the final word

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Health insurer code of conduct?

Last fall, the American Medical Association's (AMA) House of Delegates adopted a resolution brought by the Medical Society of the State of New York (MSSNY) calling for the AMA to develop a Health Insurer Code of Conduct setting forth clear and concise principles to address both medical care policies and payment issues and seek concurrence among health insurers in complying with this code of conduct as well as develop a mechanism to monitor compliance with it.

Codes of conduct are hardly a new idea. Most are self-imposed by professional organizations or trade groups on their members, often in an effort to voluntarily level up their members' general behavior, especially in the wake of legal or political scrutiny. For example, the pharmaceutical industry substantially revised its code governing interactions with health care professionals after public and professional criticism. Much of the managed care industry, in the wake of settlements governing physician profiling with New York State Attorney General Mario Cuomo Jr., signed onto the Patient Charter for Physician Performance Measurement, Reporting and Tiering Programs. In so doing, they joined the AMA, AARP, AFL-CIO, Leapfrog Group and several other national organizations in committing to minimum national standards for physician profiling by the industry.

The unique aspect of this proposed code is that it is being developed by a work group of national medical specialty societies, state medical associations and the AMA, rather than from the managed care industry, and will ultimately convey a decidedly physician perspective.

There could be many benefits from a Health Insurer Code of Conduct. Such a code could assist the AMA and its Federation partners as they:

- Challenge health plans to change their restrictive practices without the need for legislative or judicial intervention;
- Provide valuable data and public support for the AMA's efforts in state capitols to achieve legislative and regulatory reform that meaningfully addresses abusive health plan practices; and
- Provide businesses and the general public with an excellent tool to compare the performance of health plans for the purposes of making enrollment decisions.

This AMA resolution has been well received by the press and patient advocacy groups. MSSNY has already made several thoughtful recommendations to the AMA on the construction of a Health Insurer Code of Conduct. It has urged that the code be consistent with and complementary to other AMA efforts, including AMA's recently released National Health Insurer Report Card (NHIRC) that evaluates the health insurers' claim processing practices. A simple, concise code of conduct that sets forth clear principles focusing not only on payment issues but also on medical care policies could enhance the value of the NHIRC. Specifically, MSSNY has suggested that the Code of Conduct include clear, general principles for the health insurance industry to follow when establishing policies and practices impacting the medical care received by their enrollees addressing each of the following four areas:

Clinical Autonomy: Allowing physicians to make decisions based on patient needs without artificial barriers by doing such things as:

- Easing burdens for UR/pre-authorization of diagnostic tests;
- Developing formularies based on appropriate clinical evidence; and
- Protecting patients from formulary changes.

Transparency: Disclosing information regarding health plan benefits and policies to help facilitate patient decisions about which plans to join, and informing providers, regulators and the public about systems that may corrupt medical care. Such disclosures might ensure:

- Transparent ranking/tiering system based upon true assessments of quality;
- Disclosure of incentives to health plan employees and contractors, and to providers of care;
- Disclosure of reimbursement/code review and bundling policies; and
- Disclosure of factors affecting requests to change prescriptions.

Corporate Integrity: Ensuring that business practices meet generally accepted standards and don't negatively impact critical stakeholders, including requirements addressing:

- The avoidance of conflicts of interest;
- Appropriate allocations of premium dollars for health care; and
- Fair and timely reimbursement.

Patient safety and welfare: Ensuring patients are always put before profits.

As the AMA prepares its report back to the House of Delegates, the AMA will give careful consideration to all the issues raised by Res. 823–I-08, including:

- How the AMA should involve the health insurers?
- How the AMA should involve consumers?
- How the AMA should monitor adherence to the code?■

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