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Psychiatrist Thomas E. Allen, MD, said there should be patient protections built into any transition to a Medicare defined-contribution system. "If we are moving to having competing insurance plans, I think there is some risk," said Dr. Allen, a delegate for the Maryland State Medical Society who spoke on his own behalf. "There ought to be language in this report ... to make sure that this money is going to take care of patients." [Photo by Luci Pemoni / AP Images for American Medical News]

AMA delegates debate defined-contribution Medicare financing

At the Association's Interim Meeting, they also discussed how to protect the autonomy of the growing number of employed physicians.

By CHARLES FIEGL and KEVIN B. O'REILLY, amednews staff. *Posted Nov. 11, 2012.*

Honolulu Concerned about the viability of Medicare, many delegates to the American Medical Association Interim Meeting said they support an overhaul that gives seniors more coverage choices and a standard contribution toward the purchase of insurance.

At the AMA Interim Meeting on Nov. 11, delegates discussed a report and recommendations that call for giving seniors coverage options under a defined-contribution system, which also would offer the traditional Medicare insurance. Testimony ran about 2-1 in favor of the proposal.

The Medicare program is in trouble, said Robert E. Hertzka, MD, a Rancho Santa Fe, Calif., anesthesiologist who sits on the AMA Council on Medical Service. The council produced a report on a defined contribution plan that addresses the long-term financing problems facing Medicare. Something must be done, because the status quo isn't viable with 10,000 seniors joining Medicare every day, he said.

The report details an urgent need for change in the national entitlement benefit. It says Washington increasingly is concerned with large federal budget deficits that add trillions of dollars to the national debt.

Medicare's board of trustees projected that spending will reach 5.7% of gross domestic product in 2030. It represents 3.7% of the economy today.

"Our council feels that this is a strong proposal that will put us in a strong position as we're finally starting to look at entitlement reform over the next year or two," Dr. Hertzka said.

The council had met with health policy analysts — including economist Alice M. Rivlin, PhD, a former Clinton White House adviser, and former Sen. Pete Domenici (R, N.M.) — who have proposed plans for transitioning Medicare to a defined-contribution system. Lawmakers and Medicare policy analysts have warned for years that the future of the federal program is uncertain.

The report's recommendations build on existing AMA policy, proponents said. These include preserving traditional Medicare as an option for beneficiaries, who also would have HMOs, PPOs and high-deductible plans paired with health savings accounts as coverage choices.

Contribution amounts would be adjusted annually to reflect changes in health care costs and insurance fees. The report also called for mechanisms to continue financing graduate medical education.

Some members of the AMA House of Delegates opposed or offered amendments to the report. The report did not address provisions such as risk pools or caps on out-of-pocket costs, said Michael Kitchell, MD, an alternate delegate with the Iowa Medical Society and a neurologist in Ames.

The proposal was similar to premium support models discussed by Republicans and opposed by Democrats, said Maurice A. Cerulli, MD, a delegate for the American Society for Gastrointestinal Endoscopy from Rockville Center, N.Y., who spoke for himself.

"It would seem like nothing is going to happen on this type of idea for four years," he said. "There are other ways we should consider for saving Medicare because this one isn't going to fly."

Testimony on this and other reports and resolutions was presented in several sessions. Voting on the proposed policies by the entire AMA House of Delegates begins Nov. 12 and is scheduled to conclude Nov. 13.

Employment may pose ethical challenge

Delegates welcomed proposed policy to address two trends in health care: the rising number of physicians who work as employees and the growing clinical applicability of genomic-based technologies.

Hospital employment of physicians has grown by 32% during the last decade, according to the American Hospital Assn. And nearly one-third of final-year residents list hospital employment as their first choice of practice setting, reports the physician recruiting firm Merritt Hawkins.

Employed doctors "face unique challenges to their professional, ethical and financial interests," said a Board of Trustees report on such doctors. To address these challenges, the board outlined principles on conflicts of interest, contracting, hospital-medical staff relations, peer review and performance evaluations, and payment agreement.

"In any situation where the economic or other interests of the employer are in conflict with patient welfare, patient welfare must take priority," the report said.

The proposed principles for physician employment address a critical issue, delegates said.

Richard A. Evans, MD, a general surgeon from Dover-Foxcroft, Maine, said the proposed principles reinforce the idea that physicians' professional obligations are paramount regardless of practice setting.

"People make decisions about being employed or not being employed based on their own personal preferences. That's not the issue," said Dr. Evans, a Maine Medical Assn. delegate who spoke on behalf of the state delegation. "But no matter what career you choose to design for yourself, you're still a physician, and you have to understand the importance of your role in decision-making and your role in [medical staff] self-governance."

Genomic-based technologies, such as whole genome sequencing, also are changing the nature of medical care, said delegates, commenting on a Council on Science and Public Health Report.

So-called next-generation sequencing of the human genome has growing applicability in clinical practice, particularly in oncology, the report said. An entire individual genome can be sequenced within two to three days for less than $5,000, with the cost expected to fall to less than $1,000 in the near future.

The report recommends monitoring research on next-generation sequencing, informing and educating practicing doctors and physicians in training on their clinical uses and supporting regulatory policy that enables doctors to use these diagnostic tools as clinically appropriate.

Kenneth W. Crabb, MD, a St. Paul, Minn., obstetrician-gynecologist, lauded the council's report. "This has ramifications far outside of oncology. Indeed, it may well influence every disease we treat," said Dr. Crabb, a Minnesota Medical Assn. delegate who testified for himself in virtual reference committee.

Delegates also discussed proposals to eliminate legacy medical school admissions, expand the J-1 visa waiver program and examine issues of patient adherence to improve health outcomes. Improving outcomes is one of the three areas of focus of the AMA's five-year strategic plan. The other two are accelerating change in medical education and enhancing professional satisfaction and practice sustainability by helping doctors navigate delivery and payment models.

AMA Executive Vice President and CEO James L. Madara, MD, updated the house on the progress of the plan during the house's opening session on Nov. 10. During reference committee testimony on Nov. 11, some delegates said they want the plan to include more public health and advocacy efforts not mentioned in the strategic plan.

Steven J. Stack, MD, chair of the AMA Board of Trustees, told delegates that the board supports the plan and will review it annually.

"We will adjust and refine it as necessary," he said.

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