ILLINOIS STATE MEDICAL SOCIETY

Resolution 08.2021-07
(A-22)

Introduced by:	Robert F. Hamilton, MD, ISMS Member
Subject:	Health Care Reform by Means of State Legislative and Executive Activity and Action
Referred to:	Council on Economics

Whereas, health care in the United States of America excels in terms of quality, availability, and choice, but suffers from over-regulation, inefficiency, and excessive cost; and

Whereas, because the percentage of the U.S. gross national product spent on health care has risen to nearly 20%, it is imperative that we reform the health care system in order to protect our economy in a manner that preserves the quality and availability of our health care, while preserving our rightful choices as patients and providers; and

Whereas, other large, developed countries (England, Canada) that have attempted to solve this problem with centrally controlled, cumbersome and impersonal systems that have created programs in which primary care may or may not be readily accessible, but long waits and long lines are common for tests and/specialist services; and

Whereas, history shows that such centralization of regulation and authority would be detrimental to our patients and to the practice of medicine; and

Whereas, even though many innovative economists, organizations and others have devoted years to solving the complex issues involved in health care reform, most of their ideas are unknown or are poorly understood by the general public and by the medical profession; and

Whereas, many of these innovators have advocated approaching healthcare reform from the state level so that programs can be designed, tailored, implemented and monitored to address geographical differences rather than the "one size fits all" approach; and

Whereas, ISMS could be the nidus for sensible state healthcare legislation, other stakeholders must also be partners in the problem- solving process, not as members of a circular firing squad, ideologues, partisans, or profiteers, but as problem-solvers, with the patients, and ultimately "we the people" as the beneficiaries, working together to improve an excellent, but imperfect health care system; and

Whereas, many topics to be addressed will often be complex (i.e. price transparency; certificate of need; cross-border licensing; scope of practice issues; HSAs, HRAs, related variations and innovations; and the "Health Care Choices Proposal: Policy Recommendations to Congress," published by the Health Policy Consensus Group on June 19, 2019); and

Whereas, a challenge and commitment of this magnitude might best be accomplished by an ad hoc committee authorized by the ISMS Board of Trustees; therefore, be it

RESOLVED, that ISMS direct the Board of Trustees to authorize and create an ad hoc committee, whose purpose is to design health care legislation which will be submitted to the General Assembly, and to encourage executive action, when appropriate; and be it further

RESOLVED, that the committee will address the major factors leading to inefficiency and excess cost in the health care system and will consult with appropriate industry stakeholders and innovative economists, as necessary, to create state-level health care reform solutions that benefit our patients, our profession and other groups upon whom the health care industry depends, with the goals of improving inefficiencies and controlling cost, while preserving health care quality, availability, choice.

Fiscal Note:

n/a

Existing ISMS policy related to this issue:

ISMS supports the following health care system reform principles: 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)

It is the policy of ISMS to make every effort to oppose the creation of any health care provider taxes to fund health care reform. (HOD 1993; Reaffirmed 2012; Reaffirmed 2015-JAN; Last BOT Review 2015)

ISMS supports, as policy, federal medical liability reforms, similar to and including those as proposed in the "Help Efficient, Accessible, Low-cost, timely Healthcare" (HEALTH) Act. (HOD 2011; Reaffirmed 2016; Reaffirmed 2017)

It is the policy of the Society to require appropriate limits on non-economic damages for malpractice suits to be included as an integral and necessary part of any health care policy reform plan adopted and as a necessary pre-requisite for effective resolution of our current access and cost problems. (HOD 1992; Reaffirmed 2010; Reaffirmed 2011; Last BOT Review 2011)

The Illinois State Medical Society believes that an informed and educated public is critical to the creation and maintenance of a healthcare system that is defined by quality, availability, choice, efficiency, fiscal stability and sustainability. (2020 Annual Meeting)

The Illinois State Medical Society supports efforts by the American Medical Association (AMA) to educate physicians and the public about health system reform and related issues. (2020 Annual Meeting)

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)

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)

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. 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)

It is the policy of ISMS to publicize and promote the Medical Savings Account (including Health Savings Account) concept as a third major area of emphasis, in addition to medical liability reform and antitrust reform, as appropriate. (HOD 1994; Reaffirmed 2012; Reaffirmed 2015-JAN; Reaffirmed 2018; Last BOT Review 2015)

It is the policy of ISMS to provide strong leadership in support of the private practice of medicine. (HOD 1995; Reaffirmed 2012; Reaffirmed 2015-JAN; Reaffirmed 2018; Last BOT Review 2015)

ISMS supports consumers' right to purchase health insurance across state lines in order to allow people to choose the health insurance plan that best suits them, thereby offering the best form of consumer protection for all. (HOD 2008; Reaffirmed 2012; Reaffirmed 2015-JAN; Reaffirmed 2018; Last BOT Review 2015)

ISMS supports the following principles for Medicaid reform and waivers: Purpose: To improve the health of low-income individuals and families, the aged, blind, and disabled enrolled in or eligible for the Illinois Medicaid program and to control Medicaid costs by offering competition, choice and program stability. Goals: - To assist the State of Illinois in obtaining legal authority to reform the Illinois Medicaid program either through application for a Section 1115 Medicaid waiver through the Social Security Act or an alternate method, such as an interstate compact. - To propose changes in Medicaid funding which will result in cost efficiency, transparency and fraud control. Principles: 1. Fund Illinois Medicaid through federal block grants or spending caps in exchange for greater program flexibility, simplified administration and regulation relief. 2. Administer funding separately for indigent medical care and for the elderly, blind and disabled. 3. Promote reasonable and fiscally responsible eligibility standards for patient participation in the Medicaid program. 4. Patient responsibility- Premiums and copayments for those above 150% of the federal poverty level should be in addition to the Medicaid fee schedule. Copayments for nonemergency use of the Emergency Room should be stratified based on income levels. 5. Change Medicaid from a “defined

benefit" to a "defined contribution" program in order to promote cost efficiency, increase access to care, lessen the fiscal burden on the State of Illinois, restrict unnecessary care and combat fraud. 6. Patient empowerment and choice- Managed care should not be mandatory but instead should be an option for Medicaid enrollees. Managed care should compete with other models of care such as the medical home developed through the primary care case management program. In addition, beneficiaries should be given a choice between traditional Medicaid and a variety of private, customized, managed care plans with variable deductibles, copayments, benefits and coinsurance. 7. A reformed Medicaid program should promote choice, access to quality health care and financial protection for patients by implementing Health Savings Accounts; offering premium support on a sliding scale basis; paying providers on a fee-for-service basis; ensuring transparency; creating incentives to cut cost, upgrading coverage and improving living status; evaluating outcomes; and providing a grievance process for beneficiaries. 8. Medicaid should establish pilot projects that allow evaluation of health insurance programs such as health savings account plans and other means of financing health care as applied to health care for the medically indigent. 9. Consider financial and/or benefits rewards for responsible use of benefits by beneficiaries and disincentives or penalties for irresponsible use of benefits, such as co-payments for inappropriate use of the emergency department. 10. Promote wellness programs and appropriate, customized preventive testing. 11. Health care education and literacy must be an important part of any Medicaid Waiver and Medicaid should provide financial support for comprehensive health education and literacy activities performed by physicians. Medicaid should develop creative, non-traditional patient educational programs such as training via video and the internet. Additionally, Medicaid should develop initiatives in cultural competence and provide cultural competence resources for physicians. 12. Maximize the principles of Cash and Counsel [which have traditionally been used to give individuals with disabilities the option to manage a budget and decide what mix of goods and services best meets their personal and health care needs] to help patients and providers use the Medicaid system optimally. These counseling programs should also be utilized to encourage community-based alternatives to nursing home care. 13. Care coordination should be physician-led and physicians should receive adequate compensation for time and effort spent in coordinating care to allow physicians and their staffs to spend adequate time with patients who have chronic and often complicated illnesses. 14. Promote usage of and technical advances in home health care technology. 15. Encourage anti-fraud activity such as hospital and nursing home audits. 16. To ensure patient access to care, physician compensation must be adequate. (HOD 2012; Last BOT Review 2014)