

DISCLAIMER

The following is a preliminary report of actions taken by the House of Delegates at its 2005 Annual Meeting and should not be considered final. Only the Official Proceedings of the House of Delegates reflect official policy of the Association.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-05)

Report of Reference Committee B

Richard M. Peer, MD, Chair

1 In keeping with Resolution 601 (A-96), the Reference Committee recommends the
2 following consent calendar for acceptance:
3

4 **RECOMMENDED FOR ADOPTION**

- 5
- 6 1. Board of Trustees Report 9 – Health Care for the Victims of the Postal Anthrax
7 Attacks of 2001
8
 - 9 2. Board of Trustees Report 10 – Liability Protection for Adult Vaccines
10
 - 11 3. Board of Trustees Report 12 – Council on Legislation Sunset Review of 1995
12 House Policies
13
 - 14 4. Board of Trustees Report 16 – Professional Liability Alternative Financing
15
 - 16 5. Board of Trustees Report 27 – Liability Surcharges in Physician Offices
17
 - 18 6. Board of Trustees Report 29 – USA Patriot Act
19
 - 20 7. Resolution 205 – Plea Bargaining and Immunity from Prosecution
21
 - 22 8. Resolution 207 – Threats Against Physicians Based on Americans with
23 Disabilities Act
24

25 **RECOMMENDED FOR ADOPTION AS AMENDED OR SUBSTITUTED**

- 26
- 27 9. Board of Trustees Report 5 - Pay-for-Performance Principles and Guidelines
28 in lieu of
29 Resolution 217 - Pay-for-Performance
30 Resolution 218 - Pay-for-Performance Initiatives and
31 Physicians Who Serve Minority Patient Populations
32 Resolution 219 – Pay-for-Performance
33
 - 34 10. Substitute Resolution 220 – Medicare’s Sustainable Growth Rate Formula and
35 Pay-for-Performance

- 1 11. Board of Trustees Report 35 – Medicare Physician Payment
2 in lieu of
3 Resolution 231 – Repeal of Medicare’s Sustainable Growth Rate Reimbursement
4 Formula
5
- 6 12. Council on Medical Education Report 3 – Implications of the November 2003
7 Emergency Medical Treatment and Labor Act (EMTALA) Final Rule
8 in lieu of
9 Resolution 212 – EMTALA Review of Critical Access Hospitals
10 Resolution 234 – Emergency Department Physician Coverage
11 Resolution 235 – EMTALA-Mandated Claims
12
- 13 13. Resolution 209 – Opposition to Legislation that Presumes to Prescribe Patients’
14 Preferences for Artificial Hydration and Nutrition
15
- 16 14. Resolution 228 – Freedom of Practice in Medical Imaging
17
- 18 15. Resolution 230 – Minor Statute of Repose
19
- 20 16. Resolution 236 – Expedious Security Clearance and Visa Processing of
21 Physicians
22
- 23 17. Substitute Resolution 203 – Guam Professional Liability Crisis in Red Alert
24
- 25 18. Substitute Resolution 210 – Frivolous Lawsuit Management
26
- 27 19. Substitute Resolution 213 – Benzodiazepine Restrictions
28
- 29 20. Substitute Resolution 214 – Limits on Non-Economic Damages and Contingency
30 Fees
31
- 32 21. Substitute Resolution 229 – Physician Freedom to Collectively Negotiate with
33 Managed Care Plans and Health Insuring Organizations
34

35 **RECOMMENDED FOR REFERRAL**

- 36
- 37 22. Resolution 201 – Savings Accounts for Extended Reporting Endorsement
38 Policies and Other Liability Insurance Costs
39
- 40 23. Resolution 224 – Lessons From the Terri Schiavo Case
41
- 42 24. Resolution 232 – Request for Congressional Action on Insurance Antitrust
43 Exemption
44

45 **RECOMMENDED FOR NOT ADOPTION**

- 46
- 47 25. Resolution 202 – Establishing Parity Between Professions
48
- 49 26. Resolution 223 – Outsourcing of Medical Data

- 1 27. Resolution 225 – The Million Medical Provider March
- 2
- 3 28. Resolution 226 – White Coats as a Symbol of Unity
- 4
- 5 29. Resolution 227- Collaboration of Advocacy Activities with Component Societies
- 6
- 7 30. Resolution 233- Reporting Residents to the NPDB Related to Medical
- 8 Malpractice Payments While in a Training Program

1 (1) BOARD OF TRUSTEES REPORT 9 - HEALTH CARE
2 FOR THE VICTIMS OF THE POSTAL ANTHRAX
3 ATTACKS OF 2001 (RESOLUTION 919, I-04)
4

5 RECOMMENDATION:
6

7 Madam Speaker, your Reference Committee recommends
8 that the recommendations contained in Board of Trustees
9 Report 9 be adopted and that the remainder of the report
10 be filed
11

12 **HOD ACTION: Recommendations in Board of Trustees**
13 **Report 9 adopted and remainder of report filed.**
14

15 Board of Trustees Report 9 recommends (1) That our AMA advocate the issue of health
16 plans' responsibility to pay for health services provided to victims for anthrax-related
17 medical care as a result of the 2001 postal anthrax attacks with the appropriate federal
18 agencies, such as the Office of Personnel Management, and with the trade association
19 representing the health insurance industry, e.g., America's Health Insurance Plans; (2)
20 That our AMA study how the "act of war" exclusion in health insurance contracts should
21 be defined and examine ways that the AMA might work with health insurance companies
22 to ensure that individuals injured as a result of future bioterrorism events receive
23 appropriate health care that is covered by their insurance policies.
24

25 Your Reference Committee heard unanimous testimony supporting the
26 recommendations contained in Board of Trustees Report 9. Given the breadth of the
27 analysis contained in the Board report, your Reference Committee recommends
28 adoption.
29

30
31 (2) BOARD OF TRUSTEES REPORT 10 - LIABILITY
32 PROTECTION FOR ADULT VACCINES (RESOLUTION
33 710, I-04)
34

35 RECOMMENDATION:
36

37 Madam Speaker, your Reference Committee recommends
38 that the recommendation contained in Board of Trustees
39 Report 10 be adopted and that the remainder of the report
40 be filed.
41

42 **HOD ACTION: Recommendation contained in Board of**
43 **Trustees Report 10 adopted and remainder of report filed.**
44

45 Board of Trustees Report 10 recommends: that our AMA support the expansion of the
46 Vaccine Injury Compensation Fund to include any vaccine encouraged or recommended
47 by the Advisory Committee on Immunization Practices for routine use in the adult
48 population.

1 All of the testimony heard by your Reference Committee was entirely supportive. Based
2 on this unanimous support and the importance of this issue, your Reference Committee
3 recommends adoption of Board of Trustees Report 10.
4

5
6 (3) BOARD OF TRUSTEES REPORT 12 - COUNCIL ON
7 LEGISLATION SUNSET REVIEW OF 1995 HOUSE
8 POLICIES
9

10 RECOMMENDATION:

11
12 Madam Speaker, your Reference Committee recommends
13 that the recommendation contained in Board of Trustees
14 Report 12 be adopted and that the remainder of the report
15 be filed.
16

17 **HOD ACTION: Recommendation contained in Board of**
18 **Trustees Report 12 adopted and remainder of report filed.**
19

20 The Board of Trustees Report 12 recommends that the House of Delegates policies that
21 are listed in the Appendix to the report be acted upon in the manner indicated.
22

23 Other than brief testimony by our AMA Board supporting Board of Trustees Report 12,
24 no other testimony was presented. Your Reference Committee recommends adoption of
25 the Board report.
26

27
28 (4) BOARD OF TRUSTEES REPORT 16 - PROFESSIONAL
29 LIABILITY ALTERNATIVE FINANCING (RESOLUTION
30 231, A-04)
31

32 RECOMMENDATION:

33
34 Madam Speaker, your Reference Committee recommends
35 that the recommendation contained in Board of Trustees
36 Report 16 be adopted and that the remainder of the report
37 be filed.
38

39 **HOD ACTION: Recommendation contained in Board of**
40 **Trustees Report 16 adopted and remainder of report filed.**
41

42 Board of Trustees Report 16 recommends that our AMA support legislation that would
43 amend the Internal Revenue Code to allow medical professionals and entities to
44 establish tax-exempt professional liability trusts to pay medical liability claims.
45

46 Your Reference Committee heard brief testimony regarding Board of Trustees Report
47 16. Your Reference Committee agrees with the testimony which indicated that tax
48 exempt professional liability trusts may be a plausible MICRA-enhancement which could
49 be another mechanism to enable physicians to remain in practice. Although there was
50 confusion expressed about the recommendation's use of the term "entities," your

1 Reference Committee understands that the Internal Revenue Code defines the term
2 “entities,” providing this clarification. Your Reference Committee therefore recommends
3 adoption of Board of Trustees Report 16.
4

5
6 (5) BOARD OF TRUSTEES REPORT 27 - LIABILITY
7 SURCHARGES IN PHYSICIAN OFFICES (RESOLUTION
8 213, A-04; BOARD OF TRUSTEES REPORT 20, I-04)
9

10 RECOMMENDATION: A

11
12 Madam Speaker, your Reference Committee recommends
13 that the recommendation contained in Board of Trustees
14 Report 27 be adopted and that the remainder of the report
15 be filed.
16

17 1) That our AMA support the ability of physicians to institute
18 an “administrative surcharge” and/or a “liability surcharge.”
19 ~~where not prohibited from doing so.~~ (New HOD Policy)
20

21 RECOMMENDATION B:

22
23 Madam Speaker, your Reference Committee recommends
24 that the title of Board of Trustees Report 27 be changed to
25 read as follows:
26

27 ADMINISTRATIVE AND LIABILITY SURCHARGES

28
29 **HOD ACTION: Recommendation contained in Board of**
30 **Trustees Report 27 adopted as amended with change in**
31 **title and remainder of report filed.**
32

33 Board of Trustees Report 27 recommends that our AMA support the ability of physicians
34 to institute an “administrative surcharge” and/or a “liability surcharge” where not
35 prohibited from doing so.
36

37 Your Reference Committee heard overwhelming support in favor of this Board report.
38 Your Reference Committee, however, agrees with testimony asking to amend the title of
39 Board of Trustees Report 27. Your Reference Committee believes that the title should
40 be amended to indicate that surcharges encompass administrative as well as liability
41 surcharges, and that the imposition of surcharges is not limited to the physician office
42 setting. With these minor amendments to the title, your Reference Committee
43 recommends adoption.

1 (6) BOARD OF TRUSTEES REPORT 29 - USA PATRIOT
2 ACT (RESOLUTION 902, I-04)

3
4 RECOMMENDATION: A

5
6 Madam Speaker, your Reference Committee recommends
7 that the recommendations contained in Board of Trustees
8 Report 29 be adopted and that the remainder of the report
9 be filed.

10
11 RECOMMENDATION B:

12
13 Madam Speaker, your Reference Committee recommends
14 that the title of Board of Trustees Report 29 be changed to
15 read as follows:

16
17 PATIENT CONFIDENTIALITY AND USA PATRIOT ACT

18
19 **HOD ACTION: The recommendations contained in Board**
20 **of Trustees Report 29 adopted with change in title and**
21 **remainder of report filed.**

22
23 Board of Trustees Report 29 recommends (1) That Resolution 902 (I-04) be adopted; (2)
24 That our AMA advocate that Section 215 of the USA Patriot Act sunset as scheduled, or,
25 if the Act is reauthorized, for amendments to Section 215 in accordance with the
26 recommendations presented in the report.

27
28 The overwhelming testimony regarding Board of Trustees Report 29 supported our AMA
29 taking a strong stance protecting the confidentiality of the patient-physician relationship
30 and was therefore in strong support of the recommendations in Board of Trustees
31 Report 29. A small minority of speakers expressed concern about potential political
32 ramifications. Your Reference Committee believes that upholding the confidentiality of
33 the patient-physician relationship is of paramount importance and reflected in long-
34 standing AMA policy. Your Reference Committee believes that our AMA must continue
35 to be a strong advocate in safeguarding the patient-physician relationship. Additionally,
36 because your Reference Committee recognizes that this Board report addresses only
37 one section of the Patriot Act, your Reference Committee concurs with testimony
38 suggesting that the title of Board of Trustees Report 29 be changed to "Patient
39 Confidentiality and the U.S. Patriot Act." Your Reference Committee therefore
40 recommends adoption of Board of Trustees Report 29 with a minor title change.

1 (7) RESOLUTION 205 - PLEA BARGAINING AND IMMUNITY
2 FROM PROSECUTION
3

4 RECOMMENDATION:

5
6 Madam Speaker, your Reference Committee recommends
7 that Resolution 205 be adopted.
8

9 **HOD ACTION: Resolution 205 adopted.**

10
11 Resolution 205 asks that our American Medical Association oppose the use of
12 harassment and coercive plea bargaining by prosecutors to pressure physicians.
13

14 Testimony regarding Resolution 205 was limited. There was some testimony that
15 expressed a desire to amend Resolution 205 by adding the words “self-incrimination” to
16 the end of the Resolved clause. Your Reference Committee believes that this proposed
17 amendment is too limiting. Plea bargaining and immunity may pressure physicians to
18 engage in undesirable conduct that does not constitute self-incrimination. The language
19 of Resolution 205 should therefore remain broad in order to encompass all types of
20 potential prosecutorial harassment. Your Reference Committee therefore recommends
21 adoption of Resolution 205.
22

23
24 (8) RESOLUTION 207 - THREATS AGAINST PHYSICIANS
25 BASED ON AMERICANS WITH DISABILITIES ACT
26

27 RECOMMENDATION:

28
29 Madam Speaker, your Reference Committee recommends
30 that Resolution 207 be adopted.
31

32 **HOD ACTION: Resolution 207 adopted.**

33
34 Resolution 207 asks that our American Medical Association investigate the problem of
35 physicians being harassed with the threat of a lawsuit based upon a non-meritorious
36 claim using the Americans with Disabilities Act as the basis for the claim and, if found to
37 be a problem, create a corrective action plan to deal with this abuse.
38

39 The limited testimony heard by your Reference Committee supported Resolution 207.
40 Your Reference Committee believes that it is necessary to investigate whether
41 physicians are being harassed with the threat of a lawsuit based on the Americans with
42 Disabilities Act. Your Reference Committee therefore recommends adoption of
43 Resolution 207.

- 1 (9) BOARD OF TRUSTEES REPORT 5 - PAY-FOR-
 2 PERFORMANCE PRINCIPLES AND GUIDELINES
 3 RESOLUTION 217 - PAY-FOR-PERFORMANCE
 4 RESOLUTION 218 - PAY-FOR-PERFORMANCE
 5 INITIATIVES AND PHYSICIANS WHO SERVE MINORITY
 6 PATIENT POPULATIONS
 7 RESOLUTION 219 – PAY-FOR-PERFORMANCE

8
 9 RECOMMENDATION A:

10
 11 Madam Speaker, your Reference Committee recommends
 12 that the recommendation contained in Board of Trustees
 13 Report 5 be amended by insertion on page 2, lines 46-47
 14 to read as follows:

15
 16 Recommendation 1. That the following *Principles for Pay-*
 17 *for-Performance and Guidelines for Pay-for-Performance* be
 18 adopted as the official policy of the American Medical
 19 Association.

20
 21 RECOMMENDATION B:

22
 23 Madam Speaker, your Reference Committee recommends
 24 that the recommendation contained in Board of Trustees
 25 Report 5 be amended by moving the *Principles for Pay-for-*
 26 *Performance and Guidelines for Pay-for-Performance*
 27 originally in the Appendix to Board of Trustees Report 5
 28 into the recommendation, beginning on page 2, line 49.

29
 30 RECOMMENDATION C:

31
 32 Madam Speaker, your Reference Committee recommends
 33 that the recommendation contained in Board of Trustees
 34 Report 5 be amended by insertion and deletion as follows:

35
 36 **Principles for Pay-for-Performance Programs**

37
 38 Physician pay-for-performance (PFP) programs that are designed primarily to improve
 39 the effectiveness and safety of patient care may serve as a positive force in our
 40 healthcare system. Fair and ethical PFP programs are patient-centered and link
 41 evidence-based performance measures to financial incentives. Such PFP programs are
 42 in alignment with the following five AMA principles:

- 43
 44 **1. Ensure quality of care** – Fair and ethical PFP programs are committed to
 45 improved patient care as their most important mission. Evidence-based quality
 46 of care measures, created by physicians across appropriate specialties, are the
 47 measures used in the programs. Variations in an individual patient care regimen
 48 are permitted based on a physician's sound clinical judgment and should not
 49 adversely affect PFP program rewards.

- 1 **2. Foster the patient/physician relationship** – Fair and ethical PFP programs
 2 support the patient/physician relationship and overcome obstacles to physicians
 3 treating patients, regardless of patients’ health conditions, ethnicity, economic
 4 circumstances, demographics, or treatment compliance patterns.
 5
- 6 **3. Offer voluntary physician participation** – Fair and ethical PFP programs offer
 7 voluntary physician participation, and do not undermine the economic viability of
 8 non-participating physician practices. These programs support participation by
 9 physicians in all practice settings by minimizing potential financial and
 10 technological barriers including costs of start-up.
 11
- 12 **4. Use accurate data and fair reporting** – Fair and ethical PFP programs use
 13 accurate data and scientifically valid analytical methods. Physicians are allowed
 14 to review, comment and appeal results prior to the use of the results for
 15 programmatically reasons and any type of reporting.
 16
- 17 **5. Provide fair and equitable program incentives** – Fair and ethical PFP
 18 programs provide new funds for positive incentives to physicians for their
 19 participation, progressive quality improvement, or attainment of goals within the
 20 program. The eligibility criteria for the incentives are fully explained to
 21 participating physicians. These programs support the goal of quality
 22 improvement across all participating physicians.
 23

24 **Guidelines for Pay-for-Performance Programs**

25
 26 Safe, effective, and affordable healthcare for all Americans is the American Medical
 27 Association’s (AMA) goal for our healthcare delivery system. The AMA presents the
 28 following guidelines regarding the formation and implementation of fair and ethical pay-
 29 for-performance (PFP) programs. These guidelines augment the AMA’s “Principles for
 30 Pay-for-Performance Programs” and provide AMA leaders, staff and members with
 31 operational boundaries that can be used in an assessment of specific PFP programs.
 32

33 Quality of Care

- 34
- 35 • The primary goal of any PFP program must be to promote quality patient care
 36 that is safe and effective across the healthcare delivery system, rather than to
 37 achieve monetary savings.
 - 38 • Evidence-based quality of care measures must be the primary measures
 39 used in any program.
 - 40 1. All performance measures used in the program must be prospectively
 41 defined and developed collaboratively across physician specialties.
 - 42 2. Practicing physicians with expertise in the area of care in question
 43 must be integrally involved in the design, implementation, and
 44 evaluation of any program.
 - 45 3. All performance measures must be developed and maintained by
 46 appropriate professional organizations that periodically review and
 47 update these measures with evidence-based information in a process
 48 open to the medical profession.
 - 49 4. Performance measures should be scored against both absolute
 50 values and relative improvement in those values.

- 1 5. Performance Outcome measures must be subject to the best-
2 available risk- adjustment for patient demographics, severity of illness,
3 and co-morbidities.
 - 4 6. Performance measures must be kept current and reflect changes in
5 clinical practice. Except for evidence-based updates, program
6 measures must be stable for two years.
 - 7 7. Performance measures must be selected for clinical areas that have
8 significant promise for improvement.
- 9 • Physician adherence to PFP program requirements must conform with
10 improved patient care quality and safety.
 - 11 • Programs should allow for variance from specific performance measures that
12 are in conflict with sound clinical judgment and, in so doing, require minimal,
13 but appropriate, documentation.
 - 14 • PFP programs must be able to demonstrate improved quality patient care
15 that is safer and more effective as the result of program implementation.
 - 16 • PFP programs help to ensure quality by encouraging collaborative efforts
17 across all members of the healthcare team.
 - 18 • Prior to implementation, pay-for-performance programs must be successfully
19 pilot-tested for a sufficient duration to obtain valid data in a variety of practice
20 settings and across all affected medical specialties. Pilot testing should also
21 analyze for patient de-selection. If implemented, the program must be
22 phased-in over an appropriate period of time to enable participation by any
23 willing physician in affected specialties. ~~Pilot programs are encouraged prior~~
24 ~~to widespread implementation of programs~~
 - 25 • Plans that sponsor PFP programs must prospectively explain these programs
26 to the patients and communities covered by them.

27 28 Patient/Physician Relationship

- 29 • Programs must be designed to support the patient/physician relationship and
30 recognize that physicians are ethically required to use sound medical
31 judgment, holding the best interests of the patient as paramount.
- 32 • Programs must not create conditions that limit access to improved care.
 - 33 1. Programs must not directly or indirectly disadvantage patients from
34 ethnic, cultural, and socio-economic groups, as well as those with
35 specific medical conditions, or the physicians who serve these
36 patients.
 - 37 2. Programs must neither directly nor indirectly disadvantage patients
38 and their physicians, based on the setting where care is delivered or
39 the location of populations served (such as inner city or rural areas).
- 40 • Programs must neither directly nor indirectly encourage patient de-selection.
- 41 • Programs must recognize outcome limitations caused by patient non-
42 compliance, and sponsors of PFP programs should attempt to minimize non-
43 compliance through plan design.
- 44
- 45

46 Physician Participation

- 47
- 48 • Physician participation in any PFP program must be completely voluntary.
- 49 • Sponsors of PFP programs must notify physicians of PFP program
50 implementation and offer physicians the opportunity to opt in or out of the

1 PFP program without affecting the existing or offered contract provisions from
2 the sponsoring health plan or employer.

- 3 • Programs must be designed so that physician nonparticipation does not
4 threaten the economic viability of physician practices.
- 5 • Programs should be available to any physicians and specialties who wish to
6 participate and must not favor one specialty over another. Programs must be
7 designed to encourage broad physician participation across all modes of
8 practice. Programs must not favor physician practices by size (large, small,
9 or solo) or by capabilities in information technology (IT).
 - 10 1. Programs should provide physicians with tools to facilitate
11 participation.
 - 12 2. Programs should be designed to minimize financial and technological
13 barriers to physician participation.
- 14 • Although some IT systems and software may facilitate improved patient
15 management, programs must avoid implementation plans that require
16 physician practices to purchase health-plan specific IT capabilities.
- 17 • Physician participation in a particular PFP program must not be linked to
18 participation in other health plan or government programs.
- 19 • Programs must educate physicians about the potential risks and rewards
20 inherent in program participation, and immediately notify participating
21 physicians of newly identified risks and rewards.
- 22 • Physician participants must be notified in writing about any changes in
23 program requirements and evaluation methods. Such changes must occur at
24 most on an annual basis.

25 26 Physician Data and Reporting

- 27
- 28 • Patient privacy must be protected in all data collection, analysis, and
29 reporting. Data collection must be administratively simple and consistent with
30 the Health Insurance Portability and Accountability Act (HIPAA).
- 31 • The quality of data collection and analysis must be scientifically valid.
32 Collecting and reporting of data must be reliable and easy for physicians and
33 should not create financial or other burdens on physicians and/or their
34 practices. Audit systems should be designed to ensure the accuracy of data
35 in a non-punitive manner.
 - 36 1. Programs should use accurate administrative data *and* data
37 abstracted from medical records.
 - 38 2. Medical record data should be collected in a manner that is not
39 burdensome and disruptive to physician practices.
 - 40 3. Program results must be based on data collected over a significant
41 period of time and relate care delivered (numerator) to a statistically
42 valid population of patients in the denominator.
- 43 • Physicians must be reimbursed for any added administrative costs incurred
44 as a result of collecting and reporting data to the program.
- 45 • Physicians should be assessed in groups and/or across health care systems,
46 rather than individually, when feasible.
- 47 • Physicians must have the ability to review and comment on data and analysis
48 used to construct any performance ratings prior to the use of such ratings to
49 determine physician payment or for public reporting.

- 1 1. Physicians must be able to see preliminary ratings and be given the
- 2 opportunity to adjust practice patterns over a reasonable period of
- 3 time to more closely meet quality objectives.
- 4 2. Prior to release of any physician ratings, programs must have a
- 5 mechanism for physicians to see and appeal their ratings in writing. If
- 6 requested by the physician, physician comments must be included
- 7 adjacent to any ratings.
- 8 • If PFP programs identify physicians with exceptional performance in providing
- 9 effective and safe patient care, the reasons for such performance should be
- 10 shared with physician program participants and widely promulgated.
- 11 • The results of PFP programs must not be used capriciously against
- 12 physicians in health plan credentialing, licensure, and certification. Individual
- 13 physician quality performance information and data must remain confidential
- 14 and not subject to discovery in legal or other proceedings.
- 15 • PFP programs must have defined security measures to prevent the
- 16 unauthorized release of physician ratings.

17 Program Rewards

- 18 • Programs must be based on rewards and not on penalties.
- 19 • Program incentives must be sufficient in scope to cover any additional work
- 20 and practice expense incurred by physicians as a result of program
- 21 participation.
- 22 • Programs must offer financial support incentives to physician practices that
- 23 implement IT systems or software that interact with aspects of the PFP
- 24 program.
- 25 • Programs must finance bonus payments based on specified performance
- 26 measures with supplemental funds.
- 27 • Programs must reward all physicians who actively participate in the program
- 28 and who achieve pre-specified absolute program goals or demonstrate pre-
- 29 specified relative improvement toward program goals.
- 30 • Programs must not reward physicians based on ranking compared with other
- 31 physicians in the program.
- 32 • Programs must provide to all eligible physicians and practices a complete
- 33 explanation of all program facets, to include the methods and performance
- 34 measures used to determine incentive eligibility and incentive amounts, prior
- 35 to program implementation.
- 36 • Programs must not financially penalize physicians based on factors outside of
- 37 the physician's control.
- 38 • Programs utilizing bonus payments must be designed to protect patient
- 39 access and must not financially disadvantage physicians who serve minority
- 40 or uninsured patients.

41 Recommendation 2. That our American Medical Association oppose private payer,

42 Congressional, or Centers for Medicare and Medicaid Services pay-for-performance

43 initiatives if they do not meet the AMA's "Principles and Guidelines for Pay-for-

44 Performance."

1 RECOMMENDATION D:
2

3 Madam Speaker, your Reference Committee recommends
4 that the recommendation contained in Board of Trustees
5 Report 5 be adopted as amended in lieu of Resolutions
6 217, 218, and 219, and that the remainder of the report be
7 filed.
8

9 **HOD ACTION: Recommendation in Board of Trustees**
10 **Report 5 adopted as amended in lieu of Resolutions 217,**
11 **218, and 219, and the remainder of the report filed.**
12

13 Board of Trustees Report 5 recommends (1) That *Principles for Pay-for-Performance*
14 and *Guidelines for Pay-for-Performance* be adopted as the official policy of the American
15 Medical Association. Resolution 217 asks (1) That our American Medical Association
16 adopt policy that physicians should receive financial support for the adoption of
17 electronic health record technology; (2) That our AMA adopt policy that pay-for-
18 performance data collection be administratively simple and consistent with the Health
19 Insurance Portability and Accountability Act; (3) That our AMA adopt policy that
20 standards for pay-for-performance chosen by third party payers be consistent with
21 evidence based standards developed by nationally recognized specialty societies and
22 the AMA's principles for pay-for-performance programs; (4) That our AMA adopt policy
23 that pay-for-performance financial rewards be made with entirely new money aimed at
24 improving quality care; (5) That our AMA adopt policy that any limits imposed on pay-for-
25 performance bonus payments be designed to protect patient access; and (6) That our
26 AMA adopt policy that pay-for-performance bonus payment methodology be risk-
27 adjusted. Resolution 218 asks (1) That our American Medical Association and its
28 Minority Affairs Consortium monitor the Pay for Performance initiatives and make
29 recommendations that insure fair and equitable financial incentives to physicians who
30 serve minority and uninsured patient populations; (2) That our AMA oppose any Pay for
31 Performance initiatives that place; physicians who serve primarily minority or uninsured
32 patients at a financial disadvantage and (3) That our AMA oppose any Pay for
33 Performance initiative that uses quality measures outside of the physician's control as
34 the basis for physician financial incentives. Resolution 219 asks that our American
35 Medical Association reject any Pay-for-Performance or similar program initiated by
36 Congress, the Centers for Medicare and Medicaid Services, or private payers which
37 does not incorporate the AMA Principles and Guidelines for Pay-for-Performance and in
38 particular must be based on quality rather than money savings, be adequately pilot
39 tested, and reward physicians with new money.
40

41 Your Reference Committee heard a wealth of testimony that afforded an opportunity for
42 everyone who attended the hearing to consider various views on pay-for-performance
43 (P4P) initiatives. Testimony was fairly evenly split among three general options: support
44 for Board Report 5 Recommendations as drafted; support for certain amendments to the
45 Report Recommendations; and opposition to the concept of P4P. It was generally
46 recognized, however, that there was a great deal of thought and consideration put into
47 the drafting of the Report. The Board was responsive in addressing this rapidly

1 emerging issue and made a concerted effort to disseminate the Principles and
2 Guidelines to the Federation and the public. Although there was testimony opposing the
3 concept of P4P, there was significant support for our AMA to be engaged in the debate
4 on and development of performance measures.

5
6 Your Reference Committee received comments that physicians must not allow P4P to
7 be controlled by other stakeholders in health care (e.g., health plans, government) who
8 may not view P4P as a quality tool, but rather a cost cutting or payment tool. We also
9 heard compelling testimony that our AMA must position itself to play a leadership role in
10 shaping a P4P system. Without direct involvement from practicing physicians, there is a
11 good chance that we would be faced with poorly designed performance measures.
12 There is concern that this will place physicians in a defensive position where others
13 control the debate, leaving physicians to merely respond. We must also be diligent not
14 to allow any payment system to interfere with the patient-physician relationship, as some
15 who testified feared could result from a poorly designed P4P system focused on cost
16 cutting and not quality improvement.

17
18 Your Reference Committee received several comments suggesting that Report 5 be
19 adopted as drafted. Others were of the opinion that the Principles and Guidelines be
20 conditioned on a long-term fix to the flawed physician payment formula used in the
21 Medicare program. Your Reference Committee believes, however, that in order to place
22 the House of Medicine in the strongest position to influence the development of a
23 patient-centric, evidence-based P4P system, the most prudent approach for our AMA at
24 this time is to adopt the Principles and Guidelines separate from policy on physician
25 payment. Therefore, your Reference Committee determined that Resolution 220 should
26 be considered as a separate item (see Item 10).

27
28 Your Reference Committee also heard compelling testimony that targeted amendments
29 should be made to the Principles and Guidelines, and thus offer what we believe
30 provides enhanced language. As amended, we believe that the Principles and
31 Guidelines also incorporate the concepts included in Resolutions 217, 218, and 219.
32 Therefore, your Reference Committee recommends that amended Board of Trustees
33 Report 5 be adopted in lieu of Resolutions 217, 218, and 219.

34
35
36 (10) RESOLUTION 220 – MEDICARE’S SUSTAINABLE
37 GROWTH RATE REIMBURSEMENT FORMULA

38
39 RECOMMENDATION:

40
41 Madam Speaker, your Reference Committee recommends
42 that the following Substitute Resolution 220 be adopted:

1 RESOLVED, That our AMA actively lobby for any
2 legislative or regulatory changes necessary to ensure that
3 any Medicare Part A savings which are achieved when
4 physicians' efforts result in fewer in-patient complications,
5 shorter lengths-of-stays, fewer hospital readmissions, etc.,
6 are "credited" and flow to the Part B physician payment
7 pool.
8

9 **HOD ACTION: Substitute Resolution 220**
10 **adopted.**
11

12 Resolution 220 asks (1) That our American Medical Association continue to actively
13 lobby Congress and the Administration to (a) eliminate Medicare-covered outpatient
14 drugs and other incident-to services from the physician expenditure target both
15 retroactively and in the future; and (b) repeal the current Sustainable Growth Rate (SGR)
16 formula, replacing it with a system (such as the MEI) that is more predictable and
17 recognizes the true costs of providing services to Medicare beneficiaries; (2) That our
18 AMA oppose any congressional or Centers for Medicare and Medicaid Services Pay-for-
19 Performance initiative unless it meets, at a minimum, all of the following requirements:
20 (a) the program is designed to truly improve quality of care; (b) performance
21 measurements must be established by practicing physicians and/or their specialty
22 societies with expertise in the area of care in question and be based on scientifically
23 derived criteria; (c) prior to implementation, the program must be fully and successfully
24 pilot tested in a variety of practice settings and across all medical specialties; (d) if
25 successfully pilot tested, the program must be phased-in over an appropriate period of
26 time to enable participation by all physicians in all specialties; (e) the program should be
27 applicable to all physicians who wish to participate and not favor one specialty over
28 another; (f) collecting and reporting data must be reliable and easy for physicians and
29 should not create significant financial and other burdens on physicians and/or their
30 practices; (g) performance measures must be kept current and reflect changes in clinical
31 practice; (h) a non-punitive audit system should be implemented to ensure the accuracy
32 of data; (i) performance measures must be risk adjusted for patient demographics,
33 severity of illness, and comorbidities; and (j) individual physician quality performance
34 information and data must remain confidential and not be subject to discovery in legal or
35 other proceedings (e.g., credentialing, licensure, and certification) evaluating whether or
36 not a physician has met standards of care; and (3) That our AMA oppose any legislation
37 that implements a Medicare Pay-for-Performance (P4P) program that applies to all
38 physicians unless such legislation also includes a permanent "fix" to the SGR system or
39 such P4P legislation implements a voluntary program that includes new money into the
40 physician payment pool and does not merely redistribute money that already exists in
41 the Medicare Physician Payment.
42

43 As discussed in Item 9, your Reference Committee heard fervent testimony relating to
44 the issues included in Resolution 220, and determined that this Resolution should be
45 considered as a separate item. Resolution 220 has three parts. The first Resolved,
46 seeking removal of Medicare-covered outpatient drugs from the physician payment
47 formula, is embodied in existing AMA directive D-390.983, which reads "Our AMA will
48 work to exclude pharmaceutical costs from the Sustainable Growth Rate formula." Also,
49 our AMA has testified recently before the Practicing Physicians Advisory Council and
50 Congress strongly advocating for the removal of physician-administered drugs and

1 biologics from the SGR formula. Your Reference Committee also determined that the
2 majority of the items included in the second Resolved of Resolution 220 are effectively
3 covered in the Principles and Guidelines your Reference Committee recommended be
4 adopted as amended in Item 9. The third Resolved essentially calls on our AMA to draw
5 a line in the sand with respect to supporting pay-for-performance (P4P) initiatives only in
6 conjunction with a permanent fix to the SGR.

7
8 Your Reference Committee also heard (during testimony on Item 9) strong sentiment
9 both for and against the adoption of P4P being conditional on a long-term fix to the
10 flawed physician payment formula used in the Medicare program. Your Reference
11 Committee believes that Resolution 220 would preclude physicians from being able to
12 continue in a leadership position on both P4P and SGR reform. Instead, we determined
13 that our AMA should send a strong message to Congress and the public that our AMA
14 remains an innovative, progressive leader in quality improvement without drawing the
15 allegorical line in the sand. Therefore, we recommend that the flawed Medicare formula
16 issue in Resolution 220 should be addressed independently from our policy on P4P.
17 The last Resolved of the proposed amendment to Resolution 220 (included in the yellow
18 paper distributed at the hearing) calls on our AMA to “actively lobby for any legislative or
19 regulatory changes necessary to ensure that any Medicare Part A savings which are
20 achieved when physicians’ efforts result in fewer in-patient complications, shorter
21 lengths-of-stays, fewer hospital readmissions, etc., are ‘credited’ and flow to the Part B
22 physician payment pool.” Your Reference Committee heard testimony in support of this
23 concept and determined that this is consistent with recent AMA testimony to the
24 Practicing Physicians Advisory Council and to Congress, and should be adopted as a
25 Substitute Resolution in lieu of Resolution 220.

26
27 (11) BOARD OF TRUSTEES REPORT 35 - MEDICARE
28 PHYSICIAN PAYMENT
29 RESOLUTION 231 - REPEAL OF MEDICARE'S
30 SUSTAINABLE GROWTH RATE REIMBURSEMENT
31 FORMULA

32
33 RECOMMENDATION: A

34
35 Madam Speaker, your Reference Committee recommends
36 that the recommendation in Board of Trustees Report 35
37 be amended by addition of a new recommendation 2 to
38 read as follows:

39
40 2. That our AMA send all members of Congress a letter,
41 signed by all willing members of the Federation, urging
42 them to enact legislation replacing Medicare's sustainable
43 growth rate reimbursement formula with a system based on
44 appropriate updates. (Directive to Take Action)

1 RECOMMENDATION B:
2

3 Madam Speaker, your Reference Committee recommends
4 that the recommendations in Board of Trustees Report 35
5 be adopted as amended in lieu of Resolution 231 and the
6 remainder of the report be filed.
7

8 **HOD ACTION: Recommendations in Board of Trustees**
9 **Report 35 adopted as amended in lieu of Resolution 231**
10 **and remainder of the report filed.**
11

12 Board of Trustees Report 35 recommends that AMA Policy H-390.855, "Replacement of
13 Sustainable Growth Rate System," be reaffirmed in lieu of Resolution 207 (A-04) and
14 that the remainder of the report be filed. Resolution 231 asks that our American Medical
15 Association send all members of Congress a letter, signed by all 50 state AMA
16 delegations and all specialty society presidents, urging them to enact legislation, such as
17 H.R. 2356, repealing Medicare's sustainable growth rate reimbursement formula and
18 replacing it with a system based on appropriate updates.
19

20 Testimony regarding Board of Trustees Report 35 and Resolution 231 was wholly
21 supportive of both. Your Reference Committee believes that Board Report 35
22 appropriately emphasizes the urgency in having our AMA continue its aggressive
23 advocacy efforts to prevent forecasted Medicare payment cuts and a need to replace the
24 unsustainable spending targets with updates that accurately reflect annual increases in
25 physicians' practice costs. Your Reference Committee also believes that Resolution 231
26 is an important, specific step in advancing this aggressive advocacy strategy. Therefore,
27 the substance of Resolution 231 is included in new recommendation 2. Your Reference
28 Committee recommends adopting amended Board of Trustees Report 35.
29
30

- 31 (12) COUNCIL ON MEDICAL EDUCATION REPORT 3 -
32 IMPLICATIONS OF THE NOVEMBER 2003
33 EMERGENCY MEDICAL TREATMENT AND LABOR ACT
34 (EMTALA) FINAL RULE
35 RESOLUTION 212 – EMTALA REVIEW OF CRITICAL
36 ACCESS HOSPITALS
37 RESOLUTION 234 – EMERGENCY DEPARTMENT PHYSICIAN
38 COVERAGE
39 RESOLUTION 235 – EMTALA-MANDATED CLAIMS
40

41 RECOMMENDATION: A
42

43 Madam Speaker, your Reference Committee recommends
44 that recommendation 1 in Council on Medical Education
45 Report 3 be amended by insertion on page 4 lines 12-17,
46 to read as follows:

1 That our American Medical Association ask the EMTALA
2 Technical Advisory Group (TAG) and the Centers for
3 Medicare and Medicaid Services (CMS) for assistance in
4 ameliorating the differential economic and staffing burdens
5 on certain categories of facilities, including but not limited
6 to academic health centers, trauma centers, critical access
7 hospitals, and safety net hospitals, which are likely to
8 receive high volumes of patients as a result of the
9 EMTALA regulations.

10
11 RECOMMENDATION B:

12
13 Madam Speaker, your Reference Committee recommends
14 that Council on Medical Education Report 3 be amended
15 by addition of new recommendations 3, 4, 5, and 6 to read
16 as follows:

17
18 3. That our AMA initiate additional advocacy strategies to
19 implement H-130.970(5) that states: "All health payers
20 should be required to cover emergency services provided
21 by physicians and hospitals to plan enrollees, as required
22 under Section 1867 of the Social Security Act (i.e., medical
23 screening examination and further examination and
24 treatment needed to stabilize and "emergency medical
25 condition" as defined in the Act) without regard to prior
26 authorization or the emergency care physician's
27 contractual relationship with the payer" and report back at
28 the 2005 Interim Meeting. (Directive to Take Action)

29
30 4. That our AMA, with input from all interested Federation
31 members, coordinate an effort to educate the membership
32 about emergency department coverage issues and the
33 efforts to resolve them. (Directive to Take Action)

34
35 5. That our AMA seek to require all insurers, both public
36 and private, to pay promptly and fairly all claims for
37 services mandated by EMTALA for all plans they offer, or
38 face fines and penalties comparable to those imposed on
39 providers. (Directive to Take Action)

40
41 6. That our AMA seek to have CMS require all states
42 participating in Medicaid, as a condition of continued
43 participation, establish and adequately fund state
44 Emergency Medical Services funds which physicians
45 providing EMTALA-mandated services may bill, and from
46 which those physicians shall receive prompt and fair
47 compensation. (Directive to Take Action)

1 RECOMMENDATION C:
2

3 Madam Speaker, your Reference Committee recommends
4 that the recommendations in Council on Medical Education
5 Report 3 be adopted as amended in lieu of Resolutions
6 212, 234 and 235 and the remainder of the report be filed.
7

8 **HOD ACTION: Recommendations in Council on Medical**
9 **Education Report 3 adopted as amended in lieu of**
10 **Resolutions 212, 234, and 235 and the remainder of the**
11 **report filed.**
12

13 Council on Medical Education Report 3 recommends (1) That our American Medical
14 Association ask the EMTALA Technical Advisory Group (TAG) and the Centers for
15 Medicare and Medicaid Services (CMS) for assistance in ameliorating the differential
16 economic and staffing burdens on certain categories of facilities, including academic
17 health centers, trauma centers, and safety net hospitals, which are likely to receive high
18 volumes of patients as a result of the EMTALA regulations; and (2) That our AMA work
19 with the EMTALA TAG and CMS to ensure that physicians staffing emergency
20 departments and on-call emergency services be appropriately compensated for
21 providing EMTALA mandated services. Resolution 212 asks (1) That our American
22 Medical Association inform Congress of the implications of the rules and regulations of
23 the Emergency Medical Treatment & Labor Act (EMTALA) by reducing care by critical
24 access hospitals and physicians in Nebraska and other rural areas and seek to change
25 these rules and regulations; and (2) That our AMA work with the Centers for Medicare
26 and Medicaid Services to ensure fairness of EMTALA reviews of critical access
27 hospitals. Resolution 234 asks (1) that our American Medical Association, with input
28 from the Organized Medical Staff Section, coordinate an effort to educate the
29 membership about emergency department coverage issues and the efforts to resolve
30 them; and (2) that the educational effort on emergency department issues be developed
31 in print or electronic format. Resolution 235 asks (1) that our American Medical
32 Association take all actions it deems necessary to assure funding for physician services
33 mandated by Emergency Medical Treatment and Active Labor Act (EMTALA); (2) that
34 our AMA seek to have the Centers for Medicare and Medicaid Services (CMS) require
35 all insurers, both public and private, to pay promptly and fairly all claims for services
36 mandated by EMTALA for all plans they offer, or face fines and penalties comparable to
37 those imposed on providers; and (3) that our AMA seek to have the CMS require all
38 state participating in Medicaid, as a condition of continued participation, establish and
39 adequately fund state Emergency Medical Services funds which physicians providing
40 EMTALA-mandated services may bill, and from which those physicians shall received
41 prompt and fair compensation.
42

43 Your Reference Committee heard testimony in support of CME Report 3 as it
44 recommends adequate funding for all categories of hospitals, and that emergency
45 department and on-call physicians be fairly compensated for providing EMTALA-
46 mandated services. Although the report mentions all categories of hospitals, there was
47 some concern that critical access hospitals and certain inner city hospitals may require
48 specific consideration. There was also testimony voicing concern regarding CMS policy
49 that fails to ensure that the provision of medical care at critical access hospitals rests in
50 the hands of physicians, and that treats allied health professionals in a preferential

1 manner. Your Reference Committee believes that it should add critical access hospitals
2 as a category in the first recommendation to ensure consideration of their unique issues.
3 There was also testimony in support of various aspects of Resolutions 234 and 235 with
4 respect to educating physicians regarding emergency department issues and requiring
5 prompt and fair payment of claims for services mandated by EMTALA. In addition, there
6 was testimony supporting consideration of other advocacy strategies to implement
7 current AMA policy regarding coverage of emergency services without regard to prior
8 authorization or contractual relationships. Your Reference Committee therefore
9 recommends adoption of CME Report 3 as amended.

10
11
12 (13) RESOLUTION 209 - OPPOSITION TO LEGISLATION
13 THAT PRESUMES TO PRESCRIBE PATIENTS'
14 PREFERENCES FOR ARTIFICIAL HYDRATION AND
15 NUTRITION

16
17 RECOMMENDATION A:

18
19 Madam Speaker, your Reference Committee recommends
20 that Resolution 209 be amended by insertion and deletion
21 on lines 34-37 to read as follows:

22
23 That our American Medical Association oppose ~~all state~~
24 ~~and federal~~ legislation that would presume to prescribe the
25 patient's preferences for artificial hydration and nutrition in
26 situations where the patient lacks decision making capacity
27 and an advance directive or living will.

28
29 RECOMMENDATION B:

30
31 Madam Speaker, your Reference Committee recommends
32 that Resolution 209 be adopted as amended.

33
34 **HOD ACTION: Resolution 209 adopted as amended.**

35
36 Resolution 209 asks (1) That our American Medical Association oppose all state and
37 federal legislation that would presume to prescribe the patient's preferences for artificial
38 hydration and nutrition in situations where the patient lacks an advance directive or living
39 will; and (2) That our AMA reaffirm Policies D-140.976, E-0.01, E-2.20, E-8.081 and H-
40 140.970.

41
42 Testimony unanimously supported Resolution 209. The sponsor of Resolution 209
43 asked your Reference Committee to amend the first Resolved to specify its application
44 to patients lacking decision-making capacity. Your Reference Committee concurs with
45 the sponsor's request. Your Reference Committee therefore recommends adoption of
46 Resolution 209 as amended.

1 (14) RESOLUTION 228 - FREEDOM OF PRACTICE IN
2 MEDICAL IMAGING

3
4 RECOMMENDATION A:

5
6 Madam Speaker, your Reference Committee recommends
7 that Resolution 228 be amended by deletion on lines 14-15
8 to read as follows:

9
10 RESOLVED, That our American Medical Association ~~urge~~
11 ~~Congress to request further study on growth in Medicare~~
12 ~~Part B services, specifically the increases in the growth of~~
13 ~~medical imaging, and that our AMA encourage and support~~
14 collaborative specialty development and review of any
15 appropriateness criteria, practice guidelines, technical
16 standards, and accreditation programs, particularly as
17 Congress, federal agencies and third party payers consider
18 their use as a condition of payment, and to use the AMA
19 Code of Ethics as the guiding code of ethics in the
20 development of such policy (Directive to Take Action)

21
22 RECOMMENDATION B:

23
24 Madam Speaker, your Reference Committee recommends
25 that Resolution 228 be amended by insertion on line 22 to
26 read as follows:

27
28 RESOLVED, That our AMA actively oppose efforts by
29 private payers, hospitals, Congress, state legislatures, and
30 the Administration to impose policies designed to control
31 utilization and costs of medical services unless those
32 policies can be proven to achieve cost savings and
33 improve quality while not curtailing appropriate growth and
34 without compromising patient access or quality of care
35 (Directive to Take Action)

36
37 RECOMMENDATION C:

38
39 Madam Speaker, your Reference Committee recommends
40 that Resolution 228 be amended by insertion on line 35 to
41 read as follows:

1 RESOLVED, That our AMA actively oppose any attempts
2 by federal and state legislators, regulatory bodies,
3 hospitals, private and government payers, and others to
4 restrict reimbursement for imaging procedures based on
5 physician specialty, and continue to support the
6 reimbursement of imaging procedures being performed
7 and interpreted by physicians based on the proper
8 indications for the procedure and the qualifications and
9 training of the imaging specialists in that specific imaging
10 technique regardless of their medical specialty. (Directive
11 to Take Action)

12
13 RECOMMENDATION D:

14
15 Madam Speaker, your Reference Committee recommends
16 that Resolution 228 be adopted as amended.

17
18 **HOD ACTION: Resolution 228 adopted as amended.**

19
20 Resolution 228 asks (1) That our American Medical Association urge Congress to
21 request further study on growth in Medicare Part B services, specifically the increases in
22 the growth of medical imaging, and that our AMA encourage and support collaborative
23 specialty development and review of any appropriateness criteria, practice guidelines,
24 technical standards, and accreditation programs, particularly as Congress, federal
25 agencies and third party payers consider their use as a condition of payment, and to use
26 the AMA Code of Ethics as the guiding code of ethics in the development of such policy;
27 (2) That our AMA actively oppose efforts by private payers, Congress, state legislatures,
28 and the Administration to impose policies designed to control utilization and costs of
29 medical services unless those policies can be proven to achieve cost savings and
30 improve quality while not curtailing appropriate growth and without compromising patient
31 access or quality of care; (3) That our AMA actively oppose efforts to require patients to
32 receive imaging services at imaging centers that are mandated to require specific
33 medical specialty supervision and that our AMA support patients receiving imaging
34 services at facilities where appropriately trained medical specialists can perform and
35 interpret imaging services regardless of medical specialty; and (4) That our AMA actively
36 oppose any attempts by federal and state legislators, regulatory bodies, private and
37 government payers, and others to restrict reimbursement for imaging procedures based
38 on physician specialty, and continue to support the reimbursement of imaging
39 procedures being performed and interpreted by physicians based on the proper
40 indications for the procedure and the qualifications and training of the imaging specialists
41 in that specific imaging technique regardless of their medical specialty.

42
43 Your Reference Committee recommends adoption of Resolution 228, with amendments.
44 This recommendation is based on extensive testimony which overwhelmingly supported
45 Resolution 228. Your Reference Committee recognizes that the freedom of medical
46 imaging described in Resolution 228 may have positive effects on patient care,
47 convenience, and choice. Your Reference Committee believes, however, that
48 Resolution 228 should be amended. Congress and other entities are already studying
49 the growth in physician services, particularly physician imaging; therefore, it is
50 unnecessary for our AMA to urge Congress to undertake such a study. Testimony also

1 requested that Resolveds two and four of Resolution 228 be amended to include
2 hospitals, and your Reference Committee concurs. Your Reference Committee
3 therefore recommends adoption of Resolution 228 as amended.
4

5
6 (15) RESOLUTION 230 - MINOR STATUTE OF REPOSE
7

8 RECOMMENDATION A:
9

10 Madam Speaker, your Reference Committee recommends
11 that Resolution 230 be amended by insertion and deletion
12 on lines 18-26 to read as follows:
13

14 RESOLVED, That our American Medical Association ~~draft~~
15 ~~model support~~ federal legislation that would establish a
16 Minor Statute of Repose/Limitations that includes the
17 following language: An action by a minor upon a medical
18 claim shall be commenced within ~~4~~ 3 years from the date
19 of the alleged manifestation of injury, except that actions
20 by a minor under the full age of 6 years shall be
21 commenced within ~~4~~ 3 years of manifestation of injury or
22 prior to the minor's 8th birthday, whichever provides the
23 longer period. Such time limitation shall be tolled for
24 minors for any period during which a parent or guardian
25 and a health care provider or health care organization
26 have committed fraud or collusion in the failure to bring an
27 action on behalf of the injured minor. (Directive to Take
28 Action)
29

30 RECOMMENDATION B:
31

32 Madam Speaker, your Reference Committee recommends
33 that the title of Resolution 230 be changed to read as
34 follows:
35

36 MINOR STATUTE OF REPOSE/LIMITATIONS
37

38 **HOD ACTION: Resolution 230 referred for decision.**
39

40 Resolution 230 asks that our American Medical Association draft model federal
41 legislation that would establish a Minor Statute of Repose that includes the following
42 language: An action by a minor upon a medical claim shall be commenced within 4
43 years from the date of the alleged manifestation of injury, except that actions by a minor
44 under the full age of 6 years shall be commenced within 4 years of manifestation of
45 injury or prior to the minor's 8th birthday, whichever provides the longer period. Such
46 time limitation shall be tolled for minors for any period during which a parent or guardian
47 and a health care provider or health care organization have committed fraud or collusion
48 in the failure to bring an action on behalf of the injured minor.

49 Your Reference Committee heard limited testimony on Resolution 230. The sponsor
50 stated that AMA policy on statute of repose would be useful in its state advocacy efforts.

1 Other testimony cautioned that Resolution 230 needs to remain within the limits of
2 existing AMA policy. Your Reference Committee believes that a few amendments to
3 Resolution 230 are necessary in order to be consistent with AMA policy. Although the
4 Resolved is consistent with existing policy on statute of repose, the Resolved needs to
5 be amended in order to be consistent with our AMA's stronger policy on statute of
6 limitations. To achieve this consistency, your Reference Committee believes that
7 reference to "4 years" should be changed to "3 years." Because the Resolved as
8 amended reflects AMA policy on statute of limitations and statute of repose, your
9 Reference Committee believes that the term "statute of limitations" should also be
10 reflected in the title and body of the Resolution. Your Reference Committee therefore
11 recommends adoption of Resolution 230 as amended.

12
13
14 (16) RESOLUTION 236 - EXPEDITIOUS SECURITY
15 CLEARANCE AND VISA PROCESSING OF PHYSICIANS

16
17 RECOMMENDATION A:

18
19 Madam Speaker, your Reference Committee recommends
20 that Resolution 236 be amended by insertion and deletion
21 on lines 35-36 to read as follows:

22
23 That our AMA ~~instruct~~urge federal agencies and residency programs not to
24 discriminate against any IMGs, particularly those from Pakistan. (Directive to
25 Take Action)

26
27 RECOMMENDATION B:

28
29 Madam Speaker, your Reference Committee recommends
30 that Resolution 236 be adopted as amended.

31
32 **HOD ACTION: Resolution 236 adopted as amended.**

33
34 Resolution 236 asks (1) that our American Medical Association lobby the relevant
35 federal agencies to process J-1 and B-1 visa applications and security clearances more
36 expeditiously for IMGs already accepted into residency programs than those in the
37 general pool of visa applicants; (2) that our AMA lobby the relevant federal agencies to
38 issue J-1 visa to IMGs for the entire duration of their residency program up to a
39 maximum 7 years; and (3) that our AMA instruct federal agencies and residency
40 programs not to discriminate against IMGs, particularly those from Pakistan.
41 Your Reference Committee heard unanimous testimony supporting Resolution 236.
42 Your Reference Committee is sympathetic to all the concerns raised by those testifying
43 and agrees that the issues raised must be addressed. Accordingly, your Reference
44 Committee recommends adoption of Resolution 236.

1 (17) RESOLUTION 203 - GUAM PROFESSIONAL LIABILITY
2 CRISIS IN RED ALERT

3
4 RECOMMENDATION:

5
6 Madam Speaker, your Reference Committee recommends
7 that the following Substitute Resolution 203 be adopted:

8
9 RESOLVED, That our American Medical Association
10 continue to work with the National Specialty Societies and
11 State Medical Societies, as well as the Medical Societies of
12 Guam and other U.S. territories to reform the medical
13 liability system.

14
15 RESOLVED, That our AMA assess the inclusion of Guam
16 and other U.S. territories on the AMA's medical liability
17 crisis map.

18
19 **HOD ACTION: Substitute Resolution 203 adopted.**

20
21 Resolution 203 asks (1) That our American Medical Association work with the Guam
22 Medical Society in efforts to reform the tort system on the island of Guam, and seek
23 immediate passage of a reasonable capitation on damages to community physicians
24 that is equal to the current capitation within Guam's only hospital; (2) That our AMA work
25 with the Guam Medical Society and the Guam legislature and governor to encourage
26 and support a physician-led task force to provide adequate liability coverage for
27 physicians practicing on Guam; and (3) That our AMA include Guam on the AMA's
28 medical liability crisis map.

29
30 Your Reference Committee heard testimony in unanimous support of Resolution 203,
31 which highlighted the lack of affordable medical liability insurance in Guam and the dire
32 need for medical liability reform. The Delegate from Guam offered an amendment to the
33 third Resolved to allow our AMA to assess the inclusion of Guam on the AMA's medical
34 liability crisis map. A friendly amendment was also offered to expand Resolution 203 to
35 include all U.S. territories, including Guam. Your Reference Committee wholeheartedly
36 agrees with the testimony and sympathizes with the medical liability situation in Guam.
37 Furthermore, the Committee understands that our AMA's Advocacy Resource Center
38 (ARC) provides materials and legislative support on medical liability reform to all
39 members of the Federation, including Guam and U.S. territories. Your Reference
40 Committee also understands that our AMA has a process in place and specific criteria to
41 consider when determining how to categorize jurisdictions on our AMA's medical liability
42 crisis map. With this in mind, your Reference Committee recommends adopting the
43 substitute resolution. First, your Reference Committee recommends expanding the first
44 Resolved to include national specialty societies and state medical societies, as well as
45 Medical Societies of Guam and other U.S. territories. Second, your Reference
46 Committee recommends deleting the second Resolved, because this support is already
47 available through the ARC's Campaign on Medical Liability Reform. Third, your
48 Reference Committee recommends amending the third Resolved, as recommended by
49 the sponsor, to clarify the process currently in place to categorize states and jurisdictions
50 on the AMA medical liability crisis map.

1 (18) RESOLUTION 210 - FRIVOLOUS LAWSUIT
2 MANAGEMENT

3
4 RECOMMENDATION:

5
6 Madam Speaker, your Reference Committee recommends
7 that the following Substitute Resolution 210 be adopted:

8
9 RESOLVED, That our American Medical Association
10 develop a plan to advocate to deter frivolous medical
11 liability suits.

12
13 **HOD ACTION: Substitute Resolution 210 adopted.**

14
15 Resolution 210 asks that our American Medical Association develop a plan to advocate
16 to appropriately deter frivolous malpractice cases, frivolous arguments, and abusive
17 behavior in malpractice cases including, but not limited to, the following: (1) a minimum
18 \$10,000 penalty payable by the plaintiff lawyer to the defendants for any frivolous
19 argument or case and higher amounts if the defendant can prove higher actual costs
20 and/or emotional distress of a higher amount; (2) a plaintiff's lawyer should not be able
21 to assert the matter was not frivolous merely because he hired an expert, especially
22 when the expert witness's testimony is ruled inadmissible by the court or the expert
23 declines to testify; (3) a plaintiff's lawyer should not be able to assert the matter was not
24 frivolous merely because the lawyer relied on a client's or other witness's testimony if
25 reasonable investigation should have shown the witness was not truthful; (4) a plaintiff's
26 lawyer should be barred from deposing a defendant for more than 8 hours. Failure to do
27 so is frivolous and abusive discovery punishable by a minimum \$10,000 penalty payable
28 by the lawyer to the defendant; (5) any case or issue brought by the plaintiff that is
29 dismissed by the court on summary judgment or at any time before it goes to the jury
30 shall be presumed to be frivolous and subject to a minimum \$10,000 penalty payable by
31 the plaintiff lawyer to the defendants. To defeat this presumption, the plaintiff's lawyer
32 must prove by clear and convincing evidence that there was a reasonable basis for
33 bringing the case or raising the issue; and (6) Any plaintiff's lawyer found to have
34 brought a frivolous argument or case more than once in any court in the United States
35 shall pay double these penalties for the second claim or case, triple for the third, etc.
36 After the third such claim or case, the lawyer shall be reported by the court to the bar
37 association of every state in which the lawyer is admitted.

38
39 Your Reference Committee heard extensive testimony regarding Resolution 210. This
40 testimony centered on the complexity of the issues raised in Resolution 210, specifically
41 the variations from state to state regarding laws governing frivolous or meritless claims
42 and the difficulty of defining the term "frivolous." Your Reference Committee also
43 recognizes that our AMA supports federal legislation to reduce lawsuit abuse through the
44 sanctioning of attorneys who file meritless or frivolous claims. There were also
45 suggestions that Resolution 210 be referred to our Board of Trustees; however, your
46 Reference Committee believes that the issues raised are adequately addressed by
47 adopting Resolution 210 as amended.

1 (19) RESOLUTION 213 - BENZODIAZEPINE RESTRICTIONS

2
3 RECOMMENDATION:

4
5 Madam Speaker, your Reference Committee recommends
6 that the following Substitute Resolution 213 be adopted:

7
8 RESOLVED, That our American Medical Association work
9 to end the exclusion of medications of the benzodiazepine
10 class from CMS reimbursement.

11
12 **HOD ACTION: Substitute Resolution 213 adopted.**

13
14 Resolution 213 asks that our American Medical Association address the issue of
15 benzodiazepine restrictions in the Medicare Modernization Act of 2003 immediately,
16 consulting with CMS leadership and with Congressional leadership as may be required
17 to maintain continuity of medically-necessary treatment with medications of the
18 benzodiazepine class for Americans served through CMS programs.

19
20 Testimony was heard in general support of Resolution 213. Your Reference Committee
21 concurs with testimony seeking amendment of Resolution 213 by asking our AMA to
22 work to prohibit the potential exclusion of all medications of the benzodiazepine class
23 from CMS reimbursement. Your Reference Committee believes this amendment
24 provides further clarification and therefore recommends adoption of Substitute
25 Resolution 213.

26
27
28 (20) RESOLUTION 214 - LIMITS ON NON-ECONOMIC
29 DAMAGES AND CONTINGENCY FEES

30
31 RECOMMENDATION:

32
33 Madam Speaker, your Reference Committee recommends
34 that the following Substitute Resolution 214 be adopted:

35
36 RESOLVED, That our American Medical Association
37 support federal legislation that does not preempt state
38 medical tort reform laws that have contingency fee limits
39 that are more restrictive than the MICRA limits on
40 contingency fees.

41
42 RESOLVED, That our AMA explore federal legislation that
43 would correct inadequate state medical liability laws, while
44 preserving proven effective state medical liability reforms.

45
46 RESOLVED, That our American Medical Association
47 develop proposed legislation and support federal medical
48 liability insurance reform legislation based on the California
49 Medical Injury Compensation Reform Act (MICRA) which

1 (1) includes a \$250,000 cap on non-economic damages
2 and a MICRA style sliding scale for limits on attorney
3 contingency fees; (2) requires federal law to preempt state
4 law if the state law cap on non-economic damages is
5 greater than \$250,000; (3) does not preempt state medical
6 tort reform laws which are equal to or more restrictive than
7 the federal \$250,000 cap on non-economic damages; and
8 (4) does not preempt state medical tort reform laws that
9 have contingency fee limits that are more restrictive than
10 the MICRA limits on contingency fees. (Directive to Take
11 Action)

12
13 **HOD ACTION: First two Resolved statements of Substitute**
14 **Resolution 214 adopted. Third Resolved statement**
15 **referred for decision.**
16

17 Resolution 214 asks that our American Medical Association develop proposed legislation
18 and only support any federal medical liability insurance reform legislation based on the
19 California Medical Injury Compensation Reform Act (MICRA) which (1) includes a
20 \$250,000 cap on non-economic damages and a MICRA style sliding scale for limits on
21 attorney contingency fees; (2) requires federal law to preempt state law if the state law
22 cap on non-economic damages is greater than \$250,000; (3) does not preempt state
23 medical tort reform laws which are equal to or more restrictive than the federal \$250,000
24 cap on non-economic damages; and (4) does not preempt state medical tort reform laws
25 that have contingency fee limits that are more restrictive than the MICRA limits on
26 contingency fees.
27

28 Your Reference Committee heard extensive testimony on Resolution 214. While the
29 sponsor of the Resolution offered an amendment that addressed some concerns raised
30 during the hearing, the overwhelming majority of those who testified opposed the
31 Resolution, even as amended. Most of the testimony expressed the sentiment that
32 Resolution 214 would hinder our AMA's efforts to seek passage of federal medical
33 liability reforms that provide a cap on non-economic damages. Your Reference
34 Committee heard several comments that current AMA policy provides flexibility to allow
35 our AMA to thoughtfully consider all options that could advance medical liability reform at
36 the federal level. Your Reference Committee agrees that we must maintain some
37 flexibility, especially in consideration of a viable advocacy strategy to pass a bill in the
38 Senate that could be reconciled with a strong reform bill passed in the House of
39 Representatives.
40

41 The sponsor of this Resolution expressed concerns that the "flexi-cap" provision
42 included in federal legislation would not benefit those states that have passed caps on
43 non-economic damages higher than \$250,000. The federal flexi-cap legislation would
44 impose a hard \$250,000 cap on non-economic damages in states that have not enacted
45 laws that specify "a particular monetary amount of compensatory or punitive damages
46 (or the total amount of damages) that may be awarded in a health care lawsuit,
47 regardless of whether such monetary amount is greater or lesser than is provided for
48 under [federal law]." In other words, it allows states that have passed laws limiting non-
49 economic damages or total damages to maintain their laws. The flexi-cap would benefit
50 states that have been unable to enact their own laws that limit non-economic damages

1 because of state constitutional bans, rulings by state Supreme Courts that overturn caps
2 laws, or lack of political will or support to pass a cap law. It can also be argued that a
3 flexi-cap would benefit states that allow exceptions to their caps if such exceptions
4 themselves do not specify a “particular monetary amount.”
5

6 Your Reference Committee is aware that our AMA has substantial current policy that is
7 meant to protect those states that have passed effective medical liability reforms.
8 Existing policy would preclude our AMA from supporting federal legislation that
9 undermines effective tort reform provisions already in place in the states (see policies H-
10 435.978, H-165.895, D-165.980, H-435.967, H-435.964, and H-435.959). Taking this
11 into consideration, your Reference Committee believes that Resolution 214 is
12 inconsistent with current AMA policy and should not be adopted. Your Reference
13 Committee also recognizes there are two distinct issues raised in Resolution 214, and
14 that our current policy is consistent with the intent of the language in the Resolution
15 calling for protection of strong states laws on attorney contingent fees. Therefore, your
16 Reference Committee recommends a substitute resolution that clarifies that our AMA will
17 not support federal preemptive legislation that would undermine effective state medical
18 liability reforms that limit attorney contingent fees.
19

20
21 (21) RESOLUTION 229 – PHYSICIAN FREEDOM
22 TO COLLECTIVELY NEGOTIATE WITH
23 MANAGED CARE PLANS AND HEALTH
24 INSURING ORGANIZATIONS
25

26 RECOMMENDATION:
27

28 Madam Speaker, your Reference Committee recommends
29 that the following Substitute Resolution 229 be adopted:
30

31 RESOLVED, That our American Medical Association
32 increase the visibility of its campaign for antitrust relief for
33 physicians, including specific strategies for accomplishing
34 this goal.
35

36 RESOLVED, That our AMA prepare and distribute to its
37 membership educational materials pertaining to current
38 antitrust issues as it affects its members (Directive to Take
39 Action);
40

41 RESOLVED, That our AMA empower its members through
42 these educational materials to embark upon a grassroots
43 legislative campaign to secure antitrust relief for physicians
44 when negotiating with third party payers (Directive to Take
45 Action)

1 RESOLVED, That our AMA speak forcefully to its
2 membership that no member should feel compelled to sign
3 any contractual agreement that harms his/her ability to
4 provide compassionate and quality care to his/her patients
5 (Reaffirm HOD Policy);
6

7 RESOLVED, That our AMA advance as part of its patient
8 advocacy campaign that physicians must have the right to
9 enter into group discussions with managed care
10 companies, exempt from antitrust violations, for the
11 purpose of reducing the barriers to patient access and
12 administrative burdens on physicians that delay patient
13 care even if prohibited, by law, from discussing fees and
14 reimbursement rates. (Directive to Take Action
15

16 **HOD ACTION: Substitute Resolution 229 adopted.**
17

18 Resolution 229 asks (1) That our American Medical Association resurrect its antitrust
19 relief for physicians' campaign during the winter session of the 109th Congress (January
20 of 2006) and make this initiative one of its top legislative priorities; (2) That this
21 legislation promulgating antitrust relief for physicians and physician groups incorporate
22 the intent of the Campbell Bill as passed in the House of the 106th Congress in 2000; (3)
23 That our AMA prepare and distribute to its membership educational materials pertaining
24 to current antitrust issues as it affects its members; (4) That our AMA empower its
25 members through these educational materials to embark upon a grassroots campaign at
26 the legislative level to secure antitrust relief for physicians when negotiating with third
27 party payers; (5) That our AMA unveil its new "Antitrust Relief Campaign for Physicians"
28 at the 2005 Interim Meeting; (6) That our AMA speak forcefully to its membership that no
29 member should feel compelled to sign any contractual agreement that harms his/her
30 ability to provide compassionate and quality care to his/her patients (7) That our AMA
31 undertake an evaluation of the insurance industry's apparent monopsony in the health
32 care market, and present evidence of the same to legislators supportive of antitrust
33 relief; and (8) That our AMA advance as part of its patient advocacy campaign that
34 physicians must have the right to enter into group discussions with managed care
35 companies, exempt from antitrust violations, for the purpose of reducing the barriers to
36 patient access and administrative burdens on physicians that delay patient care even if
37 prohibited, by law, from discussing fees and reimbursement rates.
38

39 Your Reference Committee heard testimony in support of Resolution 229 in that there is
40 a desire for antitrust relief to remain a top priority of the AMA and that legislation such as
41 the Campbell bill that passed in the U.S. House of Representatives in 2000 should be
42 the model. It was expressed that physicians still need the ability to jointly negotiate with
43 third party payors and that, to date, State Action Doctrine legislation in the states has not
44 been effective in accomplishing this goal. There was mention that the AMA might want
45 to consider focusing strategy on obtaining introduction of a bill in the U.S. Senate. Other
46 testimony acknowledged that antitrust relief is still a priority of the AMA but that other
47 advocacy issues are a crisis and are currently the focus of the AMA's advocacy efforts in
48 Washington. Testimony also suggested that the HOD prioritization exercise conducted
49 at the conclusion of each reference committee is the appropriate mechanism for setting
50 AMA priorities. In addition, the legislation supported by the AMA since 2000 still

1 provides an option to negotiate as did the Campbell bill, but it also includes other options
2 for physicians. There was also testimony that AMA continues to extensively evaluate
3 monopsony power in the insurance industry, present evidence to the Congress and
4 Federal Agencies, and urge prompt action against powerful health insurers. Your
5 Reference Committee is aware that the AMA remains committed to introduction of a bill
6 in the Senate and that legislation identical to the Campbell bill would currently be
7 blocked in both the U.S. House of Representatives and the Senate due to opposition by
8 the chairman of the committees of jurisdiction, as acknowledged in the hearing. Your
9 Reference Committee therefore recommends adoption of Resolution 229 as amended.

10
11
12 (22) RESOLUTION 201 - SAVINGS ACCOUNTS FOR
13 EXTENDED REPORTING ENDORSEMENT POLICIES
14 AND OTHER LIABILITY INSURANCE COSTS

15
16 RECOMMENDATION:

17
18 Madam Speaker, your Reference Committee recommends
19 that Resolution 201 be referred.

20
21 **HOD ACTION: Resolution 201 referred.**

22
23 Resolution 201 asks (1) That our American Medical Association seek legislation
24 supporting a pre-tax Extended Reporting Endorsement Savings Account whereby the
25 amount of money contributed before taxes and interest on earnings from those monies
26 be allowed to grow tax free until such time as an extended reporting endorsement must
27 be purchased and that the balance of any remaining funds would return to the physician
28 without IRS penalty and be subject to taxation at that time; and (2) That our AMA work
29 with physicians and physician groups to develop and encourage the use of savings
30 plans for extended reporting liability coverage and other liability insurance costs.

31
32 Although your Reference Committee heard limited testimony regarding Resolution 201,
33 your Reference Committee believes that this resolution raises many complex political,
34 fiscal, and legal issues that demand in-depth consideration. Your Reference Committee
35 therefore recommends referral of Resolution 201.

36
37
38 (23) RESOLUTION 224 – LESSONS FROM THE
39 TERRI SCHIAVO CASE

40
41 RECOMMENDATION:

42
43 Madam Speaker, your Reference Committee recommends
44 that Resolution 224 be referred.

45
46 **HOD ACTION: Resolution 224 referred.**

47
48 Resolution 224 asks (1) That our American Medical Association maintain its leadership
49 role by further educating and encouraging Americans directly and via members and
50 component societies on the necessity of writing and appropriately distributing Advance

1 Directives long before an illness strikes; (2) That the AMA Board of Trustees discuss and
2 report back at the 2005 Interim Meeting on the feasibility of requiring by legislation or
3 regulation, a written Advance Directive at the time of enrollment in a health insurance
4 plan including Medicare and Medicaid which will be available to physicians and hospitals
5 upon request, or at the time of application for a driver's license; (3) That the AMA Board
6 of Trustees explore and report back at the 2005 Interim Meeting the feasibility of
7 collaborating with other interested organizations with the specific goals of increasing
8 awareness, creation and easy accessibility of Advance Directives by a majority of
9 Americans; (4) That our AMA consider adding to our Principles of Medical Ethics another
10 item explicitly recognizing the rights of the patients and legally responsible family
11 members when patients are unable to speak for themselves in determining the care
12 provided); and (5) That our AMA urge that the Principles of Medical Ethics be
13 consistently adhered to by all physicians, not only when they are delivering patient care,
14 but also when addressing health-related issues in a courtroom, a boardroom, a local
15 community, the media or in the Congress of the United States.

16
17 Your Reference Committee heard extensive testimony on Resolution 224. Testimony
18 addressed a host of complicated ethical issues, which deserve in-depth consideration.
19 To ensure reconciliation with current AMA policy and a thorough review and analysis of
20 these issues, your Reference Committee recommends referral of Resolution 224.

21
22
23 (24) RESOLUTION 232 – REQUEST FOR CONGRESSIONAL
24 ACTION ON INSURANCE ANTITRUST EXEMPTION

25
26 RECOMMENDATION:

27
28 Madam Speaker, your Reference Committee recommends
29 that Resolution 232 be referred.

30
31 **HOD ACTION: Resolution 232 referred for report back at I-05.**

32
33 Resolution 232 asks (1) That our American Medical Association send all members of
34 Congress a letter, signed by all 50 state AMA delegations, seeking revocation of the
35 antitrust exemption presently enjoyed by insurance companies; and (2) That our AMA
36 continue to advocate to the Federal Trade Commission and Department of Justice for
37 more flexible and fair treatment under the antitrust laws so that providers and insurers
38 alike are at least subject to the same standards of federal antitrust laws.

39
40 Your Reference Committee heard testimony in favor of Resolution 232. It also heard
41 testimony in opposition to Resolution 232, or at a minimum, in favor of referral of the
42 resolution due to the complexity of the issue. Your Reference Committee believes that
43 there is substantial confusion among physicians regarding the impact of the insurance
44 industry antitrust exemption. Our AMA has current policy H-180.975 that required our
45 AMA in 1991 to analyze proposed amendments to the McCarran-Ferguson Act to
46 determine whether it would increase physicians' ability to deal with insurance companies
47 or increase scrutiny of insurance industry practices. Since then there has been no
48 action by our AMA advocating to repeal the insurance industry antitrust exemption. Your
49 Reference Committee was informed that the revocation of the antitrust exemption, as
50 requested in Resolution 232, would not help advance our AMA's goals to increase the

1 ability of physicians to negotiate with large insurers, nor would it increase the ability of
2 Federal antitrust enforcement agencies to investigate and challenge insurance company
3 mergers or anticompetitive activity. Your Reference Committee believes that Resolution
4 232 should therefore be referred for study so that physicians may be educated on the
5 impact of repeal of the McCarran-Ferguson Act and that potential recommendations, if
6 any, may be crafted regarding the effects of advocating for such repeal.

7
8
9 (25) RESOLUTION 202 - ESTABLISHING PARITY BETWEEN
10 PROFESSIONS

11
12 RECOMMENDATION:

13
14 Madam Speaker, your Reference Committee recommends
15 that Resolution 202 not be adopted.

16
17 **HOD ACTION: Resolution 202 not adopted.**

18
19 Resolution 202 asks (1) that American Medical Association adopt a policy that lawyers
20 should be held to the same standards as physicians requiring all practicing attorneys to
21 purchase professional liability coverage and prohibiting them from the common practice
22 of fee splitting; and (2) that our AMA encourage each of the component state and
23 specialty societies and associations to take similar position.

24
25 Your Reference Committee recommends that Resolution 202 not be adopted. Although
26 some testimony supported Resolution 202, your Reference Committee believes strongly
27 that our AMA should remain sharply focused on achieving medical liability reform.
28 Diverting our AMA's advocacy efforts to address the medical liability plaintiffs' bar will
29 detract from this focus. Your Reference Committee also agrees with testimony stating
30 that Resolution 202 does not advance the practice of medicine. Your Reference
31 Committee notes that not all states mandate the purchase of medical liability insurance.
32 Your Reference Committee is concerned that adoption of Resolution 202 could be
33 construed as requiring all physicians to purchase medical liability coverage, even in
34 states where that coverage is not required.

35
36
37 (26) RESOLUTION 223 - OUTSOURCING OF MEDICAL DATA

38
39 RECOMMENDATION:

40
41 Madam Speaker, your Reference Committee recommends
42 that Resolution 223 not be adopted.

43
44 **HOD ACTION: Resolution 223 referred for report back at I-05.**

45
46 Resolution 223 asks that our American Medical Association adopt policy stipulating that
47 the outsourcing of medical and financial information outside of US jurisdiction should
48 meet with Health Insurance Portability and Accountability Act regulations for the
49 appropriate licensing of individuals providing services.

1 Your Reference Committee heard no testimony regarding Resolution 223. The
2 Committee recognizes that Resolution 223 contains important issues regarding the
3 confidentiality of medical data and certain licensing concerns with respect to outsourcing
4 of medical services to overseas physicians and other business associates. As written,
5 however, the Resolution would require clarification before this Committee could act upon
6 it. The authors of Resolution 223 were asked for clarification but no testimony was
7 presented. For these reasons, your Reference Committee recommends that Resolution
8 223 not be adopted.

9
10
11 (27) RESOLUTION 225 - THE MILLION MEDICAL PROVIDER
12 MARCH

13
14 RECOMMENDATION:

15
16 Madam Speaker, your Reference Committee recommends
17 that Resolution 225 not be adopted.

18
19 **HOD ACTION: Resolution 225 not adopted.**

20
21 Resolution 225 asks that our American Medical Association schedule and coordinate a
22 "Million Medical Provider March" in Washington, DC, to encourage reform of the
23 Medicare and professional liability insurance systems.

24
25 Your Reference Committee heard overwhelming testimony against Resolution 225. Due
26 to its exorbitant expense, mandatory nature, exclusion of patient and consumer group
27 participation and potential to generate counter-demonstrations, your Reference
28 Committee recommends that Resolution 225 not be adopted.

29
30
31 (28) RESOLUTION 226 – WHITE COATS AS A SYMBOL OF
32 UNITY

33
34 RECOMMENDATION:

35
36 Madam Speaker, your Reference Committee recommends
37 that Resolution 226 not be adopted.

38
39 **HOD ACTION: Resolution 226 not adopted.**

40
41 Resolution 226 asks that our American Medical Association encourage all physicians
42 visiting Capitol Hill or state legislatures to wear white coats as a symbol of unity and
43 solidarity of the medical profession on advocacy issues.

44
45 Testimony on Resolution 226 was limited and exclusively negative. Your Reference
46 Committee therefore recommends that Resolution 226 not be adopted.

1 (29) RESOLUTION 227 – COLLABORATION OF ADVOCACY
2 ACTIVITIES WITH COMPONENT MEDICAL SOCIETIES
3

4 RECOMMENDATION:
5

6 Madam Speaker, your Reference Committee recommends
7 that Resolution 227 not be adopted.
8

9 **HOD ACTION: Resolution 227 not adopted.**
10

11 Resolution 227 asks (1) That our American Medical Association create and maintain an
12 online advocacy calendar that tracks and facilitates scheduling of House of Delegates
13 component society members' visits to Capitol Hill with a goal of having at least one
14 society on Capitol Hill each week; (2) That our AMA publish on its web site information
15 regarding the position of the members of the United States Senate and House of
16 Representatives on major AMA advocacy issues; and (3) That our AMA include patients
17 in appropriate advocacy activities and encourage all state and specialty societies to
18 include patients in appropriate advocacy activities.
19

20 Your Reference Committee heard limited but negative testimony on Resolution 227.
21 Your Reference Committee believes that some of the activity called for in Resolution 227
22 may be duplicative of existing AMA activities or potentially detrimental. Your Reference
23 Committee therefore recommends that Resolution 227 not be adopted.
24
25

26 (30) RESOLUTION 233 - REPORTING RESIDENTS TO THE
27 NPDB RELATED TO MEDICAL MALPRACTICE
28 PAYMENTS WHILE IN A TRAINING PROGRAM
29

30 RECOMMENDATION:
31

32 Madam Speaker, your Reference Committee recommends
33 that Resolution 233 not be adopted.
34

35 **HOD ACTION: Resolution 233 adopted as amended with**
36 **deletions of Resolves 2 and 3.**
37

38 Resolution 233 asks (1) that our American Medical Association reaffirm Policy H-
39 355.980; and (2) that our AMA amend Policy H-355.980 to include "(4) a resident may
40 be included in the a report to the NPDB related to a malpractice payments that occurs
41 during the required supervised activities of their training program when it is found that
42 the resident failed to act according to the supervising faculty physician's direction or
43 according protocols established by the institution as a root cause of the event leading to
44 the malpractice suit;" (3) that our AMA amend Policy H-355.980 to include "(5) a
45 physician who is enrolled in a training program may be included in a report to the NPDB
46 related to a malpractice payment of the event leading to the suit occurs while the
47 resident is working independent of their training program and independent of faculty
48 supervisor; and (4) that our AMA work with the Association of American Medical

1 Colleges and other interested parties to reinvigorate its efforts to successfully change
2 NPDB policy through legislative or other means in accordance with AMA Policy H-
3 355.980.

4

5 Your Reference Committee heard testimony largely opposed to Resolution 233. Your
6 Reference Committee agrees with testimony that this Resolution conflicts with existing
7 AMA policy, which calls for the exclusion of residents from reports to the National
8 Practitioner Data Bank (NPDB) during supervised residency training. Your Reference
9 Committee also concurs with testimony that the NPDB is fundamentally flawed and
10 therefore recommends that Resolution 233 not be adopted.

1 Madam Speaker, this concludes the report of Reference Committee B. Your Reference
2 Committee would like to thank Dennis Agliano, MD, Seyed Aleali, MD, Ralph Coppola,
3 MD, Hazle Konerding, MD, Shannon Pryor, MD, Jack Resneck, Jr., MD, along with AMA
4 Staff: Wes Cleveland, JD, George Cox, JD, Wendy Holmes, Kimberly Horvath, JD, Mary
5 Kuffner, JD, Kai Sternstein, JD, and all those who testified before the Committee.

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