

A UNIVERSAL CODE OF CONDUCT FOR HEALTH INSURERS: IS THERE A NEED?

CONCERNS ABOUT HEALTH INSURER
PRACTICES AND UNAUTHORIZED DRUG-
SWITCHING

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PREMISES

- Health insurers are obligated to protect the health of their clients (e.g., patients)
- Health insurers are obligated to compensate providers (e.g., physicians) who are under contract to the insurers
- Health insurers are obligated to operate under scrutiny by regulatory bodies in each state (e.g., insurance commissions, legislatures, attorneys general) and are expected to function with fiscal integrity, honesty, and in the public interest
- Health insurers are obligated (e.g., by their boards of directors and stockholders) to accrue a reasonable profit from their endeavors

PARADOX

- THESE FOUR PREMISES ARE IN CONFLICT WITH EACH OTHER!!
- FINANCIAL INCENTIVES ARE THE DRIVING FORCE BEHIND INSURANCE OPERATIONS INSTEAD OF PATIENT WELFARE

IMPACT

- PATIENT CARE IS COMPROMISED
- PROVIDER COMPENSATION IS UNFAIRLY REDUCED
- THE COST OF HEALTHCARE INCREASES
- THE ECONOMIC CRISIS DEEPENS
- AND.....

**THE INSURERS GET RICHER AT
THE EXPENSE OF PATIENTS AND
PROVIDERS!!!**

THE EVIDENCE:

- Rescission (e.g., cancellation) of coverage for patients with high charges and frequent usage
- Unexplained increases in patients' premiums
- Denial of coverage for certain procedures, tests and medicines that the doctor has determined are necessary and indicated
- AND MORE...

THE EVIDENCE (CONT'D)

- Financial incentives (e.g., money) paid to some doctors and pharmacists to change the patient's medication from a branded to a generic drug, under the guise of “cost-containment”
- Use of questionable information (e.g., UnitedHealth and its use of fraudulently derived Ingenix data) to lower out-of-program reimbursement rates
- Protecting its “medical loss ratio” at all costs, in order to maximize profits

MEDICAL LOSS RATIO

An expression of health insurer profits, calculated as the percentage of premium dollars spent on payments to doctors, hospitals, and other providers for health care services rendered

THE ULTIMATE OUTCOME

- ALL OF THESE THINGS HAVE THE NET EFFECT OF DECREASING THE QUALITY OF HEALTHCARE AND MAY POSSIBLY INCREASE PATIENT MORBIDITY AND MORTALITY
- THEY ALSO DECREASE PROVIDER REIMBURSEMENT
- POOR MINORITIES ARE DISPROPORTIONATELY AFFECTED, MAKING THESE PRACTICES BY HEALTH INSURERS A TRUE HEALTHCARE DISPARITY

RECOMMENDED SOLUTIONS

- Definitely deny economic stimulus funds or bail-out money to health insurers if they should ever apply
- Teach the public about how they are getting ripped off
- Encourage greater oversight by regulatory bodies. Investigations such as those by Atty. Gen. Cuomo (New York) should be carried out
- SUE THEM!!! FINE THEM!!! (See Cuomo)

RECOMMENDED SOLUTIONS (CONT'D)

- DEVELOP A CODE OF CONDUCT FOR HEALTH INSURERS, WHICH MUST BE GLOBAL IN ITS COVERAGE, COMPREHENSIVE IN ITS APPLICATION, MONITORED CLOSELY, AND INCLUSIVE OF SANCTIONS AND PENALTIES FOR INFRACTIONS

Ingredients of an Ideal Code of Conduct (Texas Medical Association Model)

- Transparency and accountability in:
 - 1. Health insurance cancellation and rescission
 - 2. Calculation of premium quotes
 - 3. Calculation of the Medical Loss Ratio
 - 4. Unregulated secondary networks (silent PPOs)
 - 5. Physician rankings
 - 6. Claims processing

THE STATE OF NEW YORK MODEL

- Medical Society of the State of NY (MSSNY) found in a survey of doctors that 90% of their decisions on patient treatment, etc. were adversely affected by health insurer actions
- MSSNY presented a resolution to the AMA House of Delegates, resolving to develop a Health Insurer Code of Conduct containing “principles addressing both medical care policies and payment issues”
- Resolution was adopted by AMA

Medical Society of the State of New York

- Resolution Adopted at the 2008 AMA Interim Meeting calling upon AMA to develop health insurer “Code of Conduct.
- Resolution sponsored by the New York delegation

Medical Society of the State of New York

Resolution 823 – I-08

RESOLVED, That our American Medical Association develop a Health Insurer “Code of Conduct” setting forth clear and concise principles addressing both medical care policies and payment issues; and be it further

RESOLVED, That our AMA seek concurrence among health insurers in complying with this “Code of Conduct; and be it further

RESOLVED, That our AMA develop a mechanism to monitor compliance with this “Code of Conduct; and be it further

RESOLVED, That our AMA widely disseminate information regarding this “Code of Conduct,” and health insurer compliance, to physicians and consumers.

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The purpose of the Code is to establish clear, **general** principles for the health insurance industry to follow when establishing policies and practices impacting upon the medical care received by their enrollees and provided by physicians and other providers.

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Key concepts to be included in a Code of Conduct:

- Clinical Autonomy
- Transparency
- Corporate Integrity
- Patient Safety and Welfare

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Issues possibly to be covered by a Code of Conduct include:

- prior creation of formularies,
- authorization procedures,
- provider ranking or rating systems,
- Code review policies, and
- the manner by which coverage decisions are made.

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- AMA has the best expertise to develop such a Code of general applicability
- The Code would be consistent with, and complementary to, other AMA efforts. AMA recently released a terrific health plan “report card” that evaluates health plans’ claim processing practices. Some of the problems identified in the report card could form the basis for Code principles.

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A simple, concise Code of Conduct that sets forth clear principles focusing not only on payment issues but also on medical care policies, would enhance the value of these “report cards.”

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Critical to the development of a Code of Conduct is the development of an enforcement mechanism to assure compliance with the Code

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Benefits of a Code of Conduct

- challenge health plans to change their restrictive practices without the need for legislative or judicial intervention.
- it would provide valuable data and public support for our efforts in State capitols to achieve legislative and regulatory reform which meaningfully addresses abusive health plan practices.
- could also provide businesses and the general public with an excellent tool to compare the performance of health plans for the purposes of making enrollment decisions.

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Clinical Autonomy

Ability of physicians to make decisions based on patient needs without artificial barriers (In recent MSSNY survey, over 90% of physicians indicated they had to change patient treatment or medication based upon restrictions from an insurance company).

Possible concepts include:

- Ease burdens for UR/pre-authorization of diagnostic tests;
- Development of formularies based on appropriate clinical evidence
- Protection of patients from formulary changes

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Transparency

Disclosure of information regarding health plans' benefits and policies to help facilitate patient decisions about which plans to join and to inform providers, regulators and the public about systems that may influence appropriate medical care. Possible concepts include:

- Transparent ranking/tiering system based upon true assessment of quality, not economic factors
- Disclosure of incentives to health plan employees and contractors, and to providers of care
- Disclosure of Reimbursement/code review policies
- Disclosure of factors affecting requests to change prescriptions

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Corporate Integrity

Ensuring that business practices meet generally accepted standards and don't negatively impact critical stakeholders. Possible concepts include:

- Avoidance of conflicts of interest
- Appropriate Allocations of Premium for Health Care
- Fair and Timely Reimbursement

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All these factors then must relate back to the
ultimate goal of assuring patient safety and
welfare

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AMA plans to create conduct standards for insurers

November 11, 2008

ALBANY, N.Y. - The American Medical Association will create a code of conduct for health insurers that's intended to put the needs of a patient first when companies create medical policies and decide whether to pay for care and medication.

The Medical Society of the State of New York put the resolution before the AMA, arguing that health insurer practices and policies often force doctors to alter how they treat patients - sometimes to their detriment...

From *New York Newsday*

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Alliance for Patient Access Applauds AMA's Health Insurer Code of Conduct

NASHVILLE, Tenn., Nov. 14 /PRNewswire-USNewswire/ -- The Alliance for Patient Access (AfPA) today applauded the American Medical Association's newly adopted Insurer Code of Conduct and encouraged physicians to join them in encouraging health insurance plans' adoption and compliance. "We applaud the American Medical Association's House of Delegates unanimous decision to develop a Health Insurer Code of Conduct setting forth clear and concise principles addressing both medical care policies and payment issues to benefit patients, physicians, hospitals and other health care providers," said AfPA's Director, Brian Kennedy...

WHERE SHOULD WE GO FROM THIS MEETING?

- A Code of Conduct should be drafted NOW and presented in draft form to the NMA Interim HOD meeting (which is a few days from now) to CHANGE these nefarious practices
- State legislators present at this meeting should go back to their constituencies and hold Town Hall Meetings over this important issue, and then should draft appropriate legislation to CHANGE health insurer conduct
- Smart health insurers should “see the handwriting on the wall” and should work with NMA and state legislators to bring about CHANGE before public outrage occurs



CHANGE HAS
COME! YES WE
CAN!

THANK YOU

QUESTIONS?