Resolution 401-13  

TITLE: MODIFICATIONS TO THE AFFORDABLE CARE ACT

Author: Paul Kirz, MD
Contact: pkirz@aol.com
Introduced by: Paul Kirz, MD

Endorsed by: Reference Committee

October 11 - 13, 2013

This resolution constitutes a proposal for consideration by the California Medical Association House of Delegates and does not represent official CMA policy.

WHEREAS, the Affordable Care Act (ACA) mandates both employer and individual health insurance or payment of additional federal tax; and

WHEREAS, the health insurance mandate of the ACA may discourage employers from hiring full time employees and could result in severe financial hardship for lower income families; and

WHEREAS, the ACA raises the federal income tax deductibility of health care expenses to greater than 10% of one’s adjusted gross income; therefore be it

RESOLVED: That CMA support legislation modifying the ACA health insurance requirement to a high deductible catastrophic health insurance instead of the current ACA mandated health insurance; and be it further

RESOLVED: That CMA support legislation modifying the ACA to allow full federal and state income tax deductibility of all out of pocket health care expenses; and be it further

RESOLVED: That this matter be referred for national action.

Current CMA Policy:
CMA supports requiring all health plan issuers in California to offer at least one standardized catastrophic and preventive health care policy. (HOD 216a-05) CMA further supports making individual catastrophic health insurance mandatory for all Californians. (HOD 205-04) On the other hand, CMA policy supports offering patients a wide variety of health plan options to meet their individual needs, with all plans required to meet or exceed a defined minimum benefits package. (HOD B-4-08)

Fiscal Impact:
Within budget to adopt as policy and request action by the AMA; however, the cost of CMA sponsoring or opposing a federal bill could be $130,000 or more and is dependent on many factors over which CMA has no control, such as the extent of external opposition or support for the proposal, communications, and commitment of resources by opponents and proponents.
Resolution  402-13    TITLE:  90-DAY GRACE PERIOD

Author:  Laurie Reynard, MD
Contact: LBR826@aol.com
Introduced by:  Laurie Reynard, MD

Endorsed by:  District IV Delegation
Reference Committee

October 11 - 13, 2013

This resolution constitutes a proposal for consideration by the California Medical Association
House of Delegates and does not represent official CMA policy.

WHEREAS, the U.S. Department of Health and Human Services (HHS) made the decision to allow federally subsidized patients (<400 percent of FPL) a 90-day grace period for nonpayment of premiums, which presents a large risk for providers who contract with the exchange’s qualified health plans (QHPs); and

WHEREAS, the plan has the option to pend claims for services performed in the 2nd and 3rd months of delinquency until the enrollee pays the outstanding premium balance; and

WHEREAS, the plan has the option to deny all claims for services performed in the 2nd and 3rd months of delinquency if the enrollee is terminated after 3 months of delinquency; and

WHEREAS, the provider may not be notified that the patient is delinquent in their premiums and that claims may be pended and denied should the coverage be terminated, until after the services have been provided, upon receipt of a claim; and

WHEREAS, the grace period provision could strain the physician-patient relationship, and significantly impact practice viability and access to care; therefore be it

RESOLVED: That CMA demand that the Department of Managed Health Care require that insurance companies involved in health insurance exchanges make it clear on the insurance cards which patients are federally subsidized, provide a user-friendly hot-line or fax back for authorization at the time of service and guarantee payment for those claims with authorization, and that authorization will guarantee payment of the claim regardless of final coverage status; and be it further

RESOLVED: That physicians have the right to collect payment at time of service or refuse treatment to those patients whose guarantee of coverage cannot be verified at time of service; and be it further

RESOLVED: That this matter be referred for national action.

Current CMA Policy:
CMA supports requiring that payors make electronically available all the information needed to verify patients' eligibility of insurance, status of the amount of deductible remaining and the correct mailing address for sending claims, and that all such information be current. (HOD 412-00) CMA further supports requiring that insurers and
health plans issue health insurance cards that clearly identifies the plan, IPA or medical group where appropriate, and the coverage of the patient, and that all inquiries about coverage must be answered promptly by the company issuing the cards. (HOD 426-96) CMA also supports the inclusion of an accessible 800-number for accessing health plan services (e.g., prior authorization, patient eligibility, and visits authorization), among other things. (HOD 403-97) Finally, CMA supports requiring the use of “swipe card” technology with insurance cards for the purposes of verifying insurance eligibility and enabling faster insurance payment for medical services at the point of delivery. (HOD 427-12)

**Fiscal Impact:**

Within budget to adopt as policy and request action by the AMA; however, if CMA were to undertake the advocacy that would be required, costs could be as high as $130,000 and is dependent on many factors over which CMA has no control, such as the extent of external opposition or support for the proposal, communications, and commitment of resources by opponents and proponents.
TITLE: REQUIRE ALL HEALTH INSURERS TO ACCEPT COVERED CALIFORNIA PATIENTS

William Hale, MD
Contact: hale.william@gmail.com

Introduced by: William Hale, MD

Endorsed by: Reference Committee

October 11 - 13, 2013

This resolution constitutes a proposal for consideration by the California Medical Association House of Delegates and does not represent official CMA policy.

WHEREAS, a major principle of the Affordable Care Act was the notion that all would be covered and that no one would be subject to adverse selection and denied insurance coverage; and

WHEREAS, the payments that are likely to be received under the Affordable Care Act in the State of California are likely to be less than those received on the open private insurance market; and

WHEREAS, failure to participate in the Covered California market would in fact be a continuation of the adverse selection policies of the previous unregulated market; and

WHEREAS, those entities that are bearing risk in the healthcare market are licensed under the health and life section of the California insurance law; and

WHEREAS, the life insurance policies are enormously lucrative primarily due to a systematic adverse selection and misrepresentation resulting in a systematic and legally sanctioned unjust enrichment; therefore be it

RESOLVED: That all risk bearing health care providing entities in the State of California shall be required to accept a pro rata share of the Covered California patients pool.

Current CMA Policy:
None.

Fiscal Impact:
No cost to adopt as statement of policy.
Resolution 404-13  

TITLE: UNIVERSAL ELECTRONIC CLAIMS SUBMISSION

Author: Donaldo Hernandez, MD  
Contact: hernandmd@pamf.org

Introduced by: Santa Cruz County Medical Society

Endorsed by: Reference Committee  

October 11 - 13, 2013

This resolution constitutes a proposal for consideration by the California Medical Association House of Delegates and does not represent official CMA policy.

WHEREAS, conducting administrative related activities is among one of the main drivers of costs of care in the complex medical delivery system in California; and

WHEREAS, healthcare administrative cost approach $361 billion dollars annually in the United States; and

WHEREAS, physician claims submission is a necessary part of receiving, reviewing and processing physician services; and

WHEREAS, the current claims submission process is fractionated and acts a significant source of cost of care via increased overhead demands which include but are not limited to collecting copayments, seeking prior authorization, coding of services delivered, checking and submitting claims, receiving and depositing payments, appealing denials and underpayments, collecting from patients, negotiating end-of-year resolution of unsettled claims, and paying subcontracted providers such that physicians are spending hundreds of thousands of dollars annually as they attempt to collect appropriate payment for services rendered; and

WHEREAS, the Patient Protection and Affordable Care Act (ACA) of 2010 expressly seeks to improve the quality and efficiency of health care delivered in the United States such that it expressly requires the DHHS to set detailed rules for processing administrative interactions and imposes financial penalties on health plans that do not adopt standardized procedures; therefore be it

RESOLVED: That CMA request the California State Legislature to draft and pass legislation that will require the development of a single, budget neutral universal electronic claims system for all health plans conducting care under the Covered California/Healthcare Exchange program including all state sponsored entities acting as health plan providers within the State of California; and be it further

RESOLVED: That any supplemental information required to approve a claim be uniform and limited to diagnosis and date of service related data, thus eliminating the need to complete multiple unique interactions for each health plan entity; and be it further
RESOLVED: That CMA assist and facilitate that process.

Current CMA Policy:
Longstanding policy states that CMA will continue its strong support of a simplified uniform billing form for mandatory use in all third party health insurance billing. (HOD 101-74)

Fiscal Impact:
No cost to adopt as policy. If legislation is required, the potential cost is speculative and dependent on many factors over which CMA has no control, such as the extent of external opposition or support for the proposal, communications and commitment of resources by opponents and proponents. The cost of CMA sponsoring or opposing a bill could be $95,000 or more; in individual legislative actions, costs can be much higher. Endorsement or support of bills sponsored by others requires less effort and less cost.
WHEREAS, the United States, and California with it, is entering an era of potentially significant new administrative demands on the healthcare delivery system as a result of reforms brought on by the Patient Protection and Affordable Care Act; and

WHEREAS, California’s health benefit exchange, Covered California, will require more than seventy reports of participating health plans and new reporting requirements on physicians; and

WHEREAS, states like Oregon (SB 604) and Texas (SB 1150) have moved to proactively reduce the administrative burdens on physicians this year; and

WHEREAS, California should be the model for reducing unnecessary administrative waste and burdens in the healthcare delivery system; therefore be it

RESOLVED: That CMA support the reduction of administrative burdens on physicians in the implementation of health care reforms to the greatest extent possible; and be it further

RESOLVED: That CMA support legislation mandating the use of a uniform credentialing process and form; and be it further

RESOLVED: That CMA support legislation mandating the use of a uniform prior authorization process and form for medical services; and be it further

RESOLVED: That CMA urge California’s health benefit exchange to require administrative simplification by participating health plans and monitor the health plans progress in reducing unnecessary administrative burdens on the delivery system.

Current CMA Policy:
HOD 407-01 directed CMA to work with health plans, IPAs, and medical groups to create a uniform treatment authorization form available in both paper and electronic format. CMA also supports ensuring that physicians have access to fast, effective and efficient prior authorization and coverage inquiry processes. (HOD 112a-06)

Longstanding policy states that CMA will continue its strong support of a simplified uniform billing form for mandatory use in all third party health insurance billing. (HOD 101-74)
The potential cost of legislative activity is speculative and dependent on many factors over which CMA has no control, such as the extent of external opposition or support for the proposal, communications, and commitment of resources by opponents and proponents. The cost of CMA sponsoring or opposing a bill could be $95,000 or more; in individual legislative actions, costs can be much higher. Endorsement or support of bills sponsored by others requires less effort and less cost.
WHEREAS, current law states that when a health insurance company sends a contract revision or amendment(s) to a currently contracted physician, the physician has 45 days to respond amending the updated or revised contract and sending that contract back to the health insurance company signed by the physician or accepting the new contract as is without sending it back to the health plan; and

WHEREAS, the solo, small group, and mid-sized group physician has no market leverage when contracting with the major health insurance companies, resulting in a "take it or leave it" decision when contracting with a major health insurance company; therefore be it

RESOLVED: That CMA support legislation requiring that health insurance company contract revisions, changes and amendments that are more than only fee schedule changes require the physician to sign and return the health insurance company revised, updated or amended contract to the health insurance company within the 45 day review period only if that physician accepts that revised, amended or changed contract; and be it further

RESOLVED: That CMA support legislation allowing physicians who do not accept the health insurance company updated, revised, or amended contract not to return the contract and by not returning the contract within the 45 day period then the previous contract remains in force between the physician and the health insurance company; and be it further

RESOLVED: That CMA support legislation that makes it illegal to write a contract that can be modified without the signed consent of both parties.

Current CMA Policy:
None.

Fiscal Impact:
The potential cost of legislative activity is speculative and dependent on many factors over which CMA has no control, such as the extent of external opposition or support for the proposal, communications, and commitment of resources by opponents and proponents. The cost of CMA sponsoring or opposing a bill could be $95,000 or more; in individual legislative actions, costs can be much higher. Endorsement or support of bills sponsored by others requires less effort and less cost.
WHEREAS, certain medical care can be provided by physician communication with patients by telephone or other electronic means without direct face-to-face patient contact; and

WHEREAS, such care may not be associated with a recent or emergently upcoming patient visit, and CPT codes 99441, 99442, 99443, and 99444 have been established to codify such separately identifiable patient care interactions; and

WHEREAS, such medical care requires the time, judgment, and documentation of medical care provided; and

WHEREAS, such medical care can be more time effective for both physicians and patients, and reduce environmentally costly physical transportation of patients to the physicians’ office/clinic; and

WHEREAS, most medical insurance companies routinely deny payment for such care provided by contracted physicians and often simultaneously prohibit physicians from billing patients for such care provided; therefore be it

RESOLVED: That CMA sponsor legislation requiring health insurance companies licensed in the State of California to pay contracted physicians (with applicable co-pays and deductibles) for telephone or other electronic patient management services such as defined by CPT codes 99441, 99442, 99443, and 99444 (copyright American Medical Association) in amounts similar to the amounts paid for office visits with similar complexity and time expenditure, including the time taken for associated activities required to complete these services (contacting consultants, sending orders to lab or x-rays, transmitting prescriptions, possibly calling the patient back to confirm or adjust plans, and completing records, etc.).

Current CMA Policy:
In 2012, the House of Delegates referred a similar resolution (Res. 418-12) to the Board of Trustees for decision.
The Board adopted the following substitute at its July 26, 2013 meeting:
RESOLVED: That CMA encourage group practices to recognize the physician time and effort required for provision of telephone and other electronic patient management services; and be it further
RESOLVED: That CMA continue to advocate for requiring plans and insurers to recognize telephone or other electronic patient management services as covered services to be reimbursed or paid in amounts proportional to the time and associated activities required to complete these services (preparing records, transmitting prescriptions, contacting consultants, etc.) for office visits with similar complexity and time expenditure, and if not paid, such insurance companies shall not prevent physicians from billing patients directly for provision of these services; and be it further
RESOLVED: That CMA support legislation that advocates for regulatory change requiring plans and insurers to recognize telephone or other electronic management services as a covered service to be reimbursed or paid in amounts proportional to the time and associated activities required to complete these services, or in the alternative legislation that would not prevent physicians from billing patients directly for the provision of these services.

CMA longstanding policy states that physicians should be fairly and uniformly compensated for their professional services whether patients are treated in face-to-face contact, by telephone consultation, fax, E-mail or other communication form. (HOD 401-00) On the other hand, CMA policy supports the designation of telephone, fax, and email services as non-covered benefits in order to facilitate patient payment for these services. (HOD 413a-04)

Fiscal Impact:
The potential cost of legislative activity is speculative and dependent on many factors over which CMA has no control, such as the extent of external opposition or support for the proposal, communications, and commitment of resources by opponents and proponents. The cost of CMA sponsoring or opposing a bill could be $95,000 or more; in individual legislative actions, costs can be much higher. Endorsement or support of bills sponsored by others requires less effort and less cost.
Resolution 408-13  TITLE: RETRO-AUTHORIZATION FOR TESTS/PROCEDURES

Author: Susan Sprau, MD
Contact: sesacp@aol.com

Introduced by: Susan Sprau, MD

Endorsed by: California Chapter of the American College of Physicians

Reference Committee

October 11-13, 2013

This resolution constitutes a proposal for consideration by the California Medical Association House of Delegates and does not represent official CMA policy.

WHEREAS, many third party payers are adding prior authorization requirements for tests/procedures at a rate that is difficult for physicians to keep abreast of; and

WHEREAS, at least one third party payer has elected to not provide a retro-authorization process for tests requiring a prior authorization; and

WHEREAS, the California Department of Insurance and the Department of Managed Care do not require insurers to provide a retro-authorization process; and

WHEREAS, physicians may incur significant financial costs for medically necessary tests/procedures that require a prior authorization, merely because they were not aware of the need for a prior authorization; and

WHEREAS, CMA is committed to decreasing the “hassle factor” in health care; therefore be it

RESOLVED: That CMA support inclusion of a requirement for a retro-authorization process in all physician-insurer contracts, including CMA sample contracts, with requirements that the timeframe for consideration be the same as urgent appeals, and with similar provisions for third party review of appeal denials; and be it further

RESOLVED: That CMA work with the California Department of Insurance and the Department of Managed Health Care to mandate that insurers, IPAs, etc., provide a retro-authorization process for all tests/procedures that require a prior authorization with requirements that the timeframe for consideration be the same as urgent appeals, and with similar provisions for third party review of appeal denials; and be it further

RESOLVED: That this matter be referred for national action.

Current CMA Policy:

CMA supports third-party payers providing an “urgent” prior authorization system where approvals can be granted within four hours, including nights and weekends, and a prompt (5-minute maximum) electronic and phone access for prior authorization. (HOD A-2-08) CMA also supports ensuring that physicians have access to fast, effective and efficient prior authorization and coverage inquiry processes. (HOD 112a-06)
Fiscal Impact:

Within budget to adopt as policy and request action by the AMA; however, if CMA were to undertake the advocacy that would be required, costs could be as high as $130,000 and is dependent on many factors over which CMA has no control, such as the extent of external opposition or support for the proposal, communications, and commitment of resources by opponents and proponents. If legislation is required, the potential cost is speculative and dependent on many factors over which CMA has no control, such as the extent of external opposition or support for the proposal, communications, and commitment of resources by opponents and proponents. The cost of CMA sponsoring or opposing a bill could be $95,000 or more; in individual legislative actions, costs can be much higher. Endorsement or support of bills sponsored by others requires less effort and less cost.
**Resolution 409-13**

**TITLE:** REQUIREMENT TO STUDY ACCESS TO MEDICAL TREATMENT BY ADMINISTRATIVE DIRECTOR OF DEPARTMENT OF WORKERS COMPENSATION

**Author:** Michael Bazel, MD  
Contact: BazMD@aol.com

**Introduced by:** Michael Bazel, MD

**Endorsed by:** Reference Committee  
October 11 - 13, 2013

*This resolution constitutes a proposal for consideration by the California Medical Association House of Delegates and does not represent official CMA policy.*

**WHEREAS,** Labor Code 5307.2 states “the administrative director shall contract with an independent consulting firm, to the extent permitted by state law, to perform an annual study of access to medical treatment for injured workers,” and

**WHEREAS,** based on such study, if deficiency is detected, the adjustment to the fees or other factors in order to improve the access could be made; and

**WHEREAS,** despite all the difficulties imposed by new legislative laws and many qualified physicians leaving the field of Workers Compensation, no such studies are regularly conducted; therefore be it

**RESOLVED:** That CMA work with the State Legislature to amend Labor Code Section 5307.2 to change the language of “the administrative director shall contract with an independent consulting firm, to the extent permitted by state law, to perform an annual study of access to medical treatment for injured workers” to “the administrative director must … perform an annual study”; and be it further

**RESOLVED:** That CMA work with the Legislature to make sure the law requiring an independent consulting firm, to the extent permitted by state law, to perform an annual study of access to medical treatment for injured workers is enforced.

**Current CMA Policy:**  
None.

**Fiscal Impact:**  
The potential cost of legislative activity is speculative and dependent on many factors over which CMA has no control, such as the extent of external opposition or support for the proposal, communications, and commitment of resources by opponents and proponents. The cost of CMA sponsoring or opposing a bill could be $95,000 or more; in individual legislative actions, costs can be much higher. Endorsement or support of bills sponsored by others requires less effort and less cost.
Resolution 410-13

TITLE: Merging Premiums for Covered California and Workers’ Compensation Programs

Author: William Hale, MD
Contact: hale.william@gmail.com

Introduced by: William Hale, MD

Endorsed by: Reference Committee

October 11 - 13, 2013

This resolution constitutes a proposal for consideration by the California Medical Association House of Delegates and does not represent official CMA policy.

WHEREAS, injured workers have historically had an excellent healthcare program giving 24-hour coverage and including disability benefits; and

WHEREAS, Covered California is now going to bestow a major portion of these benefits for the whole public; and

WHEREAS, this double benefit represents an unnecessary duplication of costs to the employer; therefore be it

RESOLVED: That employers who offer a platinum level or equal coverage to all employees shall be allowed to be exempt from the health care portion of the workers’ compensation premium.

Current CMA Policy:
None.

Fiscal Impact:
No cost to adopt as policy. If legislation is contemplated, the potential cost is speculative and dependent on many factors over which CMA has no control, such as the extent of external opposition or support for the proposal, communications and commitment of resources by opponents and proponents. The cost of CMA sponsoring or opposing a bill could be $95,000 or more; in individual legislative actions, costs can be much higher. Endorsement or support of bills sponsored by others requires less effort and less cost.
Resolution 411-13  

**TITLE:** ENFORCING RULES SET FOR INDEPENDENT MEDICAL REVIEW

**Author:** Michael Bazel, MD  
Contact: BazMD@aol.com  

**Introduced by:** Michael Bazel, MD  

**Endorsed by:** Reference Committee  

October 11 - 13, 2013

This resolution constitutes a proposal for consideration by the California Medical Association House of Delegates and does not represent official CMA policy.

WHEREAS, on 8/31/12, the California Legislature passed a new Workers’ Compensation Reform Bill (SB863); and

WHEREAS, as part of the report, Independent Medical Review (IMR) has been established to resolve UR denials; and

WHEREAS, IMR opinion is final and it cannot be overturned based on anything beyond fraud; and

WHEREAS, there is nothing in the Labor Code to make reviewers adhere to the rules; therefore be it

RESOLVED: That CMA work with legislators to allow dismissal of the Workers’ Compensation Independent Medical Review if the reviewer fails to follow the rules set by the Labor Code.

**Current CMA Policy:**

HOD 205-80 urged the Department of Health Services to retain physicians and other advisory or consultant personnel who are sufficiently well trained medically to responsibly review claims and requests for hospitalization.

**Fiscal Impact:**

The potential cost of legislative activity is speculative and dependent on many factors over which CMA has no control, such as the extent of external opposition or support for the proposal, communications, and commitment of resources by opponents and proponents. The cost of CMA sponsoring or opposing a bill could be $95,000 or more; in individual legislative actions, costs can be much higher. Endorsement or support of bills sponsored by others requires less effort and less cost.
Resolution 412-13

TITLE: UTILIZATION REVIEW AND INDEPENDENT MEDICAL REVIEW MEDICAL NECESSITY BASIC STANDARD

Author: Michael Bazel, MD
Contact: BazMD@aol.com

Introduced by: Michael Bazel, MD

Endorsed by: Reference Committee

October 11 - 13, 2013

WHEREAS, on 8/31/12, the California Legislature passed a new Workers’ Compensation Reform Bill (SB863); and

WHEREAS, as part of the report Independent Medical Review has been established to resolve UR denials; and

WHEREAS, decisions on medical necessity are based on Medical Treatment Utilization Standards adopted by the Administrative Director of the Department of Workers’ Compensation or other national guidelines; and

WHEREAS, treatment may be denied because national guidelines are silent on such treatment; therefore be it

RESOLVED: That CMA supports a physician’s innovation and values his or her professional experience over existing written guidelines, as long as his or her practice is within the standard of care; and be it further

RESOLVED: That CMA work with legislators to amend the Labor Code by introducing the following language: “Treatment may not be denied solely because it is not discussed or specifically recommended in California Medical Treatment Utilization Standards or any other national guidelines, but can only be denied if care severely deviates from the standard.”

Current CMA Policy:
CMA supports the establishment of guidelines for utilization review, including appropriate protections for patients and physicians. (HOD 501a-92) Additionally, CMA recognizes that utilization review or the determination of medical necessity for health care covered services is different from engaging in the peer review process, and CMA will work with the appropriate regulatory bodies to investigate inappropriate use of peer review laws to shield medical necessity or utilization review decisions. (HOD D-2-10)

Fiscal Impact:
No cost to adopt as policy. If legislation is required, the potential cost is speculative and dependent on many factors over which CMA has no control, such as the extent of external opposition or support for the proposal, communications and commitment of resources by opponents and proponents. The cost of CMA sponsoring or opposing a bill could be $95,000 or more; in individual legislative actions, costs can be much higher. Endorsement or support of bills sponsored by others requires less effort and less cost.
Resolution 413-13

TITLE: INDEPENDENT MEDICAL REVIEWER BASIC QUALIFICATIONS

Author: Michael Bazel, MD
Contact: BazMD@aol.com

Introduced by: Michael Bazel, MD

Endorsed by: Reference Committee

October 11 - 13, 2013

This resolution constitutes a proposal for consideration by the California Medical Association House of Delegates and does not represent official CMA policy.

WHEREAS, on 8/31/12, the California Legislature passed a new Workers’ Compensation Reform Bill (SB863); and

WHEREAS, as part of the report Independent Medical Review has been established to resolve UR denials; and

WHEREAS, no specific qualifications for reviewing physicians are set forth in the regulations; and

WHEREAS, there is no requirement that the reviewer have any experience with the procedure he is to make his opinion on; and

WHEREAS, frequently, the reviewer’s experience has nothing to do with a procedure he is to review; therefore be it

RESOLVED: That CMA work with legislators to amend Labor Code Section 4610.6 by introducing the following language: “The reviewer must be actively involved in clinical practice and must have personal experience in his practice with the procedure he is to review.”

Current CMA Policy:
CMA policy urges the Department of Healthcare Services to retain physicians and other advisory or consultant personnel who are sufficiently well trained medically to responsibly review claims and requests for hospitalization (HOD 205-80).

Fiscal Impact:
The potential cost of legislative activity is speculative and dependent on many factors over which CMA has no control, such as the extent of external opposition or support for the proposal, communications, and commitment of resources by opponents and proponents. The cost of CMA sponsoring or opposing a bill could be $95,000 or more; in individual legislative actions, costs can be much higher. Endorsement or support of bills sponsored by others requires less effort and less cost.
TITLE: UTILIZATION REVIEW PHYSICIAN QUALIFICATIONS

WHEREAS, insurance companies perform utilization review (UR) to limit patients’ access to medical care; and

WHEREAS, medical necessity is defined as community standard for medical care; and

WHEREAS, current law allows hiring physicians from out of California to perform UR; and

WHEREAS, frequently such physicians are not related by specialty or qualifications to the treating physician; and

WHEREAS, AB 584 (Fong) was introduced to require all physicians performing UR in the Workers’ Compensation arena to be licensed in California, but the bill was vetoed by the Governor on 10/07/11, reasoning that no other commercial insurance has such limitation; therefore be it

RESOLVED: That CMA support legislation requiring that any physician who performs utilization review for medical treatment in California be licensed in California and be in the same specialty and have the same qualifications as the treating physician.

Current CMA Policy:
CMA supports the establishment of guidelines for utilization review, including appropriate protections for patients and physicians. (HOD 501a-92) It is CMA policy that primary treating physicians in workers’ compensation should be licensed in California. (HOD 408a-05)

Fiscal Impact:
The potential cost of legislative activity is speculative and dependent on many factors over which CMA has no control, such as the extent of external opposition or support for the proposal, communications, and commitment of resources by opponents and proponents. The cost of CMA sponsoring or opposing a bill could be $95,000 or more; in individual legislative actions, costs can be much higher. Endorsement or support of bills sponsored by others requires less effort and less cost.
WHEREAS, the main goal of implementation of SB863 was an attempt to minimize lien filing; and

WHEREAS, there is no direct or indirect mechanism imposed by SB863 or any previous “reform” to guarantee expedient payment to a provider, even when the treatment has been approved, leaving lien litigation as the only practical method to collect appropriate payment; and

WHEREAS, the language of Labor Code sections 3202.5 and 5705 force providers to litigate anew, when the case-in-chief settles; and

WHEREAS, it places the lien claimant at a disadvantage by requiring the claimant to produce the evidence of industrial injury, while the employee, who had direct knowledge of the events and the employer who had an opportunity to investigate decline to produce such evidence and instead elect to settle; therefore be it

RESOLVED: That CMA endorse and promulgate the concept that, when a patient’s Workers’ Compensation case settles and the claimant receives compensation, this denotes agreement among all parties that, in fact, an injury occurred; and be it further

RESOLVED: That CMA endorse and promulgate the concept that among the parties involved in a Workers’ Compensation case, agreement that an injury occurred constitutes evidence of injury sufficient to meet the burden of proof needed by a lien claimant who has been providing medical care to the injured claimant in order to bill workers’ compensation insurance for services rendered; and be it further

RESOLVED: That CMA work with legislators to amend the Labor Code by introducing the following exception: “The burden of proof is met by the lien claimant, when the employee and the employer chose to compromise.”

Current CMA Policy:
It is CMA policy to take an active role in eliminating the lien filing fees imposed on workers' compensation cases or find an alternative means for physicians to have disputes resolved without using liens (HOD 423-12).
Fiscal Impact:
Costs to “endorse and promulgate” could be as high as $50,000. The potential cost of legislation is speculative and dependent on many factors over which CMA has no control, such as the extent of external opposition or support for the proposal, communications and commitment of resources by opponents and proponents. The cost of CMA sponsoring or opposing a bill could be $95,000 or more; in individual legislative actions, costs can be much higher. Endorsement or support of bills sponsored by others requires less effort and less cost.
Resolution  416-13   TITLE:  REIMBURSEMENT FOR SETTLED WORKERS’ COMPENSATION CASES

Author:  Michael Bazel, MD
Contact:  BazMD@aol.com

Introduced by:  Michael Bazel, MD

Endorsed by:  Reference Committee

October 11 - 13, 2013

This resolution constitutes a proposal for consideration by the California Medical Association House of Delegates and does not represent official CMA policy.

WHEREAS, a majority of denied cases in Workers Comp at the end either settle via C&R or become awarded compensable after the trial; and

WHEREAS, no matter the outcome of the case-in-chief, the maximum reimbursement allowed is Official Medical Fee Schedule; and

WHEREAS, litigating the lien costs much more money than treating an accepted case; and

WHEREAS, SB 457 (Calderon), which was approved by the Governor on 10/7/11, allows payments to the private insurer, which paid for self-procured care, to be made at their C&U; therefore be it

RESOLVED: That the CMA take an active role in changing the Labor Code to require insurers to pay a physician’s usual and customary charges rather than the contracted rates or the rates set by Department of Workers’ Compensation as the maximum reimbursement rates, when the previously denied case either settles via Compromise and Release or is awarded compensable by the judge.

Current CMA Policy:
None.

Fiscal Impact:
If legislation is required, the potential cost is speculative and dependent on many factors over which CMA has no control, such as the extent of external opposition or support for the proposal, communications and commitment of resources by opponents and proponents. The cost of CMA sponsoring or opposing a bill could be $95,000 or more; in individual legislative actions, costs can be much higher. Endorsement or support of bills sponsored by others requires less effort and less cost.
Resolution 417-13  

**TITLE:** RENEWAL OF MEDICAL PROVIDER NETWORK MEMBERSHIP AGREEMENT

**Author:** Jeffrey Young, MD  
Contact: jly59@hotmail.com

**Introduced by:** Jeffrey Young, MD

**Endorsed by:** California Society of Physical Medicine and Rehabilitation  
Reference Committee

October 11 - 13, 2013

This resolution constitutes a proposal for consideration by the California Medical Association House of Delegates and does not represent official CMA policy.

WHEREAS, physicians apply for inclusion to insurer medical provider networks; and

WHEREAS, the current practice of some medical providers networks is to include physicians on the networks indefinitely; and

WHEREAS, physicians remain members of the network after a company is sold to another entity or the physician has stopped practicing; and

WHEREAS, this will result in decreased patient access to medical care; and

WHEREAS, over time, this will result in physicians belonging to network they were unaware of; therefore be it

RESOLVED: That CMA work to require medical provider networks to renew their physician membership on a yearly basis; and be it further

RESOLVED: That this matter be referred for national action.

**Current CMA Policy:**

HOD 410-10 directed CMA to advocate that: (1) any contract by which any California licensed physician is restrained from participating in any medical provider network (MPN) for Workers' Compensation is void; (2) exclusion of California licensed physicians from any MPN for Workers' Compensation is a restraint of trade that violates California Business and Professions Code section 1660; and (3) employers, third party administrators and industrial carriers not be permitted to exclude any California licensed physicians from any MPN for Workers' Compensation. BoT Min 07-31:10:13(4) reaffirmed CMA opposition to any attempts by insurers to force physicians into MPNs without their knowledge and consent.

**Fiscal Impact:**

The potential cost of any legislative activity is speculative and dependent on many factors over which CMA has no control, such as the extent of external opposition or support for the proposal, communications and commitment of resources by opponents and proponents. The cost of CMA sponsoring or opposing a bill could be $95,000 or more; in individual legislative actions, costs can be much higher. Endorsement or support of bills sponsored by others requires less effort and less cost.
Resolution 418-13  TITLE: RATE REGULATION FOR HEALTH INSURANCE PLANS

Author: Harrison Hines
Contact: hines.harrison@gmail.com

Introduced by: Medical Student Section

Endorsed by: Reference Committee

WHEREAS, health insurance rate increases from 2002 to 2012 have been significant for families; premiums rose 97 percent while the general rate of inflation only increased 28 percent and wages have only increased 33 percent; and

WHEREAS, Covered California has reported that premiums will be lower for individuals in 2014 than in 2013, but there is no estimate for subsequent years and no mention of regulations on further increases in rates; and

WHEREAS, health insurers are increasing premiums in response to higher medical loss ratios mandated by the Affordable Care Act; and

WHEREAS, the increase in health insurance rates will disproportionately burden the uninsured; therefore be it

RESOLVED: That CMA study the effects of health plan rates on coverage to determine the threshold at which coverage is excessively decreased due to increased premiums; and be it further

RESOLVED: That CMA advocate for the development of a threshold above which increases in existing health plan rates or the implementation of new rates must be reviewed and approved by the California Legislature.

Current CMA Policy:
Longstanding CMA policy supports requiring health plans to fully disclose the percentage of premium dollars expended on medical care. (HOD 911a-96) CMA supports the examination of all medical care insurance payment programs and the development of recommendations to reduce the administrative costs of these programs and, thereby, increase the proportion of the premium which is allocated to pay for patient care. (HOD 418a-89)

Fiscal Impact:
Indeterminate; potentially high costs due to actuarial and other studies that would be required. If CMA were to undertake the advocacy that would be required, costs could be as high as $130,000 and is dependent on many factors over which CMA has no control, such as the extent of external opposition or support for the proposal, communications, and commitment of resources by opponents and proponents.
TITLE: POLICY SUNSET REVIEW

Introduced by: Speaker of the House
Luther F. Cobb, MD

Attached are the policies assigned to Reference Committee D for review pursuant to the process adopted by the House of Delegates in Report C-10-04, “CMA Policy Review.” The process provides that all House of Delegates policy presumptively terminates after ten years unless specifically renewed by further action of the House, based on recommendations of the relevant reference committee.

CMA staff renewal/non-renewal recommendations to the reference committee, based on research of actions and developments subsequent to adoption ten years ago, are shown beneath each policy. Reasons cited for non-renewal are those set forth in Report C-10-04. After hearing testimony and evaluating staff recommendations and any available background information, the reference committee will recommend to the House of Delegates whether the policies should be renewed or allowed to sunset.

It should be emphasized that policy reviewed is subject only to renewal or non-renewal (termination). Accordingly, amendment of the reviewed policies is not in order.

Should a delegate wish to recommend renewal of a particular policy not recommended for renewal by the reference committee, the policy review report of that reference committee must be extracted when the committee’s report is presented to the House. When the policy review report is being considered, an opportunity will be offered to then extract an individual policy or policies for renewal. After adoption of the recommendations concerning the remaining reviewed policies, the extracted policies will be considered individually. Debate will be limited to the decision to renew or not renew the particular policy.

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POLICY SUNSET REVIEW:
Policies Assigned to Reference Committee D

Resolution 402-03
SINGLE ADDRESS FOR INSURANCE BILLING

RESOLVED: That CMA support the following requirements: (1) that all payers maintain a single mail address for the submission of claims, (2) that this address be clearly printed on enrollees’ insurance cards, (3) that all payers maintain a single electronic address for receipt of claims, and (4) that payers notify physicians in advance of any changes to these addresses; and be it further

RESOLVED: That health insurance companies providing health care benefits in California shall immediately enter all claims received from providers into their systems, assign a number to each claim received, and provide this information to the physician who submitted the claim; and be it further

RESOLVED: That health plans be responsible for promptly routing claims to subcontracted payers.

Renew.

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Resolution 404a-03
INSURANCE VERIFICATION FOR PAYMENT OF LABORATORY SERVICES

RESOLVED: That laboratories and other providers of outpatient services be responsible for verification of insurance eligibility and authorization for services provided to patients; and be it further

RESOLVED: That CMA oppose the imposition of any monetary penalty on a physician who in good faith refers a patient for laboratory or other outpatient services.

Renew.

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Resolution 405a-03
FULL DISCLOSURE IN PPO CONTRACTS

RESOLVED: That CMA support the requirement that all payers who contract with physicians for health care services provide all necessary fee schedules, payment rules, and other information required for physicians to determine their reimbursement for each CPT code and any other service covered by the contract; and be it further

RESOLVED: That CMA support the following requirements: (1) that all payers make available a copy of the executed contract to physicians within three business days of the request; (2) that all health plan EOBs contain documentation regarding the precise contract used for determining the reimbursement rate; (3) that once a year, all contracts must be made available for physician review at no cost; (4) that no contract may be changed without the physician's prior written authorization; and (5) that when a contract is terminated pursuant to the terms of the contract, the contract may not be used by any other payer; and be it further

Renew.

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Resolution 410-03
INSURANCE COMPENSATION WHEN MEDICARE RATES ARE DECREASED

RESOLVED: That CMA support legislation that prohibits insurance companies from decreasing their compensation rates for services provided to non-Medicare patients when Medicare rates are decreased; and be it further

RESOLVED: That this matter be referred for national action.

1st Resolved: Renew.
2nd Resolved: Sunset – Resolutions that direct action based on prior CMA policy automatically sunset when the action has been carried out or is no longer required.

* * *
Resolution 413-03
WORKER’S COMPENSATION,
NEGOTIATIONS, STATE ACTION
EXEMPTION

RESOLVED: That CMA consider legislation to create a board modeled after the Federal Reserve Board to address issues related to workers’ compensation, and that such board include representation from leaders in workers’ organizations, business, insurance and medicine; and be it further

RESOLVED: That CMA reaffirm its commitment to legislation to create a state action exemption enabling physicians to negotiate rates and contract terms collectively with public and private payors.

1st Resolved: Renew.
2nd Resolved: Sunset – Resolutions that direct action based on prior CMA policy automatically sunset when the action has been carried out or is no longer required.

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Resolution 414-03
RBRVS AND WORKER’S COMPENSATION FEE SCHEDULE

RESOLVED: That CMA oppose introduction of an unmodified RBRVS as the sole template for developing the new Official Medical Fee Schedule (OMFS) by the Administrative Director of the Division of Worker’s Compensation; and be it further

RESOLVED: That CMA convene a workgroup of key stakeholders, including Specialty Society Representatives, to identify the necessary resources, develop a work plan, and explore the feasibility of creating a California Relative Value Unit Committee (RUC) to develop a new Workers’ Compensation Official Medical Fee Schedule (OMFS).

1st Resolved: Renew.
2nd Resolved: Sunset – Resolutions that direct action based on prior CMA policy automatically sunset when the action has been carried out or is no longer required.

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