Board Did Not Adopt Resolution
(January 2021)
(Affirmed; 2021 Annual Meeting)

ILLINOIS STATE MEDICAL SOCIETY

Resolution 12.2019-22
(A-20)

Introduced by: Titus Hou, ISMS Member

Subject: Health System Reform Language Neutralization

Referred to: Council on Economics

RESOLVED, that ISMS revise the policy adopted by the HOD in 2007 related to health system reform by deletion and addition by replacing "supports" with "utilizes" and inserting "when engaging in health system reform" after "principles" in the first sentence thereby establishing a set of principles to engage health system reform; and be it further

RESOLVED, that ISMS revise existing policy by deletion and addition by removing condemnatory language directed toward any particular broad category of healthcare reform and neutralizing opposition towards healthcare reform ideas by removing the first two sentences of the 1986 HOD adopted policy and replacing them with "ISMS is invested in working on any policy where patient safety is improved, high-quality care processes are promoted, and physician reimbursements are commensurate to the value of their work".

Author's Recommended Changes to ISMS Policies:

ISMS ~~supports~~ utilizes the following health care system reform principles when engaging in health system reform: 1. Health care delivery and finance system reform should use the current public-private system as a basis and focus on incremental evolutionary change. 2. All patients should have access to a health benefit plan that would include catastrophic coverage as well as preventive services, appropriate screening, primary care, immunizations, and prescription drug coverage. 3. Health insurance reform is needed to allow public and private plans to develop innovative coverage plans, including the development of health savings accounts and other high deductible plans to encourage patients, physicians, and other health care providers to pursue high value care. 4. All health care expenditures should receive equal treatment

for purposes of tax deduction and tax credits. 5. Professional liability reform – including caps on noneconomic damages – should continue to be pursued and defended as a way to reduce direct and indirect costs (defensive medicine) and to address the adverse effect the current medical liability system has on the physician-patient relationship and access to health care. 6. Use of information technology in health care delivery should be encouraged to improve quality and safety of care, enhance efficiency, and control costs. 7. Health care education and literacy must be an important part of any medical care financing and delivery system reform. 8. Health care reform proposals should include provisions for physicians to set and negotiate their own fees in order to adequately compensate physicians and other health care providers for the promotion of personal and public health. 9. Evidence-based protocols should support, not replace the patient-physician relationship. 10. ISMS objects to third party insurance carriers interfering with the practice of medicine and the patient-physician relationship. (HOD 2007; Revised 2008; Reaffirmed 2011; Reaffirmed 2012; Reaffirmed 2015-JAN; Reaffirmed 2017;Reaffirmed 2018; Reaffirmed 2019; Last BOT Review 2015)

~~The Illinois State Medical Society is opposed to compulsory governmentally mandated national health insurance plans and will continue to point out its dangers and disadvantages to the public, including those in which quality of care is compromised. It is opposed to national~~ compulsory catastrophic health insurance. ISMS is invested in working on any policy where patient safety is improved, high-quality care processes are promoted, and physician reimbursements are commensurate to the value of their work. Health insurance benefits for mental illness should be comparable to benefits for any other medical condition. Governmental health insurance programs providing reimbursement for medical services under the direction of practitioners other than doctors of medicine or osteopathic medicine should establish a separate category for such reimbursement, with separate payment, and be optional to the insured as long as the plan has a demonstrated physician-supported patient care management program in effect. ISMS will actively oppose any state or federal legislation which proposes reimbursement under health insurance programs for limited license practitioners without direct supervision and responsibility for patient care by a physician licensed to practice medicine in all its branches in Illinois. (HOD 1986; Revised 2008; Reaffirmed 2011; Reaffirmed 2012; Reaffirmed 2015-JAN;Reaffirmed 2018; Last BOT Review 2015)

Health care must continue as a priority item of funding at the national, state, and local levels. Health care coverage must be expanded to all citizens of the United States. As our health care delivery system evolves, direct, meaningful and obligatory physician input is essential and must be present at every level of debate. The private practice of medicine must be permitted as the U.S. health care delivery system evolves. (HOD 2008; Reaffirmed 2012; Reaffirmed 2015-JAN; Reaffirmed 2018; Last BOT Review 2015)

It is desirable to afford maximum flexibility and latitude in creating an economic environment acceptable to the individual physician's right to choose which method of economic reimbursement for care that best suits the needs of that physician and his/her patients. Where appropriate, ISMS supports the right of physicians to seek payment from patients for the difference between the physician's charges and the amount of payment an insurance carrier pays. To the extent practicable, ISMS should strive to assist physicians in understanding alternative reimbursement systems, including but not limited to Usual and Customary or Reasonable (UCR). (HOD 1985 Amended; Reaffirmed 2009; Reaffirmed 2015; Last BOT Review 2012)

ISMS supports private, voluntary catastrophic health insurance, including freedom of choice of physician. It supports the policy of a tax credit or deduction for the premium expense of medical insurance and endorses the principle that, under federal rules and regulations, the costs and premiums for health care, whether incurred directly by an individual or conferred as an employee benefit, should be equally deductible. Inasmuch as the fee coverage by insurance plans may not cover the full fee of the physician, the physician is encouraged to develop a prior agreement with the patient outlining the patient's individual responsibility for the physician's fee. When insurance benefits are assigned to a physician by a patient, care should be exercised by the insurance company, or its agent, in seeing that such wishes of a patient are followed. If an error is made by the insurance company, or its agent, and payment is made to the patient, the insurance company is urged to admit its error and pay the physician as it was originally directed to do. Under such circumstances, recouping of money from the patient should be the responsibility of the insurance company, or its agent, that committed the error and not be the responsibility of the physician. ISMS objects to third party carriers interfering with the practice of medicine and the patient-physician relationship by: • Implying to patients that physicians' charges above insurance benefit allowances are excessive; • Suggesting to physicians that insurance company reimbursement amounts be accepted as payment in full; • Suggesting that physicians perform alternative surgical procedures; • Instituting utilization review of hospital patients in the private sector which bypasses local physician review mechanisms; • Discriminating against the physician who does not have a separate contractual relationship with the carrier and inhibiting the patient's free choice of physician. ISMS endorses long-held principles that: • A contractual relationship that exists between a patient and a third party does not involve the physician (unless the physician has agreed to such involvement); and • The third party is not involved in the contract existing between the patient and his/her physician (unless such involvement has been agreed to by both patient and the physician). (HOD 1982; Revised 2008; Reaffirmed 2015-JAN; Reaffirmed 2015; Reaffirmed 2017; Reaffirmed 2018; Last BOT Review 2015)