

RESOLUTION 1 - 2008

Subject: Reducing Excessive Costs of Medical Care
Introduced by: Dane County Medical Society
Referred to: Health Insurance Coverage and Access

- 1 Whereas, US health care (HC) expenditures continue to rise much faster than wages and inflation;
2 and
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4 Whereas, HC bills are the major cause of US personal bankruptcy; and
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6 Whereas, HC cost has been a major factor in the loss of US jobs overseas; and
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8 Whereas, Cost is a major cause of millions of uninsured in the richest country in the world; and
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10 Whereas, American HC expenditures far exceed that of everywhere else in the world and is now
11 considered by many to be a social "crisis" that threatens our democracy; and
12
13 Whereas, Failure of American medicine to provide effective leadership to control cost has led to
14 being excluded from the policy table and subjected to increasingly oppressive
15 micromanagement; and
16
17 Whereas, Recent evidence from the National Ambulatory Study shows that physicians are
18 responsible for \$47 - 194 million in costs for overuse of just three screening tests during periodic
19 health exams (ECG, Chest Xray, and Urinalysis) not recommended by respected guidelinesⁱ; and
20
21 Whereas, Recent evidence from RAND reports Americans receive only 55% of care for primary
22 prevention, or acute and chronic illness recommended by respected guidelines resulting in
23 unnecessary death and expensive rescue medical and surgical careⁱⁱ; and
24
25 Whereas, Much credible evidence now shows that physicians are by their daily clinical behavior
26 avoidably contributing to the excess cost of medical care; therefore be it
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28 RESOLVED, That the Wisconsin Medical Society appoint a task group to determine all the
29 currently known ways physicians can reduce their daily contributions to the excessive costs of
30 medical care; and be it further
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32 RESOLVED, That this task group shall recommend an affordable action plan for the Wisconsin
33 Medical Society to advise and regularly remind physicians of these ways; and be it further
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35 RESOLVED, That this report shall be presented to the House of Delegates in 2009 for action; and
36 be it further
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38 RESOLVED, That the Wisconsin Medical Society request that the American Medical
39 Association complete a similar study and develop an action plan at the national level.

Fiscal note: \$5,000-\$10,000 for a Task Force (five hours/week, times forty weeks at \$34.50/hr = \$6900).

ⁱ Merenstein D, Daumit GL, Powe NR. Use and costs of nonrecommended tests during routine preventive health exams. *Am J Prev Med* 2006;30:521-527.

ⁱⁱ McGlynn EA, Asch SM, Adams J, et. al. The quality of health care delivered to adults in the United States. *New Engl J Med* 2003;348:2635-45.

Relevant Policies

Society: None

AMA:

H-155.985 Fairness in Cost Containment

Our AMA(1) supports continued efforts, at all appropriate opportunities and as one of its highest priorities, to seek remedies eliminating any discriminatory treatment against physicians; (2) supports continued and intensified efforts to promote voluntary health care cost containment without compromising quality of care; (3) believes that any cost containment recommendations or activities adopted by the AMA should be applied equally to federal and state hospitals, facilities and medical programs and government administrative mechanisms; (4) urges a similar commitment to cost containment I governmental health care facilities; and (5) urges government to acknowledge and minimize the adverse impact that governmental controls have on health care cost. Our AMA supports and will seek (a) legislation to require that medical programs administered by all federal government agencies, exclusive of military health care systems, make publicly available annually, and publish separately, their medical care costs and their administrative costs; and (b) legislation to require that federal agencies, exclusive of military health care systems, provide a fiscal impact report on any proposed new program or modifications to present programs, clearly demonstrating how the cost of care will be reduced or the quality improved, and the expected effect of such new or altered programs on the providers of the services. (Res. 61, A-78; Res. 29, A-78; Res. 53, A-80; BOT Rep. QQ, I-86; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: CLRPD Rep. B, I-90; CMS Rep. 12, A-95; Reaffirmation A-00; Reaffirmation A-01; Reaffirmation A-02)

H-120.978 Principles of Drug Utilization Review

Our AMA adopts the following Principles of Drug Utilization Review. Principle 1: The primary emphasis of a DUR program must be to enhance quality of care for patients by assuring appropriate drug therapy. Characteristics: (a) While a desired therapeutic outcome should be cost-effective, the cost of drug therapy should be considered only after clinical and patient considerations are addressed; (b) Sufficient professional prerogatives should exist for individualized patient drug therapy.

Principle 2: Criteria and standards for DUR must be clinically relevant. Characteristics: (a) The criteria and standards should be derived through an evaluation of (i) the peer-reviewed clinical and scientific literature and compendia; (ii) relevant guidelines obtained from professional groups through consensus-derived processes; (iii) the experience of practitioners with expertise in drug therapy; (iv) drug therapy information supplied by pharmaceutical manufacturers; and (v) data and experience obtained from DUR program operations. (b) Criteria and standards should

identify underutilization as well as overutilization and inappropriate utilization. (c) Criteria and standards should be validated prior to use.

Principle 3: Criteria and standards for DUR must be nonproprietary and must be developed and revised through an open professional consensus process. Characteristics: (a) The criteria and standards development and revision process should allow for and consider public comment in a timely manner before the criteria and standards are adopted. (b) The criteria and standards development and revision process should include broad-based involvement of physicians and pharmacists from a variety of practice settings. (c) The criteria and standards should be reviewed and revised in a timely manner. (d) If a nationally developed set of criteria and standards are to be used, there should be a provision at the state level for appropriate modification.

Principle 4: Interventions must focus on improving therapeutic outcomes. Characteristics: (a) Focused education to change professional or patient behavior should be the primary intervention strategy used to enhance drug therapy. (b) The degree of intervention should match the severity of the problem. (c) All retrospective DUR profiles/reports that are generated via computer screening should be subjected to subsequent review by a committee of peers prior to an intervention. (d) If potential fraud is detected by the DUR system, the primary intervention should be a referral to appropriate bodies (e.g., Surveillance Utilization Review Systems). (e) Online prospective DUR programs should deny services only in cases of patient ineligibility, coverage limitations, or obvious fraud. In other instances, decisions regarding appropriate drug therapy should remain the prerogative of practitioners.

Principle 5: Confidentiality of the relationship between patients and practitioners must be protected. Characteristic: The DUR program must assure the security of its database.

Principle 6: Principles of DUR must apply to the full range of DUR activities, including prospective, concurrent and retrospective drug use evaluation.

Principle 7: The DUR program operations must be structured to achieve the principles of DUR. Characteristics: (a) DUR programs should maximize physician and pharmacist involvement in their development, operation and evaluation. (b) DUR programs should have an explicit process for system evaluation (e.g., total program costs, validation). (c) DUR programs should have a positive impact on improving therapeutic outcomes and controlling overall health care costs. (d) DUR programs should minimize administrative burdens to patients and practitioners. (BOT Rep. PPP, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 6, A-03)

H-155.963 Health System Expenditures

1. Our AMA supports the development and adoption of a consistent format for estimating and publicly reporting health care administrative costs, in order to facilitate unbiased comparisons across insurers, and from different sources. The format would:

(a) Report all government expenditures for the administration of Medicare, Medicaid, and other public programs, including those incurred but not currently reported by the Centers for Medicare and Medicaid Services (CMS) and state Medicaid agencies (e.g., staff salaries, building costs, promotion of benefits to beneficiaries);

(b) Report all government expenditures for administration of Medicare, Medicaid, and other public programs that are incurred by all government entities, including agencies other than the CMS and state Medicaid agencies (e.g., Inspector General audits, Social Security Administration revenue collection);

(c) Identify and report those overhead expenditures that can be defined as either administrative or non-administrative (e.g., profits and retained earnings);

(d) Identify and report those overhead expenditures that arise from legislative or regulatory requirements (e.g., compliance expenses, premium taxes);

(e) Express administrative expenditures in the following metrics: dollars per-member-per-month, dollars per claim, percentage of total expenditures, and percentage of total claims payments.

2. Our AMA supports efforts to educate the medical profession and the public about health care costs, including administrative costs and the costs of defensive medicine. (CMS Rep. 1, A-06; Reaffirmation A-07)

H-155.960 Strategies to Address Rising Health Care Costs

Our AMA:

- (1) recognizes that successful cost-containment and quality-improvement initiatives must involve physician leadership, as well as collaboration among physicians, patients, insurers, employers, unions, and government;
- (2) supports the following broad strategies for addressing rising health care costs: (a) reduce the burden of preventable disease; (b) make health care delivery more efficient; (c) reduce non-clinical health system costs that do not contribute value to patient care; and (d) promote "value-based decision-making" at all levels;
- (3) will continue to advocate that physicians be supported in routinely providing lifestyle counseling to patients through: adequate third-party reimbursement; inclusion of lifestyle counseling in quality measurement and pay-for-performance incentives; and medical education and training;
- (4) will continue to advocate that sources of medical research funding give priority to studies that collect both clinical and cost data; use evaluation criteria that take into account cost impacts as well as clinical outcomes; translate research findings into useable information on the relative cost-effectiveness of alternative diagnostic services and treatments; and widely disseminate cost-effectiveness information to physicians and other health care decision-makers;
- (5) will continue to advocate that health information systems be designed to provide physicians and other health care decision-makers with relevant, timely, actionable information, automatically at the point of care and without imposing undue administrative burden, including: clinical guidelines and protocols; relative cost-effectiveness of alternative diagnostic services and treatments; quality measurement and pay-for-performance criteria; patient-specific clinical and insurance information; prompts and other functionality to support lifestyle counseling, disease management, and case management; and alerts to flag and avert potential medical errors;
- (6) encourages the development and adoption of clinical performance and quality measures aimed at reducing overuse of clinically unwarranted services and increasing the use of recommended services known to yield cost savings;
- (7) encourages third-party payers to use targeted benefit design, whereby patient cost-sharing requirements are reduced for maintenance medications used to treat chronic medical conditions, particularly when non-compliance poses a high risk of adverse clinical outcome and/or high medical costs. Consideration should be given to tailoring cost-sharing requirements to patient income and other factors known to impact compliance; and
- (8) supports ongoing investigation and cost-effectiveness analysis of non-clinical health system spending, to reduce costs that do not add value to patient care. (CMS Rep. 8, A-07)

H-155.979 Future Health Care Costs

It is the policy of the AMA to study projections of future health care costs and assist society in prioritizing services. (Res. 33, A-90; Modified: Sunset Report, I-00)

H-155.978 Correcting Misinformation on Health Care Costs and Spending

It is the policy of the AMA to continue to use press releases, press conferences, and appropriate paid advertising to inform the public of the reasonableness of health care costs and their increases, with such information to include (a) the similarity of increases in medical and non-medical costs when increases in population served and intensity of service are considered, and (b) the importance of healthy lifestyle choices. (Sub. Res. 18, A-90; Res. 56, A-91; CMS Rep. O, A-

92; Reaffirmed in lieu of Res. 811, I-93; CMS Rep. 12, A-95; Reaffirmed and Modified: CMS Rep. 7, A-05)

H-155.988 Public Health and Safety Awareness

The AMA believes that attention to personal health and safety can dramatically improve well-being and reduce health care costs. (Res. 42, I-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CMS Rep. 5, A-04)

H-155.998 Voluntary Health Care Cost Containment

(1) All physicians, including physicians in training, should become knowledgeable in all aspects of patient-related medical expenses, including hospital charges of both a service and professional nature. (2) Physicians should be cost conscious and should exercise discretion, consistent with good medical care, in determining the medical necessity for hospitalization and the specific treatment, tests and ancillary medical services to be provided a patient. (3) Medical staffs, in cooperation with hospital administrators, should embark now upon a concerted effort to educate physicians, including housestaff officers, on all aspects of hospital charges, including specific medical tests, procedures, and all ancillary services. (4) Medical educators should be urged to include similar education for future physicians in the required medical school curriculum. (5) All physicians and medical staffs should join with hospital administrators and hospital governing boards nationwide in a conjoint and across-the-board effort to voluntarily contain and control the escalation of health care costs, individually and collectively, to the greatest extent possible consistent with good medical care. (6) The AMA, assisted by the American Hospital Association, should inform physicians of the actual costs of the services they order for patients and join with their patients in decisions regarding the most cost effective use of health care resources; and should form a coalition with the AHA and third party payers for the purpose of enabling physicians and patients to make cost effective choices for quality medical services. (7) All physicians, practicing solo or in groups, independently or in professional association, should review their professional charges and operating overhead with the objective of providing quality medical care at optimum reasonable patient cost through appropriateness of fees and efficient office management, thus favorably moderating the rate of escalation of health care costs. (8) The AMA, as a part of the public communications activities of the Campaign to Strengthen the U.S. Health Care System and other appropriate communications efforts, should widely publicize and disseminate information on activities of the AMA and state, county and national medical specialty societies which are designed to control or reduce the costs of health care. (Res. 34, A-78; Reaffirmed: CLRPD Rep. C, A-89; Res. 100, I-89; Res. 822, A-93; Reaffirmed: BOT Rep. 40, I-93; CMS Rep. 12, A-95; Reaffirmed: Res. 808, I-02)

H-155.993 Increases in the Costs of Medical Care

Our AMA recognizes that medical and health care costs have increased in part because of the increased demand for services as a result of third party payment, the number of regulations generated by federal and state agencies, professional liability insurance premiums, and because of deficit spending by the federal government. (Res. 103, I-78; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00)

