

**CALIFORNIA MEDICAL ASSOCIATION  
2009 HOUSE OF DELEGATES**

**LACMA-01**

**Title:** ABUSIVE PRACTICES OF NOT FOR PROFIT HOSPITALS

**Author:** Dinesh Ghiya, MD  
dghiya@gmail.com  
Steve Vouis, MD  
ccerda49@yahoo.com

**Introduced by:** Dinesh Ghiya, MD

**Endorsed by:** LACMA – District IV

---

**WHEREAS**, not- for- profit hospitals enjoy a tax exempt status. They can issue preferred bonds. Cities help build these hospitals by imposing levies and issuing bonds; and

**WHEREAS**, the tax exempt status is granted to not-for-profit hospitals if the hospitals are taking care of an indigent patients, involved in teaching and doing medical research. However, many not-for-profit hospitals don't take care of indigent patients, are not involved in medical research and the only teaching is through a community based family practice residency program; and

**WHEREAS**, many not-for-profit hospitals are in fact more profitable than traditional for profit hospitals; and

**WHEREAS**, not-for-profit hospitals use their foundations and tax exempt status to buy medical groups thereby circumventing the bar against the corporate practice of medicine in California. This ability enables the hospitals to become a local monopoly which controls hospitals and doctors particularly if they possess a Knox Keene license; therefore be it

**RESOLVED:** That the California Medical Association (CMA) support legislative means to prevent the corporate medicine of medicine by not-for-profit hospitals by their ability to use foundation funds and tax exempt status; and be it further

**RESOLVED:** That the California Medical Association (CMA) support legislative action prohibiting not-for-profit hospitals from canceling their Medi - Cal contracts and denying care to indigent patients.

**Current CMA Policy:**

**Estimate Cost to CMA:**

**CALIFORNIA MEDICAL ASSOCIATION  
2009 HOUSE OF DELEGATES**

**LACMA-02**

**Title:** ALTERNATE DELEGATE ELIGIBILITY FOR COUNTY DELEGATION  
LEADERSHIP

**Author:** Marvin S. Kaplan, MD, FACS  
mskfac@aol.com

**Introduced by:** Marvin S. Kaplan, MD, FACS

**Endorsed by:** LACMA – District IV

---

**WHEREAS**, there is general consensus to involve younger and newer members in California Medical Association (CMA) activities, but current California Medical Association (CMA) Bylaws prohibit Alternate Delegate participation in County California Medical Association (CMA) delegations; and

**WHEREAS**, Alternate Delegates are considered full members of the delegation except for voting on the floor or in elections; and

**WHEREAS**, there is a need for new, capable leadership in the California Medical Association (CMA) House of Delegates; and

**WHEREAS**, in many delegations where leadership serves two year terms, Alternate Delegates may likely become Delegates during this time; therefore be it

**RESOLVED:** That California Medical Association (CMA) Bylaws will be changed to include and make Alternate Delegates eligible to serve as County Delegation Officers.

**Current CMA Policy:**

**Estimate Cost to CMA:**

**CALIFORNIA MEDICAL ASSOCIATION  
2009 HOUSE OF DELEGATES**

**LACMA-03**

**Title:** ATTESTATION OF REPRESENTATIVE'S FULL READING OF HR 3200

**Author:** JoAnn Giaconi, MD  
giaconi@jsei.ucla.edu

**Introduced by:** Robert Bitonte, MD

**Endorsed by:**

---

**WHEREAS,** H.R. 3200 America's Affordable Health Choices Act of 2009 is one of the most important pieces of legislation that will be presented this year with effects that will touch every American's health and healthcare for generations to come; and

**WHEREAS,** the passing of this legislation will have far reaching economic impact on every American individual, business, and government; therefore be it

**RESOLVED:** That the California Medical Association (CMA) General Counsel send a letter to the House of Representatives requesting all Representatives sign an attestation that they have read and understood the bill before they vote on it.

**Current CMA Policy:**

**Estimate Cost to CMA:**

**CALIFORNIA MEDICAL ASSOCIATION  
2009 HOUSE OF DELEGATES**

**LACMA-04**

**Title:** BIOLOGIC DATA PROTECTION RESEARCH SUPPORT

**Author:** Robert Bitonte, MD  
rbitonte@aol.com

**Introduced by:** Robert Bitonte, MD

**Endorsed by:** LACMA – District IV

---

**WHEREAS**, pharmaceuticals have helped enable physicians to extend life and reduce suffering over the entire spectrum of human disease; and

**WHEREAS**, the emerging biologic medicines industry, including the stem cell research sector holds great promise to relieve human suffering, and restore human functional capacity; and

**WHEREAS**, the therapeutic biologics industry involves biologic medicines that in some part came from living organisms, and are 100-1000 times more complex than traditional pharmaceuticals; and

**WHEREAS**, there is currently competing legislation regarding the “Data Protection Period” of Biologic development companies; and

**WHEREAS**, the Association of American Universities, and the California Institute for Regenerative Medicine support a 12-14 year period of data protection for Biologic Similar going to market; therefore be it

**RESOLVED:** That the California Medical Association (CMA) support legislation that provides a twelve year period of data protection for Biologic Similar going to market.

**Current CMA Policy:**

**Estimate Cost to CMA:**

**CALIFORNIA MEDICAL ASSOCIATION  
2009 HOUSE OF DELEGATES**

**LACMA-05**

**Title:** CALIFORNIA MEDICAL ASSOCIATION (CMA) MEMBERSHIP  
RECRUITMENT

**Author:** Michael Borok, MD

**Introduced by:** Michael Borok, MD

**Endorsed by:**

---

**WHEREAS**, the physician and surgeon population in California has grown over the past thirty years while the CMA active physician membership has slowly declined; and

**WHEREAS**, the membership recruitment efforts of CMA and the county medical societies and associations relying on member physicians directly engaging and recruiting potential member physicians has not translated into an overall increase of membership in CMA; therefore be it

**RESOLVED:** That the CMA together with the county medical societies/associations employ a professional sales staff that goes directly to non-member physician offices repeatedly to sell CMA/County Medical Society or Association memberships informing these potential CMA member physicians of the services and value a CMA/County Medical Society or Association offers especially with respect to representation at the State Legislative and regulatory levels that governs a physician's practice its relationship with patients and health plans.

**Current CMA Policy:** I don't think there is any policy.

**Estimated Cost to CMA:** This will cost CMA a lot of money but it should be worth it.

**CALIFORNIA MEDICAL ASSOCIATION  
2009 HOUSE OF DELEGATES**

**LACMA-06**

**Title:** COMMUNITY GRADUATE EDUCATION

**Author:** Robert Bitonte, MD ([rbitonte@aol.com](mailto:rbitonte@aol.com))  
Keith Norris, MD, FACP ([keithnorris@cdrew.edu](mailto:keithnorris@cdrew.edu))  
Richard Baker, MD ([richardbaker@cdrew.edu](mailto:richardbaker@cdrew.edu))  
Carmen Puliafito, MD ([cpuliafito@usc.edu](mailto:cpuliafito@usc.edu))  
Clint Adams, MD ([cadams@westernu.edu](mailto:cadams@westernu.edu))

**Introduced by:** Robert Bitonte, MD

**Endorsed by:** LACMA – District IV

---

**WHEREAS**, community training in the graduate medical education context has been promoted as a valuable and viable supplement to traditional graduate medical education; and

**WHEREAS**, current opportunities in graduate medical education have not increased as is necessary to produce enough physicians to prevent an anticipated physician shortage; therefore be it

**RESOLVED:** That to help accomplish this goal of community assisted graduate medical education, that the California Medical Association (CMA) utilize any, and all methods and measures to supplement payment to physicians providing community medical education training

**Current CMA Policy:**

**Estimate Cost to CMA:**

**CALIFORNIA MEDICAL ASSOCIATION  
2009 HOUSE OF DELEGATES**

**LACMA-07**

**Title:** CONFLICT OF INTEREST AT CALIFORNIA DEPARTMENT OF MANAGED CARE

**Author:** Sidney Gold, MD  
sidney.x.gold@kp.org

**Introduced by:** Sidney Gold, MD

**Endorsed by:** LACMA- District IV

---

**WHEREAS,** as the California Department of Managed Care is responsible for the regulation of managed care organizations; and

**WHEREAS,** the regulators of the Department interact with the organizations they review; and

**WHEREAS,** the regulators' decisions have significant impact on the function of the MCO; and

**WHEREAS,** these decisions should be based on the facts and

**WHEREAS,** there are reports that regulators in the Department have taken employment with companies that they have reviewed; and

**WHEREAS,** such actions could be seen as a possible conflict of interest in their prior decisions; therefore be it

**RESOLVED:** That the Department of Managed Health Care, the Attorney General and Legislators develop a code of conduct for persons who have regulatory responsibility within the department that would include the prohibition of taking a position in an organization which has been regulated by the Department of Managed Care for at least three years after leaving the department of managed care.

**Current CMA Policy:**

**Estimate Cost to CMA:**

**CALIFORNIA MEDICAL ASSOCIATION  
2009 HOUSE OF DELEGATES**

**LACMA-08**

**Title:** CONGRESS MEMBERS VOTING ON HEALTH CARE REFORM

**Author:** Maria Lymberis, MD  
maria@lymberis.com  
Laurie Reynard, MD  
LBR826@aol.com

**Introduced by:** Maria Lymberis, MD

**Endorsed by:**

---

**WHEREAS**, the US Congress is about to pass major health care reform legislation that will impact the lives of all citizens for generations; and

**WHEREAS**, there are numerous members of Congress that have openly noted that they do not and will not actually review the legislation that they will vote on, including the upcoming health care reform legislation; therefore be it

**RESOLVED:** That the California Medical Association (CMA) join with the American Medical Association (AMA) to strongly advocate that no legislator should vote unless they have actually read legislation they are to vote on, (especially the health care reform legislation) and that the names of the legislators who do not read the legislation they vote on, be widely published.

**Current CMA Policy:**

**Estimate Cost to CMA:**

**CALIFORNIA MEDICAL ASSOCIATION  
2009 HOUSE OF DELEGATES**

**LACMA-09**

**Title:** DIRECT PATIENT PAYMENT AS A MEANS OF COST CONTROL

**Author:** Michael Borok, MD  
mborok@pol.net

**Introduced by:** Michael Borok, MD

**Endorsed by:**

---

**WHEREAS,** Payment for non-hospital medical services including imaging, laboratory and physician services has becoming increasingly reliant on third party payment insulating the patient from the true cost of the above listed services leading to excess utilization of the above services and costs spiraling out of control; and

**WHEREAS,** the response to this accelerating cost is to impose top down cost controls resulting in delays in treatment and inappropriate denials of care; therefore be it

**RESOLVED:** That the CMA adopt the policy that patients should bear a greater share of the financial responsibility directly at the time of service moving away from an increasing dependence on third party payment; and be it further

**RESOLVED:** That it be shown that the above method of payment would result in greater cost control reducing medical costs resulting in less pain, suffering, impairment, death and disability even though it might at first be more costly to patients at the time of service.

**Current CMA Policy:**

**Estimate Cost to CMA:**

**CALIFORNIA MEDICAL ASSOCIATION  
2009 HOUSE OF DELEGATES**

**LACMA-10**

**Title:** DIRECT PRACTICE EDUCATION BY CALIFORNIA MEDICAL ASSOCIATION

**Author:** Thomas LaGrelius, MD, FAAFP  
tlagrelius@pol.net

**Introduced by:**

**Endorsed by:**

---

**WHEREAS,** the health insurance system has created a wedge between patients and doctors; and

**WHEREAS,** Medicare will be insolvent in less than 18 months and bankrupt before 2017 according to the Medicare Trustee report of 2009; and

**WHEREAS,** patients who are in direct financial relationships with their doctors can be more confident that their doctor is actually working for them rather than trying to please a third party payer; and

**WHEREAS,** tens of thousands of doctors have or soon will convert to direct practice relationships with their patients and need advise and training on how to do it; therefore be it

**RESOLVED:** That the CMA launch an active program to educate its members as to how to form direct financial relationships with their patients eliminating or reducing their dependence on the failed public and private health insurance systems and thus to form more functional relationships with their patients.

**Current CMA Policy:**

**Estimate Cost to CMA:**

**CALIFORNIA MEDICAL ASSOCIATION  
2009 HOUSE OF DELEGATES**

**LACMA-11**

**Title:** DOCTORS MUST BE EQUAL PARTICIPANTS IN THE PROCESS

**Author:** Daniel Gross, MD

**Introduced by:**

**Endorsed by:**

---

**WHEREAS**, the federal government is a work to drastically alter the delivery of health care to our patients in the United States; and

**WHEREAS**, patients and doctors, not politicians, are the centers of the health care delivery system; and

**WHEREAS**, the American Medical Association (AMA) and the state medical societies appear to be peripheral entities in shaping the health care of our patients; therefore be it

**RESOLVED:** That an official full voting organization composed of doctors representing the American Medical Association (AMA) and doctors representing state medical associations have direct input to this process of determining the health delivery system for our patients.

**Current CMA Policy:**

**Estimate Cost to CMA:**

**CALIFORNIA MEDICAL ASSOCIATION  
2009 HOUSE OF DELEGATES**

**LACMA-12**

**Title:** Education Pandemic H1N1 Influenza

**Author:** Jeffrey Gunzenhauser, MD  
rbitonte@aol.com

**Introduced by:** Robert Bitonte, MD

**Endorsed by:** LACMA – District IV

---

**WHEREAS**, a pandemic H1N1 influenza virus has continued to cause outbreaks of illness among persons in Los Angeles county throughout the summer of 2009; and,

**WHEREAS**, most persons in Los Angeles county lack pre-existing immunity to the pandemic H1N1 influenza virus that is now circulating so that the pandemic may expand during the 2009 -2010 fall and winter season to affect a large proportion of the population; and

**WHEREAS**, this is a new strain of influenza virus and may require two doses of vaccine to be administered to provide adequate protection, and that this vaccine will be in addition to the vaccine that will be provided to protect against other seasonal strains of influenza; and

**WHEREAS**, pandemic H1N1 influenza virus is infecting and causing serious illness among younger age groups that are not normally at risk for serious complications of influenza virus; and

**WHEREAS**, optimal protection of the health of persons in Los Angeles County and all of California against the pandemic H1N1 influenza virus will require close and timely coordination between public health and health care professionals to provide and manage the care of sick individuals, to provide immunizations to those who are well, and to provide accurate information to all persons; therefore be it

**RESOLVED:** That California Medical Association use all methods and measures to ensure,

- 1) That physicians in California continue to be educated about the immunization, clinical management, reporting, and public health actions regarding H1N1 and,
- 2) That immunizations for both seasonal and pandemic H1N1 are administered to those who are recommended to receive them,
- 3) That timely information made available by all county departments of health regarding H1N1 be made available to clinical providers

**Current CMA Policy:**

**Estimate Cost to CMA:**

**CALIFORNIA MEDICAL ASSOCIATION  
2009 HOUSE OF DELEGATES**

**LACMA-13**

**Title:** ELIGIBILITY AGE FOR MEDICARE PATIENTS

**Author:** Paul Kirz, MD  
pkirz@aol.com

**Introduced by:** Paul Kirz, MD

**Endorsed by:**

---

**WHEREAS**, cutbacks in Medicare reimbursements have seriously affected the ability of the health care community to provide adequate health care for Medicare recipients; and

**WHEREAS**, increasing Medicare payroll taxes to cover the increased costs for Medicare patients is unreasonable; and

**WHEREAS**, the United States federal budget deficit has grown tremendously in the past year; and

**WHEREAS**, the United States Social Security Department is currently raising the age eligibility for full Social Security to age 67; and

**WHEREAS**, the Medicare program was enacted more than 40 years ago when average life expectancy and health care costs were much less than today; therefore be it

**RESOLVED:** That the California Medical Association (CMA) in conjunction with the American Medical Association (AMA) endorse federal legislation to raise the Medicare eligibility age from the current age 65 to the age 67.

**Current CMA Policy:**

**Estimate Cost to CMA:**

**CALIFORNIA MEDICAL ASSOCIATION  
2009 HOUSE OF DELEGATES**

**LACMA-14**

**Title:** FORCED OFF LABEL

**Author:** David Aizuss, MD  
daizuss@pacbell.net

**Introduced by:** David Aizuss, MD

**Endorsed by:** LACMA – District IV

---

**WHEREAS:** the center of the health care system must be the physician-patient relationship, and the autonomy of physicians in concert with their patients to define medically necessary care; and

**WHEREAS:** a recommendation made by a treating physician should be presumed to be correct regardless of coverage, albeit challengeable; and

**WHEREAS:** health insurers, pharmacy benefit managers and health maintenance organizations are increasingly interfering in the sacred doctor-patient relationship; and

**WHEREAS:** some California health insurers refuse to initially cover provider-prescribed and FDA-approved treatments, instead requiring that patients try and fail on several other off-label indications for the same diagnosed condition; and

**WHEREAS:** sixteen State Attorneys General wrote a letter dated March 6, 2009 to the U.S. Center for Medicaid and Medicare Services (CMS) regarding this practice. The problems identified in the attached letter go far beyond CMS and are now being replicated by California commercial health plans; and

**WHEREAS:** such substitution or fail-first protocols put providers in the untenable position of assuming greater liability in the event of an adverse patient reaction; and

**WHEREAS:** such substitution is allowing Blue Shield of California and other health plans to act as de facto regulatory agencies in bypassing the use of medications which have been tested and approved by the FDA for prescribed indications, in favor of off-label use of other pharmaceuticals; therefore be it

**RESOLVED:** That in the absence of widely used guidelines or clinical literature, California health plans will not be permitted to require insured to try and fail on drugs supported only by an off-label indication (an indication only supported in the statutory compendia) before providing access to a drug supported by an FDA approved indication (on-label indication).

**RESOLVED:** That the California Medical Association (CMA) support legislation banning fail-first protocols that required use of medications on an off-label basis before reimbursing for use of medications approved for the same diagnosed condition when recommended and prescribed by the patient's personal physician.

**CALIFORNIA MEDICAL ASSOCIATION  
2009 HOUSE OF DELEGATES**

**LACMA-15**

**Title:** FULL DISCLOSURE OF PAYMENT SCHEDULES

**Author:** Nelman Low, MD  
sbohns@pol.net

**Introduced by:** Nelman Low, MD

**Endorsed by:** LACMA – District IV

---

**WHEREAS**, some insurance companies have provider fee schedules that physicians have limited access to (as little as 10 codes per year); and

**WHEREAS**, some insurance companies unilaterally change reimbursement policies and fee schedules without due notice; and

**WHEREAS**, informed decision making on contracting with insurance companies can not be made without knowledge of reimbursement policies and fee schedules; therefore be it

**RESOLVED:** That changes in reimbursement policies and payment schedules are provided at least three months in advance of the effective date of changes so physicians can withdraw from provider panels and notify patients in a timely manner

**Current CMA Policy:**

**Estimate Cost to CMA:**

**CALIFORNIA MEDICAL ASSOCIATION  
2009 HOUSE OF DELEGATES**

**LACMA-16**

**Title:** GOVERNMENT RECOVERY PROGRAMS

**Author:** Robert Bitonte, MD  
rbitonte@aol.com

**Introduced by:** Robert Bitonte, MD

**Endorsed by:** LACMA – District IV

---

**WHEREAS**, federal and state governments have acknowledged anticipated increased participation in recovery of monies programs in healthcare; and

**WHEREAS**, the fraud Enforcement and Recovery Act of 2009 further funds such recovery programs; and

**WHEREAS**, for example, the Recovery Audit Contractor (RAC) and Medicaid Integrity Contractor (MIC) programs are now scheduled for increased activity; and

**WHEREAS**, the recovery programs have the potential for catastrophic consequences for physicians and their practices; therefore be it

**RESOLVED:** That the California Medical Association (CMA) utilize any and all means to ensure that all government recovery programs contain the following provisions:

1. All levels of appeals are subject to Equal Access to Justice Act (EAJC),
2. There is complete access to any data mining criteria and programs,
3. There is same specialty physician reviewer prior to denial of claims

**Current CMA Policy:**

**Estimate Cost to CMA:**

**CALIFORNIA MEDICAL ASSOCIATION  
2009 HOUSE OF DELEGATES**

**LACMA-17**

**Title:** GRADUATE MEDICAL EDUCATION

**Author:** Keith Norris, MD, FACP (keithnorris@cdrew.edu)  
Richard Baker, MD (richardbaker@cdrew.edu)  
Carmen Puliafito, MD (cpuliafito@usc.edu)  
Clint Adams, MD (cadams@westernu.edu)  
Robert Bitonte, MD ([rbitonte@aol.com](mailto:rbitonte@aol.com))

**Introduced by:** Debra Judelson, MD

**Endorsed by:**

---

**WHEREAS**, the impending future physician shortage is well documented in various sources; and

**WHEREAS**, medical schools have been successful in increasing medical school enrollment over the past decade; and

**WHEREAS**, this increased enrollment has not, and will not, add to a net increase in practicing physicians because of lack of opportunities of graduate medical education; therefore be it

**RESOLVED:** That the California Medical Association (CMA) communicate with the Centers for Medicare and Services (CMS) to increase the funding for, and number of internship and residency training positions in graduate medical education in California; and be it further,

**RESOLVED:** That the CMA refer for this for national action.

**Current CMA Policy:**

**Estimate Cost to CMA:**

**CALIFORNIA MEDICAL ASSOCIATION  
2009 HOUSE OF DELEGATES**

**LACMA-18**

**Title:** HEALTH CARE REFORM IMPACT ON GRADUATE MEDICAL EDUCATION

**Author:** Brittney DeClerck, MD  
Brittney.declerck@gmail.com

**Introduced by:**

**Endorsed by:**

---

**WHEREAS,** the federal government is currently investigating options for healthcare reform which may drastically improve access to medical care; and

**WHEREAS,** the federal government is currently investigating options for healthcare reform which may drastically improve access to medical care; and

**WHEREAS,** these public institutions may suffer a lack of financial reimbursement as a consequence, leading to cuts in residency positions nationally; therefore be it

**RESOLVED:** That the California Medical Association (CMA) will endorse that the Centers for Medicare and Services (CMS) will monitor for adequate funding and maintenance of all ACGME accredited residency programs while healthcare reform and egress of previously uninsured patients may impact graduate medical education.

**Current CMA Policy:**

**Estimate Cost to CMA:**

**CALIFORNIA MEDICAL ASSOCIATION  
2009 HOUSE OF DELEGATES**

**LACMA-20**

**Title:** IMPROVING EVALUATION OF RESOLUTIONS WITH ADDITIONAL  
INFORMATION

**Author:** Marvin S. Kaplan, MD, FACS  
[mskfacs@aol.com](mailto:mskfacs@aol.com)

**Introduced by:** Marvin S. Kaplan, MD, FACS

**Endorsed by:** LACMA – District IV

---

**WHEREAS**, adequate evaluation of resolutions frequently elicits questions regarding the need for more information at both the California Medical Association (CMA) and American Medical Association (AMA) meetings; and

**WHEREAS**, recognition of authors' efforts are encouraging to physicians and indicated to show the actions of delegates in their behalf and leadership of Los Angeles County Medical Association (LACMA) have identified these efforts to our members; and

**WHEREAS**, knowledge of financial costs, (especially to Government agents), should be part of support or non-support of any resolution; therefore be it

**RESOLVED:** That the original author's name and contact information (e-mail, phone and fax numbers) should be retained in any Resolution considered by the California Medical Association (CMA); and be it further

**RESOLVED:** That an estimate of the cost of any proposed Government activity or benefit be provided by the author with the advice of the county or California Medical Association (CMA) staff; and be it further

**RESOLVED:** That this be sent for National Action.

**Current CMA Policy:**

**Estimate Cost to CMA:**

**CALIFORNIA MEDICAL ASSOCIATION  
2009 HOUSE OF DELEGATES**

**LACMA-21**

**Title:** INCENTIVIZING PHYSICIANS IN UNDERSERVED COMMUNITIES

**Author:** Keith Norris, MD, FACP (keithnorris@cdrew.edu)  
Richard Baker, MD (richardbaker@cdrew.edu)  
Carmen Puliafito, MD (cpuliafito@usc.edu)  
Clint Adams, MD (cadams@westernu.edu)  
Robert Bitonte, MD ([rbitonte@aol.com](mailto:rbitonte@aol.com))

**Introduced by:**

**Endorsed by:**

---

**WHEREAS**, it has been well documented that various areas of Los Angeles County have been chronically underserved by the physician community; and

**WHEREAS**, some of these areas meet designation as health professional shortage areas (HPSAs); and

**WHEREAS**, previous measures have been unsuccessful in correcting this issue of physician shortage communities; therefore be it

**RESOLVED:** That California Medical Association (CMA) use any and all measures to identify these HPSA physician-underserved communities by ZIP code, and formulate a supplemental code for physician services provided in these codes, intending to increase remuneration for physician services provided in these ZIP codes by at least 75 percent regardless of payor.

**Current CMA Policy:**

**Estimate Cost to CMA:**

**CALIFORNIA MEDICAL ASSOCIATION  
2009 HOUSE OF DELEGATES**

**LACMA-22**

**Title:** INDIGENT CARE TAX CREDIT

**Author:** William Hale, MD  
HALE.WILLIAM@GMAIL.COM

**Introduced by:** William Hale, MD

**Endorsed by:** LACMA – District IV

---

**WHEREAS**, emergency care must be provided to patients who present themselves to emergency rooms; and

**WHEREAS**, many patients presenting themselves to emergency rooms are indigent and unable to pay for services needed and rendered; and

**WHEREAS**, alternative methods to finance health care must be entertained; therefore be it

**RESOLVED:** That the California Medical Association (CMA) adopts policies that endorse payment for uncompensated medical care by means of a state income tax credit for California income tax at 100% of current Medi-Cal rates.

**Current CMA Policy:**

**Estimate Cost to CMA:**

**CALIFORNIA MEDICAL ASSOCIATION  
2009 HOUSE OF DELEGATES**

**LACMA-23**

**Title:** INTEGRATING MENTAL, MEDICAL AND SUBSTANCE ABUSE  
TREATMENTS

**Author:** Elizabeth Galton, MD  
egalton@ucla.edu

**Introduced by:** Elizabeth Galton, MD

**Endorsed by:** LACMA – District IV

---

**Whereas,** Mental Illnesses are diseases of the brain, an organ in the body, and

**Whereas,** Mental Health has been "carved out" from Medical Health for many years, in both public and private sectors, and

**Whereas,** Substance Abuse Treatment often falls between the cracks in both of the above, and

**Whereas,** "Separate" has never meant "Equal"; it is extremely difficult to access prompt first time mental health care, and

**Whereas,** many people with mental illnesses and substance abuse can be treated in primary care settings, with referrals to psychiatrists as necessary, and

**Whereas,** Mental patients often do not get the medical care they need, and

**Whereas,** conversely, medical patients often do not get the mental health care they need, and the whole system is fragmented, with many gaps, and

**Whereas,** The World Health Organization advocates integration of mental health, substance abuse care and medical care, therefore be it

**Resolved:** That the CMA adopt a policy of integration of mental health care, substance abuse care and medical care in both public and private sectors, and be it further

**Resolved:** That the California Medical Association (CMA) advocate for the inclusion of psychiatric care within the "Medical Home" being recommended for the MediCal program, and be it further

**Resolved:** That CMA advocate for a similar integration in insurance companies, HMO's, etc, and be it further

**Resolved:** That CMA recommends this for national action.

To be appended:

1. a summary of the work done in a primary care clinic in Sacramento, where chronically mentally ill patients can be treated by primary care physicians with extra training in psychiatry
2. The WHO recommendations
3. A summary of the Minnesota experience (still evolving)

Background information: in spite of the passage of Prop 63, (the millionaire tax to support mental health treatments), there is an appalling paucity of treatment options for the severely mentally ill. And with the current budget crunch limiting funding as well as social support payments, the need is about to become even greater. It is very hard to get first time appointments, or sometimes any appointment. The results may be seen on our city streets, where obviously mentally ill folks are living, and in our jails and prisons, the mental hospitals of last resort. There are a number of primary care clinics already in existence where mentally ill people are seen, by doctors with minimal extra training in psychiatry. Psychiatrists are available either on site or by referral, as would any other specialty be.

This would also be consonant with the currently proposed concept of a "Medical Home" for each patient.

It also is interesting to note that, were the Departments of Health and those of Mental Health joined, that this could save our State a lot of money!

**CALIFORNIA MEDICAL ASSOCIATION  
2009 HOUSE OF DELEGATES**

**LACMA-24**

**Title:** IN MEMORIAM – CARL PHILLIP TRELING, MD

**Author:** Jack Moore, MD

**Introduced by:** Jack Moore, MD

**Endorsed by:** LACMA – District IV

---

WHEREAS: Our esteemed colleague, Carl Phillip Treling, MD passed away suddenly and unexpectedly on February 14, 2009, and

WHEREAS: Doctor Treling practiced Clinical and Anatomical Pathology for many years, and,

WHEREAS: Doctor Treling had a long association on the staff at Hollywood Presbyterian Medical Center and.

WHEREAS: Doctor Treling was a member of the Los Angeles County Medical Association (LACMA) and the California Medical Association (CMA), therefore be it

RESOLVED: That the California Medical Association (CMA) convey this resolution as well as its deepest sympathy to his daughters, Maureen Lubitz, and Lisa Treling, and former wife Antoinette Treling, and be it further

RESOLVED: That the California Medical Association House of Delegates, recognize the outstanding contributions made by Carl Phillip Treling, MD to the medical profession, his association, his community, his family, and his colleagues.

**CALIFORNIA MEDICAL ASSOCIATION  
2009 HOUSE OF DELEGATES**

**LACMA-25**

**Title:** LOCAL PATIENT CARE

**Author:** Benjamin Paz, MD

**Introduced by:** Benjamin Paz, MD

**Endorsed by:**

---

**WHEREAS**, some health care plans insist on distant referrals for economic consideration; and

**WHEREAS**, some patients are referred to distant health care providers when local providers can provide equally effective care; and

**WHEREAS**, Health and Safety Code 1367G prohibits management of health care by administrative or economic or administrative management; therefore be it

**RESOLVED:** That the health care plans doing business in California be prohibited from mandatory distant referrals for care that can be provided equally locally

**Current CMA Policy:**

**Estimate Cost to CMA:**

**CALIFORNIA MEDICAL ASSOCIATION  
2009 HOUSE OF DELEGATES**

**LACMA-26**

**Title:** PROFESSIONAL LIABILITY REFORM TO REDUCE COST OF HEALTH CARE  
IN ANY IMPENDING HEALTH CARE LEGISLATION

**Author:** Dinesh Ghiya, MD  
dghiya@gmail.com  
Manohar Senra, MD  
dghiya@gmail.com

**Introduced by:** Dinesh Ghiya, MD /Manohar Senra, MD

**Endorsed by:** LACMA – District IV

---

**WHEREAS**, tort reform has kept professional liability insurance premiums down in California. However, a number of lawsuits and judgment awards have continued to increase. As a result, many specialists cannot afford these premiums; and

**WHEREAS**, professional liability insurers have no explanation why premiums are raised on doctors even when they had not professional liability cases; and

**WHEREAS**, the cost of health care keeps going up partly because of defensive medicine; therefore be it

**RESOLVED:** That the California Medical Association (CMA) and the American Medical Association (AMA) should work to introduce the following reforms in any impending health care legislation.

1. There should be a nationwide cap on judgment for pain and suffering
2. Professional liability litigation should not be outcome based. If appropriate guidelines were followed, a case should not be allowed to go forward.
3. Arbitration should be encouraged
4. The increase in professional liability insurance rates should be based on a reasonable criteria

**Current CMA Policy:**

**Estimate Cost to CMA:**

**CALIFORNIA MEDICAL ASSOCIATION  
2009 HOUSE OF DELEGATES**

**LACMA-27**

**Title:** Martin Luther King Harbor Hospital

**Author:** Keith Norris, MD, FACP (keithnorris@cdrew.edu)  
Richard Baker, MD (richardbaker@cdrew.edu)  
Carmen Puliafito, MD (cpuliafito@usc.edu)  
Clint Adams, MD (cadams@westernu.edu)  
Robert Bitonte, MD ([rbitonte@aol.com](mailto:rbitonte@aol.com))

**Introduced by:** Robert Bitonte, MD

**Endorsed by:** LACMA – District IV

---

**WHEREAS**, there is a vast discrepancy in comprehensive hospital care in various parts of Los Angeles County; and

**WHEREAS**, according to at least one analysis, South Los Angeles needs an estimated 2100 hospital beds; and

**WHEREAS**, after the closure of Martin Luther King Harbor Hospital the number of available beds is about 700; and

**WHEREAS**, in terms of hospital beds per 1000 residents, South Los Angeles ranks amongst the lowest urban regions in the country; and

**WHEREAS**, the national average is about 3 beds per 1000 residents and South Los Angeles has about 1 bed per 1000 residents; and

**WHEREAS**, discussions are currently underway to establish a comprehensive hospital at the former site of Martin Luther King Harbor Hospital; therefore be it

**RESOLVED:** That California Medical Association (CMA) use all methods and measures to ensure the establishment of a comprehensive hospital at the former site of Martin Luther King Harbor Hospital

**Current CMA Policy:**

**Estimate Cost to CMA:**

**CALIFORNIA MEDICAL ASSOCIATION  
2009 HOUSE OF DELEGATES**

**LACMA-28**

**Title:** NO EXEMPTIONS FOR HEALTH CARE LEGISLATION

**Author:** Stephanie Booth, MD  
[millens@digilink.net](mailto:millens@digilink.net) (not for publication)

**Introduced by:** Stephanie Booth, MD

**Endorsed by:** LACMA – District IV

---

**WHEREAS**, there is a Congressional practice of exempting itself from the laws it imposes on the rest of the government and the private sector; and

**WHEREAS**, it is not common knowledge that this practice may occur with laws related to health care; and

**WHEREAS**, making Congress subject to the laws it approves will promote better understanding of a given bill in its entirety and thereby raise the likelihood of detection and correction of potential problems; therefore, be it

**RESOLVED:** That the California Medical Association (CMA) adopt as policy that it will oppose any federal legislation related to health care that exempts anyone; and be it further

**RESOLVED:** That, whenever the California Medical Association (CMA) confirms Congress will be voting on a bill related to health care that exempts any person or group of people, it will quickly take all appropriate steps to publicize this fact to the general public; and be it further

**RESOLVED:** That the California Medical Association (CMA) work with the American Medical Association (AMA) and other state medical organizations to garner support for this policy on a national basis.

**Current CMA Policy:**

**Estimate Cost to CMA:**

**CALIFORNIA MEDICAL ASSOCIATION  
2009 HOUSE OF DELEGATES**

**LACMA-30**

**Title:** OPPOSITION TO HR 3200

**Author:** Thomas LaGrelius, MD, FAAFP

**Introduced by:**

**Endorsed by:**

---

**WHEREAS:** HR 3200 will destroy our current health care freedoms including the freedoms to choose what is covered by our own health insurance; and

**WHEREAS:** HR 3200 will interfere with patient freedom to get discounts on health insurance for good health habits; and

**WHEREAS:** HR 3200 will limit patient freedom to choose inexpensive high deductible insurance linked to health savings accounts; and

**WHEREAS:** HR 3200 will, contrary to President Obama's promises, prevent patients from keeping the insurance they already have; and

**WHEREAS:** HR 3200 will limit patient freedom to choose our own quality doctors; therefore be it

**RESOLVED:** That the California Medical Association (CMA) oppose HR 3200 and do everything in its power to prevent it's enactment into law.

**Current CMA Policy:**

**Estimate Cost to CMA:**

**CALIFORNIA MEDICAL ASSOCIATION  
2009 HOUSE OF DELEGATES**

**LACMA-31**

**Title:** PALMETTO REIMBURSEMENT

**Author:** Robert Bitonte, MD  
rbitonte@aol.com

**Introduced by:** Robert Bitonte, MD

**Endorsed by:** LACMA – District IV

---

**WHEREAS**, Palmetto GBA was awarded a Medicare contract to handle claims from residents of California, Hawaii, Nevada, American Samoa, Guam, and the Northern Mariana Islands; and

**WHEREAS**, this contract is valued at \$400 million if the contract is maintained for 5 years; and

**WHEREAS**, implementation of the program was flawed for whatever reason; and

**WHEREAS**, some physicians' payment was delayed for various amounts of time; and

**WHEREAS**, the California Medical Association (CMA) has data on the number of physicians impacted, and the average amount of monies of delayed payment in question; therefore be it

**RESOLVED:** That the California Medical Association (CMA) General Counsel send a demand letter to Palmetto GBA requesting all physicians impacted by the delayed payments by Palmetto GBA be made whole, and be it further

**RESOLVED:** That the California Medical Association (CMA) Legal Counsel utilize any and all measures to make impacted physicians whole because of delayed payments by Palmetto GBA

**Current CMA Policy:**

**Estimate Cost to CMA:**

**CALIFORNIA MEDICAL ASSOCIATION  
2009 HOUSE OF DELEGATES**

**LACMA-32**

**Title:** PHYSICIAN LABORATORY BILLING

**Author:** Michael E. Borok, MD  
mborok@pol.net

**Introduced by:** Michael Borok, MD

**Endorsed by:** LACMA - District IV

---

**Whereas,** California law prohibits physicians from charging patients and health plans more than the physician pays an outside laboratory to perform laboratory testing; and

**Whereas,** physicians incur expenses to collect and process the laboratory specimens(beyond a blood draw charge) usually charged as a "handling fee" are routinely denied by health plans and are not reimbursed by the outside laboratory; and

**Whereas,** clinical laboratories can bill a physician directly for physician ordered tests at a substantially lower rate and the same clinical laboratory can directly bill the patient or the patient's health plan at a much higher rate generally agreed upon by contract between the clinical laboratory and the health plan; therefore be it

**RESOLVED:** That the CMA support legislation that would allow physicians who collect laboratory specimens directly from the patient and send the specimen to an outside independent clinical laboratory for testing be allowed to charge for the entire global fee at the agreed contracted rate with the health plan if that physician is contracted with the health plan, and if that physician is allowed by contract with that health plan to bill for laboratory services in lieu of billing for any handling fee or other administrative charge.

**Current CMA Policy:**

Unknown. Support for this type of legislation may be construed as endorsing marking up of laboratory services by physician that they do not directly perform which would violate current AMA Policy: therefore, the CMA should petition the AMA to alter its policy if necessary.

**Estimate Cost to CMA:**

Unknown. Support for legislation is only being requested, not sponsorship of legislation; therefore, the cost should be substantially less than for sponsoring legislation.

**CALIFORNIA MEDICAL ASSOCIATION  
2009 HOUSE OF DELEGATES**

**LACMA-33**

**Title:** PHYSICIAN WELLNESS

**Author:** Maria Lymberis, MD  
maria@lymberis.com  
Laurie Reynard, MD  
LBR826@aol.com

**Introduced by:** Maria Lymberis, MD

**Endorsed by:** LACMA – District IV

---

**WHEREAS**, there is ample medical evidence of the adverse impact of stress on both physical and mental health; and

**WHEREAS**, the rate of serious physical and mental impairments including suicide in physicians remains higher than in the general population. However, these problems have not been systematically addressed by organized medicine; therefore be it

**RESOLVED:** That the California Medical Association (CMA) make Physician Wellness & Health a top priority and launch an active educational program to overcome the silence and stigma associated with the presence of physical and mental problems in physicians by systematically and regularly distributing meaningful information for the identification of signs of stress & impairment as well as resources for physicians to access help. Mechanisms must be put in place such that a physician's treatment for depression and suicide risk will be kept confidential and would not jeopardize their practice, since this has been an impediment to treatment.

**Current CMA Policy:**

**Estimate Cost to CMA:**

**CALIFORNIA MEDICAL ASSOCIATION  
2009 HOUSE OF DELEGATES**

**LACMA-34**

**Title:** POLLING THE GENERAL MEMBERSHIP OF THE CMA ON PHYSICIAN AID  
IN DYING

**Author:** David Priver, MD

**Introduced by:** Debra Judelson, MD

**Endorsed by:** LACMA – District IV

---

**WHEREAS**, the CMA’s House of Delegates adopted resolution 506a-08, “that CMA continue to study the inter-related ethical and legal issues pertaining to end-of-life care”; and

**WHEREAS**, it is also CMA policy [HOD516-97] that the Association “...remains receptive to multiple views and perspectives expressed by various participants in the societal dialogue...on this issue”; and

**WHEREAS**, the American Public Health Association, the American College of Legal Medicine, the American Medical Women’s Association, the American Medical Students’ Association and the California Association of Physician Groups all have policies supporting decriminalization of physician aid in dying modeled upon Oregon’s Death with Dignity Act, and the American Academy of Hospice and Palliative Medicine has adopted a policy of neutrality with regard to such legislation; and

**WHEREAS**, the states of Oregon and Washington have enacted laws that prohibit active euthanasia but decriminalize physician aid in dying under the circumstances and with the safeguards defined in those laws, and in the years since enactment of the laws none of the potential negative outcomes feared by opponents have come to pass; and

**WHEREAS**, nationwide polls have indicated that a majority of America’s physicians and their patients support the concept of decriminalizing physician aid in dying in accordance with the model that exists in Oregon and Washington but CMA has never polled its own members to guide its response to this issue; therefore be it

**RESOLVED**, That, prior to August 1, 2010 and in such a manner that the results shall be known by that date, the California Medical Association will conduct an electronic survey of the opinions of its general membership posing the following question: “With respect to the prospect of California decriminalizing physician aid in dying as defined and sanctioned by ‘Death with Dignity’ Acts in Oregon and Washington, the CMA should (please check one of the following choices): (a) oppose, (b) support, or (c) adopt a position of neutrality?”

**Current CMA Policy:**

**Estimate Cost to CMA:**

**CALIFORNIA MEDICAL ASSOCIATION  
2009 HOUSE OF DELEGATES**

**LACMA-35**

**Title:** PRIVATE HEALTH INSURANCE

**Author:** Paul Kirz, MD  
pkirz@aol.com

**Introduced by:** Paul Kirz, MD

**Endorsed by:** LACMA – District IV

---

**WHEREAS,** Medicare functions as a single payer Federal Government health insurance program; and

**WHEREAS,** patients, health care providers, tax payers and the federal government are becoming increasingly dissatisfied with Medicare Health Insurance; and

**WHEREAS,** it is currently illegal for an US citizen or permanent resident to opt out of the Medicare Program and purchase private health insurance; therefore be it

**RESOLVED:** That the CMA adopt a policy that Medicare patients should be legally permitted to opt out of the Medicare Program and purchase private insurance using a voucher issued by the Federal Government; and be it further

**RESOLVED:** That, the California Medical Association (CMA) refers this policy to the AMA for action at the level of the Federal Government.

Background: In our country, which prides itself on freedom, senior citizens are trapped in a single payer health care system. It is illegal for a health insurance company to sell traditional private insurance to a US citizen or legal resident over the age of 65. Senior citizens can either accept Medicare fee for service or Medicare HMO. Let's free up our Medicare Program and allow full competition. Seniors should be able to opt out of Medicare and buy private health insurance using a voucher along with their own funds.

**CALIFORNIA MEDICAL ASSOCIATION  
2009 HOUSE OF DELEGATES**

**LACMA-36**

**Title:** PRESERVATION OF SOLO OR SMALL PRACTICE OPTIONS

**Author:** Marvin S. Kaplan, MD, FACS  
[mskfacs@aol.com](mailto:mskfacs@aol.com)

**Introduced by:** Marvin S. Kaplan, MD, FACS

**Endorsed by:** LACMA – District IV

---

**WHEREAS**, numerous patients prefer to obtain their medical care from physicians in solo or small group practices; and

**WHEREAS**, the present Federal Administration seems to favor large practice physician groups; and

**WHEREAS**, the quality, efficiency and satisfaction of patients receiving care from physicians in solo and small practice is at least as good at other modes of health care delivery; and

**WHEREAS**, new Federal legislation threatens the availability of patient care from physicians practicing in solo or small group modes. This proposed Federal action may influence State and local government and private insurance policies; therefore be it

**RESOLVED:** That the California Medical Association (CMA) should support actions to allow patients to seek consultation and treatment for their medical care from physicians practicing in solo or small modes; and be it further

1. The CMA should support actions that allow individual and small practice physicians to prove that they meet requirements of quality and efficiency of care while retaining their modes of practice.
2. Send forward for national action.

**Current CMA Policy:**

**Estimate Cost to CMA:**

**CALIFORNIA MEDICAL ASSOCIATION  
2009 HOUSE OF DELEGATES**

**LACMA-37**

**Title:** PROVISION FOR 50 MILLION UNINSURED

**Author:** S.M. Rezanian, MD  
rbitonte@aol.com

**Introduced by:** Robert Bitonte, MD

**Endorsed by:**

---

**WHEREAS,** there have been reported up to 50 million uninsured in this country; and

**WHEREAS,** the government as an assistance program has distributed food stamps; and

**WHEREAS,** a method to provided limited health insurance to the presently uninsured would be denominated health stamps; and

**WHEREAS,** these health stamps could be utilized for physician services, studies, or pharmaceuticals over the entire country; and

**WHEREAS,** the value of the health stamps may be negotiated for cash payment and/or tax credits by the providing source; and

**WHEREAS,** the this is a viable option of providing health care services to the presently uninsured; therefore be it

**RESOLVED:** That the California Medical Association (CMA) adopt policy that endorses the concept of health stamps as a viable option of providing health insurance.

**Current CMA Policy:**

**Estimate Cost to CMA:**

**CALIFORNIA MEDICAL ASSOCIATION  
2009 HOUSE OF DELEGATES**

**LACMA-38**

**Title:** QME WAITING ROOM TIME

**Author:** Michael E. Borok, MD  
mborok@pol.net

**Introduced by:** Michael Borok, MD

**Endorsed by:** LACMA – District IV

---

WHEREAS, claimants, applicants and workers' compensation patients may arrive at highly variable times at the Qualified Medical Examiner's, Agreed Medical Examiner's, or Independent Medical Examiner's office; and

WHEREAS, claimants, applicants, and workers' compensation patients may have to fill out extensive medical and work history information questionnaires sometimes the assistance of an interpreter requiring highly variable time periods waiting in the evaluators waiting room; therefore be it

**RESOLVED:** That the CMA achieve changing section 41 (f) of the Qualified Medical Evaluator Regulations changing the maximum waiting time an injured worker, claimant, or applicant in the evaluator's office from one hour to two hours.

**Current CMA Policy:**

None

**Fiscal Impact:**

Unknown. Only a regulatory change is requested, not legislation, or changes to legislation so the cost should be much less than sponsoring legislation.

**CALIFORNIA MEDICAL ASSOCIATION  
2009 HOUSE OF DELEGATES**

**LACMA-39**

**Title:** REDUCTION OF THE STATE LABORATORY FIELD SERVICES

**Author:** Michael E. Borok, MD

**Introduced by:** Michael Borok, MD

**Endorsed by:** LACMA – District IV

---

**WHEREAS,** The State of California Department of Public Health/Laboratory Field Services has created over the years a regulatory program regulating all medical laboratories duplicating Federal CLIA Program that already regulates and inspects all medical laboratories in California; and

**WHEREAS,** The State Bureau of Audits performing an incomplete and incompetent audit not auditing any of the budgetary, monetary, or fiscal aspects of the State Laboratory Field Services came to the conclusion that the State Laboratory Field Services was doing a poor job regulating medical laboratories in California without demonstrable impairment of laboratory quality, patient safety, or the public health; and

**WHEREAS,** The duplicate Laboratory Field Services in many instances charges a medical laboratory more in fees on a yearly basis than the Federal CLIA Program; and

**WHEREAS,** The process of a state achieving exemption from the Federal CLIA Program resulting in a single regulator of medical laboratories with a single fee and a single set of rules has been attempted by the State Laboratory Field Services in the past and has been a failure due to the exaggerated cost of paying a yearly overhead fee to the Federal CLIA Program to continue and maintain exemption from the Federal CLIA Program; and

**WHEREAS,** The State Laboratory Field Services has more recently postponed and delayed the attempt and application for achieving exemption from the Federal CLIA Program so as to have a duplicate laboratory regulatory program forever squeezing excessively more money out of medical laboratories and physician office laboratories performing a duplicative service; therefore be it

**RESOLVED:** That the CMA sponsor legislation eliminating the medical laboratory regulatory function of the State Laboratory Field Services leaving intact its laboratory personnel licensing function

**Current CMA Policy:**

CMA is for the reduction of the duplicative fee assessments of the State Laboratory Field Services.

**Fiscal Impact:** Probably approximately \$50,000.

**CALIFORNIA MEDICAL ASSOCIATION  
2009 HOUSE OF DELEGATES**

**LACMA-40**

**Title:** REMUNERATION FOR PHYSICIAN AND STAFF TIME

**Author:** Stephanie Booth, MD  
[millens@digilink.net](mailto:millens@digilink.net) (not for publication)

**Introduced by:** Stephanie Booth, MD

**Endorsed by:** LACMA – District IV

---

**WHEREAS**, many hours of physician and staff time are consumed communicating with representatives of insurance companies and their affiliates\* in order to 1) obtain approval for medical care, to 2) assist patients in their efforts to follow through with physician’s recommendations regarding medical care, as well as to 3) obtain compensation for the medical care provided; and

**WHEREAS**, these time-consuming administrative procedures are not reimbursed, but they are necessary and use the same time that would otherwise be available for reimbursable patient care; and

**WHEREAS**, some insurance companies and their affiliates are more difficult than others to work with, in terms of consuming an inordinate amount of non-reimbursable, administrative time; and

**WHEREAS**, it is likely that all insurance companies and their affiliates could improve their efficiency around this problem; therefore be it

**RESOLVED:** That the CMA develop recommendations regarding reasonable remuneration for time consumed by these administrative procedures; and be it further

**RESOLVED:** That this be referred for national action.

**Current CMA Policy:**

**Estimate Cost to CMA:**

\* “Affiliates” includes, but is not limited to laboratories, pharmacies, radiology centers, hospitals, any individual or group responsible to accept referrals, general physicians, specialist physicians, therapists (Physical or Occupational or Speech or Psychological), PA’s, nurses (NP’s, RN’s LVN’s etc) etc.

**CALIFORNIA MEDICAL ASSOCIATION  
2009 HOUSE OF DELEGATES**

**LACMA-41**

**Title:** RESPECT FOR EXPECTATION OF PRIVACY

**Author:** Robert Bitonte, MD  
[rbitonte@aol.com](mailto:rbitonte@aol.com)

**Introduced by:** Robert Bitonte, MD

**Endorsed by:** LACMA – District IV

---

**WHEREAS**, the United States Constitution affords great protection for reasonable expectations of privacy; and

**WHEREAS**, most persons expect a degree of privacy in their physicians' office that may exceed their expectation of privacy in their homes; and

**WHEREAS**, law enforcement agents are increasingly using the tactic of unauthorized visits to physicians offices; and

**WHEREAS**, an unauthorized and unanticipated visit by law enforcement invades the privacy of both physicians and patients; therefore be it

**RESOLVED:** That the California Medical Association (CMA) utilize any and all means to prohibit unauthorized visits to physicians' office during working hours by law enforcement and regulators unless they are authorized by warrants or subpoenas.

**Current CMA Policy:**

**Estimate Cost to CMA:**

**CALIFORNIA MEDICAL ASSOCIATION  
2009 HOUSE OF DELEGATES**

**LACMA-42**

**Title:** REQUIRING SKI HELMET USE BY ALPINE SKIERS AND  
SNOWBOARDERS

**Author:** Samuel I. Fink, M.D., F.A.C.P.  
samfink@pacbell.net

**Introduced by:** Samuel I. Fink, M.D., F.A.C.P.

**Endorsed by:** LACMA – District IV

---

**WHEREAS,** Actress Natasha Richardson died this past winter after suffering a head injury during a ski lesson while she was not wearing a ski helmet; and

**WHEREAS,** a Norwegian study revealed that the use of a ski helmet was associated with a 60% reduction in the risk for a head injury; and

**WHEREAS,** only 48% of alpine skiers and snow boarders in the United States wore ski helmets during the 2008/9 ski season; and

**WHEREAS,** the National Ski Area Association (NSAA) has set a goal of near-universal helmet usage for all children by 2012; therefore be it

**RESOLVED:** That the California Medical Association will support legislation requiring the wearing of approved ski helmets by all alpine skiers and snowboarders while skiing or snowboarding in California; and be it further

**RESOLVED:** That this matter shall be referred for national action.

**Current CMA Policy:**

**Estimated Cost to CMA:**

**CALIFORNIA MEDICAL ASSOCIATION  
2009 HOUSE OF DELEGATES**

**LACMA-43**

**Title:** SEEKING RECOVERY OF ATTORNEYS' FEES

**Author:** Robert Bitonte, MD  
rbitonte@aol.com

**Introduced by:** Robert Bitonte, MD

**Endorsed by:** LACMA – District IV

---

**WHEREAS**, the California Medical Association (CMA) is and will continue to be actively engaged in litigation in the state and federal courts to protect and advance the interests of physicians; and

**WHEREAS**, the California Medical Association (CMA) uses in-house attorneys to work on such litigation and to represent CMA and/or its members and county medical associations; and

**WHEREAS**, in certain circumstances, it may be possible for the California Medical Association (CMA) to collect reasonable attorneys' fees and costs should the California Medical Association (CMA) prevail in litigation; therefore be it

**RESOLVED:** That the California Medical Association (CMA) considers and pursues all practical ways to collect reasonable attorneys' fees and costs that the California Medical Association (CMA) incurs for engaging in litigation to protect and advance the interests of physicians.

**Current CMA Policy:**

**Estimate Cost to CMA:**

**CALIFORNIA MEDICAL ASSOCIATION  
2009 HOUSE OF DELEGATES**

LACMA-44

**Title:** STEP THERAPY/FAIL FIRST

**Author:** Robert Bitonte, MD  
rbitonte@aol.com

**Introduced by:** Robert Bitonte, MD

**Endorsed by:** LACMA – District IV

---

**WHEREAS:** the center of the health care system must be the physician-patient relationship, and the autonomy of physicians in concert with their patients to define medically necessary care; and

**WHEREAS:** a recommendation made by a treating physician should be presumed to be correct regardless of coverage, albeit challengeable; and

**WHEREAS:** physicians are the best advisors to prescribe medication and to authorize alternative prescriptions; and

**WHEREAS:** health insurers, pharmacy benefit managers and health maintenance organizations are increasingly interfering in the sacred doctor-patient relationship; and

**WHEREAS:** health insurer interference includes the practice of “step therapy” or “fail first,” which is being used by insurers to help control healthcare costs, making patients experiment with different medications or treatments before receiving the one deemed best by their health care provider; therefore be it

**RESOLVED:** That medications for the treatment of any medical condition are restricted for use by a health carrier or PBM by a step therapy or fail first protocol, a prescriber may override such restriction if:

(1) The preferred treatment by the health carrier or the PBM has been ineffective in the treatment of the covered person's disease or medical condition; or

(2) Based on sound clinical evidence and medical and scientific evidence:

(a) The preferred treatment is expected to be ineffective based on the known relevant physical or mental characteristics of the covered person and known characteristics of the drug regimen, and is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance; or

(b) The preferred treatment has caused or based on sound clinical evidence and medical and scientific evidence is likely to cause an adverse reaction or other harm to the covered person.

The duration of any step therapy or fail first protocol shall not be longer than a period of fourteen days when such treatment is deemed clinically ineffective by the prescribing physician.

For medications with no generic equivalent and for which the prescribing physician in their clinical judgment feels that no appropriate therapeutic alternative is available a health carrier or PBM shall provide access to United States Food and Drug Administration (FDA) labeled medications without restriction to treat such medical conditions for which an FDA labeled medication is available.

**Current CMA Policy:**

**Estimate Cost to CMA:**

**CALIFORNIA MEDICAL ASSOCIATION  
2009 HOUSE OF DELEGATES**

**LACMA-45**

**Title:** SUPPORT FOR NON-GOVERMENTAL HEALTH STANDARDS

**Author:** Marvin S. Kaplan, MD, FACS

**Introduced by:** Marvin S. Kaplan, MD, FACS

**Endorsed by:** LACMA – District IV

---

**WHEREAS**, new proposals seem to advocate government setting of criteria for diagnostic and therapeutic care which may not be in the best interest of our patients; and

**WHEREAS**, even more patients will have their health care benefits paid by the government, including patients receiving Medicare, Medi-Cal, VA Care, Military Care, Public Health Care and possibly new Government programs for patients who may not receive optimal Health Care; therefore be it

**RESOLVED:** That the CMA should support non-governmental groups that evaluate appropriate medical diagnosis and therapy that improves the quality of patient care; and be it further

**RESOLVED:** That the CMA should support non-governmental groups that evaluate new diagnostic and therapeutic tests, procedures, medications and other procedures that improve the quality of patient care.

**Current CMA Policy:**

**Estimate Cost to CMA:**

**CALIFORNIA MEDICAL ASSOCIATION  
2009 HOUSE OF DELEGATES**

**LACMA-46**

**Title:** THOUGHTS ON MEDICAL CARE REFORM

**Author:** Paul Jacobsen, MD  
pkirz@aol.com

**Introduced by:** Paul Kirz, MD

**Endorsed by:**

---

**WHEREAS,** Congress and President Obama are pursuing a radical restructuring of the American Health Care system; and

**WHEREAS,** 85% of the population has health coverage and of those 258 million people, 89% are satisfied with their coverage (Investors Business); and

**WHEREAS,** of the 47 million uninsured, 18 million earn \$50, 000 or more per year, 9.7% are illegal immigrants, 14 million are eligible for Medicaid but have not applied, others are between jobs and only temporarily uninsured, 8.4 million are between the ages of 18-25 and don't feel they need insurance, leaving 12 million or less than 4% of the population in need of assistance; and

**WHEREAS,** attempts at universal coverage by Massachusetts and Maine have resulted in huge cost overruns and the need for future rationing of heal care; and

**WHEREAS,** those countries being held up as models – Canada and Great Britain – face long waiting lists and rationing; and

**WHEREAS,** the United States has one of the best health care systems in the world in terms of technology and innovation, cancer survival, etc; therefore be it

**RESOLVED:** That reform should be directed at helping those 4% of the population that need it, steering those who are eligible for coverage to obtain it allowing total deductibility of all health care expenses, allow the sale of health care insurance between states, and tort reform nationally, as has been done in California; and be it further

**RESOLVED:** That the Los Angeles County Medical Association (LACMA) and the California Medical Association (CMA) go on record as opposing the reforms proposed in the 2009 US congressional bill, "HR 3200."

**Current CMA Policy:**

**Estimate Cost to CMA:**

**CALIFORNIA MEDICAL ASSOCIATION  
2009 HOUSE OF DELEGATES**

LACMA-48

**Title:** UNIVERSAL MEDICAL NECESSITY LEGISLATION

**Author:** Robert Bitonte, MD  
rbitonte@aol.com

**Introduced by:** Robert Bitonte, MD

**Endorsed by:** LACMA – District IV

---

**WHEREAS**, the definition of medical necessity is the linchpin as to the service that patients are entitled to receive and providers are entitled to be compensated for ; and

**WHEREAS**, the definition of medical necessity is written by each health plan and insurer; and

**WHEREAS**, since 1985, the Medi-Cal program has had a definition of medical necessity, Welfare and Institutions Code Section 14059.5 which has not been amended; and

**WHEREAS**, Welfare and Institutions Code Section 14059.5 was overwhelmingly supported, including by the California Medical Association (CMA) ; therefore be it

**RESOLVED:** That the California Medical Association (CMA) support legislation requiring that the Health and Safety Code, Insurance Code, Corporation Code, be amended to include:

- a) All health care plans marketed in California, regardless of corporate domicile, shall include one, and only one written definition of medical necessity in its plan language, and it shall be as follows: "all health care is medically necessary when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain."
- b) When a health care plan receives a request for provision and payment of care accompanied by a treating physician's written determination that such a service is medically necessary, that treating physician's determination shall be binding on the health care plan unless it is contradicted by the plan with substantial medical evidence within three calendar days, including medical literature offered by researchers whose work was not financed by any insurance company, or health care plan, or pharmaceutical company.
- c) All health care plans, third party administrators, and others involved in providing for or approving health care services, have a legal duty to do so reasonably. Because health care plans are not legally permitted to practice medicine under Business and Professions Code Section 2400, any breach of this legal duty by any entity shall give rise to tort damages unlimited by the medical injury compensation reform act of 1975 MICRA,

but not limited to, the injurious worsening of any medical, mental or nervous disorder as a result of failure to provide for such requests for medically necessary care.

- d) Any and all arbitration clauses are void and unenforceable as to any dispute that Includes a claim that any of the terms of this statute were violated by any health care plan. It is the intent of this legislation to have the state and federal courts alone determine all questions pertaining to the scope of medically necessary health care.

**Current CMA Policy:**

**Estimate Cost to CMA:**

**CALIFORNIA MEDICAL ASSOCIATION  
2009 HOUSE OF DELEGATES**

**LACMA-49**

**Title:** VACCINE FOR CHILDREN, PROGRAM FOR ALL CHILDREN

**Author:** Dinesh Ghiya, MD  
dghiya@gmail.com

**Introduced by:** Dinesh Ghiya, MD

**Endorsed by:**

---

**WHEREAS**, vaccines are covered by different mechanisms, depending on the insurance. Patients with commercial plans are supposed to reimburse doctors either through IPA Medical Group or directly through insurance companies. Children who are on Medicaid or uninsured are covered through the Vaccines for Children Program; and

**WHEREAS**, physicians have constant problems getting paid appropriately and in a timely fashion. The IPA and insurance companies underpay and never update increased prices. They don't pay for the cost of administering these vaccines. IPA and insurance companies blame each other for this problem, but it ends up hurting the doctors. IPA's and medical groups have failed to do a good job in the vaccine reimbursement area; and

**WHEREAS**, the Vaccines for Children Program have higher rates of immunization than commercial plans do. Vaccines for the children program also pay for the cost of administration, storage, documentation, and patient education; therefore be it

**RESOLVED:** CMA should pursue legislative means, as followed.

1. All childhood vaccines should be covered under the Vaccines for Children Program irrespective of the insurance status.
2. Until such legislation is passed, all commercial health plans must be responsible to pay for the vaccines..

**Current CMA Policy:**

**Estimate Cost to CMA:**

**CALIFORNIA MEDICAL ASSOCIATION  
2009 HOUSE OF DELEGATES**

**LACMA-50**

**Title:** WORKER SAFETY AND HEALTH IN THE ADULT FILM INDUSTRY: NEED TO REDUCE STD/HIV OCCUPATIONAL EXPOSURE RISK

**Author:** Peter Kerndt, MD  
pkerndt@ph.lacounty.gov

**Introduced by:** Robert Bitonte, MD

**Endorsed by:** LACMA – District IV

---

**WHEREAS**, California is the largest center for adult film production worldwide, with an estimated retail value of product produced in Los Angeles County at \$3 billion in 2003; and

**WHEREAS**, the adult film industry is also a national industry, with a growing concern both nationwide and in California about unsafe health practices found within this industry; and

**WHEREAS**, performers in the adult film industry are routinely exposed to unhealthy working conditions as part of their employment, such as having multiple sex partners over short time periods, prolonged episodes of sexual contact, riskier types of sexual practices, and lack of protective equipment such as condoms, which significantly increases risks for the acquisition of transmission of HIV and other sexually transmitted diseases (STDs); and

**WHEREAS**, transmission of HIV and other common STDs, such as chlamydia, gonorrhea, syphilis, hepatitis B and C, and herpes and Human papillomavirus has serious health consequences for performers, their partners and the larger community; and

**WHEREAS**, reported cases of HIV transmission occurred among heterosexual AFI performers in 1995, 1997, 1998, 1999, and 2004, and between 2004 and 2008, nearly 2,850 STDs were diagnosed among 2,000 performers, with approximately 70% of STD infections having occurred in female performers, and one-fourth of females infected had a repeat STD infection; and

**WHEREAS**, nationally, the federal Occupational Safety and Health Administration (OSHA) and in California the California Occupational Safety and Health Administration (Cal/OSHA) require employers to provide a safe and healthful workplace for employees, and to pay the costs of any required medical monitoring part of a health and safety program, and this same act gives Cal/OSHA jurisdiction over virtually all private employers in California, including employers in the adult film industry, and those employers must comply with all relevant regulations, which are contained in Title 8 of the California Code of Regulations (CCR); and

**WHEREAS**, per requirements under the Bloodborne Pathogens and Illness and Injury Prevention Standards in Title 8 of the CCR, Cal/OSHA has determined that these requirements for the AFI include: employer financing of HIV/STD testing and vaccine, following a written safety and health

program, keeping confidential employee records, providing personal protective equipment such as condoms at the workplace, training employees in health and safety hazards, protecting employees from hazards associated with bloodborne pathogens, and not discriminating against employees who complain about safety and health conditions; and

**WHEREAS**, despite OSHA and Cal/OSHA requirements, there has been no apparent compliance by the industry and a continued lack of employer responsibility for worker health and safety in the AFI, with the burden of health and safety placed directly on the performers; and

**WHEREAS**, despite Cal/OSHA and public health requirements, there has been limited cooperation in the investigation of workplace practices and contact tracing of exposed workers and other sex partners of performers by adult film production companies and some of the clinics that currently provide pre-employment STD/HIV testing; and

**WHEREAS**, the Los Angeles County Commission on HIV, Planned Parenthood Affiliates of California and the California Family Health Council have taken policy positions in support of legislation to improve the health and safety of workers in this industry; and

**WHEREAS**, video/films this industry produces demonstrate and model unsafe sex and can affect behavior of those who view them and a clearly at-risk population is youngsters who learn sexual expectations and practices in-part via these media; and

**WHEREAS**, the County of Los Angeles, AIDS Healthcare Foundation and San Francisco AIDS Foundation and the has agreed to co-sponsor legislation to improve the health and safety practices within the adult film industry; therefore be it

**RESOLVED:** That the California Medical Association (CMA) support legislation that would require the mandatory use of condoms in the production of adult films; and be it further

**RESOLVED:** That the California Medical Association (CMA) support legislation that would improve the ability of local health departments and OSHA\Cal\OSHA to investigate and control occupational exposures to infectious diseases and enforce workplace regulations in a timely manner; and be it further

**RESOLVED:** That California Medical Association (CMA) urges that existing OSHA and other occupational standards be vigorously enforced to reduce exposure to infectious diseases within the adult film industry; and be it further

**RESOLVED:** That the California Medical Association (CMA) refer this matter to the American Medical Association (AMA) for national action.

**Current CMA Policy:**

**Estimate Cost to CMA:**

**CALIFORNIA MEDICAL ASSOCIATION  
2009 HOUSE OF DELEGATES**

**LACMA-51**

**Title:** WORKERS COMPENSATION MEDICAL TREATMENT AUTHORIZATION

**Author:** Michael Bazel, MD  
bazmd@aol.com

**Introduced by:** Michael Bazel, MD

**Endorsed by:**

---

**WHEREAS,** insurance companies use the issue of Medical Necessity after the treatment is provided in attempt to get the service without paying for it; and

**WHEREAS,** SCIF vs. WCAB (Sadhagen), states that insurance must perform Utilization Review prior to denying the treatment; and

**WHEREAS,** the treatment still needs to be Medically Necessary, and

**WHEREAS,** frequently, Agreed Medical Evaluator report, which is not presented to the Primary Treating Physician for a review until the end of the treatment, is used by the insurance company to argue Medical Necessity, and therefore be it

**RESOLVED:** That the California Medical Association (CMA) takes an active role in establishing a legislature forbidding arguing Medical Necessity of the treatment after the treatment has already been rendered, and be it further

**RESOLVED:** That Utilization Review to be the only pathway to approve or deny medical treatment, and be it further

**RESOLVED:** That payment for treatment can not be denied after it has been provided and the insurance company failed to use Utilization Review to argue Medical Necessity.

**Current CMA Policy:**

**Estimate Cost to CMA:**

## Background Info:

### SCIF vs. WCAB (Sandhagen):

One purpose of utilization review is to prevent disputes about medical treatment from ever arising. Before 2003, the medical treatment the employer was obligated to provide for work-related injuries was only vaguely defined as “treatment . . . that is reasonably required to cure or relieve from the effects of the injury.” (Former § 4600, as amended by Stats. 1998, ch. 440, § 2.) This indistinct standard left a lot of room for disagreement. The Legislature’s reforms of the workers’ compensation law in 2003 and 2004 much more precisely define the employer’s medical treatment obligation in terms of detailed treatment guidelines. (See §§ 4600, subd. (b), 4610, subd. (c).) Because proper application of these treatment guidelines requires medical expertise, the decision to modify, delay, or deny a treatment request must be made by a licensed physician. (§ 4610, subd. (e).) Thus, utilization review is best understood as a *threshold* procedure that the employer must follow before any dispute about medical treatment has arisen.

### LC 4600 (b):

(b) As used in this division and notwithstanding any other provision of law, medical treatment that is reasonably required to cure or relieve the injured worker from the effects of his or her injury means treatment that is based upon the guidelines adopted by the administrative director pursuant to Section 5307.27 or, prior to the adoption of those guidelines, the updated American College of Occupational and Environmental Medicine’s Occupational Medicine Practice Guidelines.