During the November 2015 HOD in Atlanta, I had the privilege of sitting with the leadership of our delegation and leaders of other prominent AMA coalitions in four separate in-person forums to discuss national “hot-button” Issues—not just what was taking place on the floor of the HOD, but high-priority items for specific state medical societies (SMS). CMA leadership discussed these issues with its counterparts from the three other “Big 4” societies (New York, Florida and Texas) and the Southeast and Heart of America conferences. Together these coalitions represent 60% of all HOD members.

Among the issues discussed were payment models, “balance billing” and “narrow networks,” which cause extreme physician shortages and excessive surprise, out-of-network charges. We were all in agreement that neither patients nor physicians should bear these surprise charges since they are caused by insurance companies, which often claim to have complete networks when in reality many of these networks do not provide adequate access to in-network care at contracted hospitals. Networks like these simply should not be sold to health care consumers. One proposed solution to these surprise charges for out-of-network care is to help arbitrate out-of-network cost using the 80th percentile level found on Fairhealth.com published charges.

Most are within patient deductibles.

With other AMA factions, such as Southeastern, we discussed SMS governance—for example, the recent downsizing of the CMA Board of Trustees (BoT) from 57 to 35. We noted that most of the smaller societies have BoTs of just 10-15 members. Even the AMA Board has only 22 members. The North Carolina and Minnesota societies have abolished their HODs as well, in order to streamline their organizations and cut costs.

While this would not work for California, our new system of year-round resolution submissions, with testimony and BoT decisions made every quarter, will enable our HOD to more easily handle the review of the 250 annual resolutions during the shortened (from three days to two—leading to a 37% cost reduction) in-person HOD meeting. Most importantly, it has made possible more online testimony.

Maintenance of Certification (MOC):

There was extensive testimony at the HOD that the cost of MOC as run by the American Board of Internal Medicine (ABIM) is “out of control,” with the cost of recertification sometimes exceeding $20,000 a year. In Georgia, MOC is accomplished simply with CMEs. Several large hospital systems have approved the newly formed National Board of Surgeons and Physicians (NBSAP) as their MOC-accrediting body. Dr. (and Senator) Rand Paul is starting his own ophthalmology board.

Medicaid Expansion in California resulting from ACA is about 1.4 million new patients. Across the state, physician revenues are down 30-40%. Here physicians are the losers, but this may be less related to Medicaid expansion than to insurance issues and artificially induced physician shortages caused by narrow networks. Kentucky, a “red state,” enjoys Medicaid expansion brought about by its state exchange, which is called “Not Obama Care.”

Code Modernization: Currently, the Council of Ethical and Judicial Affairs (CEJA) can only modify the code all at once, which is very inefficient, as every meeting for the past six years has not been able to produce a finished product. Dividing this task into sections should be more efficient. Several coalitions wish to collaborate in this process. Unfortunately, CEJA has authority over the final product, and the HOD enjoys only advisory status in the modernization process. Nevertheless, HOD approval is required for Code Ratification. A call for process change, in which CEJA seeks Code Modernization, was brought forth by our California delegation and is gaining traction.

Other issues were discussed in debating resolutions—for example EMR-Meaningful Use burdens on physicians, asking CMS for a delay in implementing the penalty phase of compliance, and a call to defund IPAD through MACRA (Medicare Reform Law and CHIP Reauthorization Act of 2015). The outcome of all significant resolutions can be found in the AMA Proceedings (http://goo.gl/mcVjZn).

As a member of the California delegation to the AMA, I have learned a great deal in the past 15 years. For example,
Health Care Policy (HCP) is never an accident, easy or simple. It is forged by dedicated leaders in the CMA and AMA. How your leaders work at each HOD is truly an amazing democratic process. Your California delegation to the AMA is in the forefront of the discussions that help mold health care policy at both state and national levels. These policies often lead to laws. HCP also helps senators and representatives in Congress understand the thinking that goes into our very transparent process. The California delegation works hard for all of our practices in this time of rapid, difficult change. It fights to keep our profession independent of the purely financial forces that motivate large corporations. However, our delegation’s strength in accomplishing anything nationally depends on your membership. Please continue your generous support of our CMA and consider joining the AMA, since together we are stronger.

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The California delegation to the AMA consists of almost 50 physicians, about 10% of the AMA’s total House of Delegates membership, making it the organization’s largest delegation. Delegates are elected by CMA delegates who are also AMA members. Each district is entitled to elect at least one delegate and alternate, as well as additional delegates for every 1,000 AMA members in that district. The AMA HOD meets every six months—in Chicago every June for five days and again in November for four days in rotating cities. Last fall, this “interim” meeting was held in Atlanta. I have been helping represent District X at the AMA since 2003.

The CMA leads the AMA’s Pacific Rim Coalition, which also includes Alaska, Hawaii and Guam. Until 20 years ago it also included Oregon and Washington. However, those state societies’ delegates elected to leave the Pac Rim Coalition for perceived lack of representation. Nevertheless, talks have been taking place for the past 10 years to bridge this divide, and in the past month the talks have successfully led to the reconstitution of the PAC Rim Coalition. This will help it be more effective in determining AMA national health care policy and legislative matters.

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Your support is needed to ensure that the Marin Medical Society (MMS) continues to be an effective advocate on your behalf on local and state health care issues.

Through the MMS’s political action committee—MMPAC—the MMS is able to support candidates for local office who are responsive to our concerns about health care issues in Marin. Often the impact of this support goes far beyond our local community, as these candidates move on to higher office in Sacramento.

MMPAC-supported candidates look to MMS for input on vitally important local health care issues. MMPAC’s success is dependent on your support.

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Questions? Call Rachel at 415-924-3891.

MMPAC is a voluntary political organization that contributes to candidates for local office. Political law and MMPAC policy determine how your contribution to MMPAC is allocated. A decision not to contribute to MMPAC will not affect your membership status with the MMS. MMPAC is sponsored by the Marin Medical Society. Contributions are not deductible for income tax purposes.