to enhance its activities in standard setting and enforcement, including the pursuit of protection from antitrust and tort liability necessary to facilitate self regulatory activities.

Global Budgeting in Health System Reform Proposals

The Board of Trustees submitted a forceful report that expressed strong opposition to a national ceiling on health care spending otherwise known as "global budgeting." The House amended and adopted the following recommendations:

1. That the AMA continue to pursue enhanced involvement in the development of health care policy and regulations by the federal Medicare program and Medicaid programs, including the use of mechanisms established by the AMA and the national medical specialty societies, with participation by other provider and trade associations in the health care industry and representatives of the federal government, for the purpose of developing Medicare and Medicaid medical review criteria.

2. That the AMA reaffirm policy opposing global budgeting, expenditure targets, price controls, and similar methods of limiting health care expenditures.

Health Access America—Policy Revisions

The Board and the House of Delegates continue to modify AMA's own reform proposal called "Health Access America." The Board submitted a report that addressed issues contained in nine resolutions from the 1992 Annual Meeting calling for various refinements in the proposal.

The House adopted several revisions and additions to Health Access America including:

1. Adding language stating, "AMA negotiation with the federal government regarding the Medicare program be extended to include..."
federal Medicaid responsibilities."

2. Revising policy to read, "All Americans should have defined health care coverage that includes access to a fully licensed physician (i.e., MD/DO) when such persons believe that they have a health problem."

3. Adding Policy to read,

- **Patient Responsibility**: Patients have a responsibility to share in the health care decisions that affect their lives.

- **Innovative Insurance Underwriting**: (a) States should prohibit all insurers and self-insurers from biased risk selection through premium-setting, underwriting, or marketing techniques. (b) To the extent possible, patients who change insurers should be permitted to retain their physicians.

- **Health Promotion and Disease Prevention**: States should encourage educating the public regarding health risk and expectations regarding the efficacy of health care services through school health programs and accurate media reporting.

- **Administrative Costs and Paperwork**: (1) All administrative systems (including utilization management) should be as uniform as possible. (2) The administrative systems of all third-party payors should be evaluated regularly by the National Association of Insurance Commissioners as to their total efficiency, including their costs to patients and physicians.

- **Portability and Continuity of Coverage**: All full-time employees covered through the work place should (1) have the right to convert an employer group plan to individual or family-based coverage upon termination of employment at the same terms, conditions, and premiums as under the group plan; (2) upon start of new employment, be eligible for coverage in a basic benefits plan with no waiting periods or preexisting condition exclusions.

4. That the Board and the TAC, in conjunction with relevant AMA councils, continue to analyze potential HAA policy enhancements to include practice parameters and quality assurance, additional preventive services in the minimum benefits package, and other options addressing healthcare spending, for possible inclusion in HAA policy, advocacy, and legislative initiatives as appropriate.

5. That, pending completion of the Association's analysis of criteria for inclusion of services in the AMA minimum benefits package, the AMA should: (a) urge all insurance companies to make available for purchase group and individual policies providing coverage for preventive services including those already in the minimum benefit package; and (b) urge employers to offer, as an optional benefit, coverage for such additional preventive services at the employee's expense, and that the employers offering such coverage inform their employees of the additional premium cost incurred for each preventive service covered.

6. That the AMA 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.

7. Reaffirming policy that reads: "Health insurance market reform is essential, particularly for the small business market, and community rating, elimination of preexisting conditions, guaranteed renewability, limits on premium increases, portability and continuity are critical elements to assuring universal coverage" be reaffirmed.

Physician Ownership of Medical Facilities (Conflicts of Interest-Self-Referral)

The House of Delegates reconciled an apparent discrepancy between the Council on Ethical and Judicial Affairs policy and a resolution adopted at the last meeting by (1) reaffirming the Council's guidelines on Conflicts of Interest: Physician Ownership of Medical Facilities, and (2) rescinding the earlier resolution.

In addition the House requested CEJA to continue to study and revise these guidelines as changes in the health care system may require, considering some suggested guidelines from the College of Legal Medicine.

Also the House adopted as amended a resolution calling on the AMA to

- study the corporate practice of medicine and determine whether key components of the health care delivery system should function independently (and thereby be forced to undergo vertical divestiture, if necessary) and, if so, how such "independence" need be defined.
With over 300 items of business, it would be impossible to include every important issue in this brief report.

Listed below are some actions that seemed to generate unusual interest among members of the House or the public media:

### Autologous Blood Transfusions

Adopted recommendations that the AMA:

1. Support the collection of autologous blood from candidates for elective surgery who are without contraindications to phlebotomy and when such donations are medically indicated because transfusion is likely to be needed; and

2. Promote the position that autologous blood is medically preferable to homologous blood whenever possible; and

3. Support efforts to remove any and all economic barriers to the collection and use of autologous blood for transfusion, in order to promote its wider use.

### Family Violence

The House adopted the following substitute resolution:

RESOLVED, That the American Medical Association take the following actions to reaffirm and expand current policy by:

1. Declaring violence in America to be a major public health crisis.

2. Supporting research into the causes of violent behavior and appropriate interventions which may result in its prevention or cure.

3. Supporting an educational program designed to increase knowledge of the causes, manifestations and harmful effects of interpersonal violence, and be it further

RESOLVED, That the American Medical Association direct its programs, policies and other resources as appropriate toward achieving a violence free society.

### Professional Liability Issues

The House adopted a substitute resolution calling on the AMA to:

- continue to support professional liability insurance reform legislation that will provide a cap on non-economic damages;

- through its normal publications, widely disseminate to its members the wisdom of reviewing their professional liability policies and becoming aware of the provisions in their own policy, especially regarding settlement;

- seek to prevent contingent fees for expert witnesses for medical testimony or for organizations which arrange for such testimony.

### CLIA '88 Regulations

The House adopted a resolution calling for the AMA to work through appropriate regulatory, legislative or judicial channels for changes in CLIA '88 to achieve changes that markedly reduce or eliminate the obstacles experienced by physicians under CLIA '88, with the understanding that should this not be successful, the Association shall move to seek legislative repeal of CLIA '88.

### Caring for the Poor

The House adopted a report from the Council on Ethical and Judicial Affairs which provides guidelines for physician obligations to care for the poor. Stating that "Caring for the poor has always been a normal part of the physician's overall service to patients," the Council explained that this report does not infringe on the physician's freedom to choose whom to serve, but is a means of contributing to an improved community under Principle VII of the Principles of Medical Ethics.

### Conclusion

The meetings of the AMA House are conducted in a most democratic manner. They provide those who attend a unique educational experience as a wealth of information is disseminated and discussed. I would encourage you to attend and participate. Any member of the Association may present testimony at the Reference Committee and, of course, corridor discussions on the issues provide additional 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.

Your delegates will be happy to respond to any question.

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