

RESOLUTION 201

SUBJECT: Sunset Mechanism for Generated Legislative Initiatives

INTRODUCED BY: Council on Legislation

1
2 **WHEREAS**, LSMS established procedure requires unsuccessful legislative initiatives of
3 the LSMS be maintained for two regular sessions before being abandoned, therefore be it
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5 **RESOLVED**, the following legislative initiatives of the House of Delegates on the
6 following matters are **abandoned**, but the positions enunciated in each such Resolution shall
7 remain LSMS policy:
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9 2003: 206 – retained in 2006;

10 2004: 204, 207 (1st Resolve)

11 2007: 202 (2nd Resolve), 207 (1st Resolve)

Referenced Resolutions:

Resolution 206-03, Any Willing Provider: LSMS seek or support legislation that would prohibit a health insurance issuer from refusing to allow a physician, who is located within the coverage area of the health insurance issuer and is willing to accept the terms and conditions of participation, to join the panel of the issuer as a participating provider.

Reason: Arkansas' 2005 "Any Willing Provider" statute was constitutionally upheld by the federal 8th Circuit of Appeal, in part, and unconstitutional, in part, and it remains under federal appellate review for possible violation of ERISA. Until a final judgment is rendered, this issue should be LSMS policy and, thereafter, codified in Louisiana law.

Resolution 204-04, Pharmaceutical Company Rebates for Nursing Home Pharmacies (1st resolve): LSMS seek and/or support legislation or rules/regulations to disallow nursing home pharmacies from receiving pharmaceutical company rebates for soliciting nursing home physicians to utilize specific drugs based on purely economic reasons while disregarding quality, effectiveness or lack of reactions with other drugs, . . .

Reason: PhRMA's development and strong urging all pharmaceutical companies comply with its updated "Code on Interactions with Healthcare Professionals". This Code's Article 10, third (3rd) paragraph states, in part, "Payments in cash or cash equivalents (such as gift certificates) should not be offered to healthcare professionals either directly or indirectly, except as compensation for bona fide services.... Cash or equivalent payments of any kind create a potential appearance of impropriety or conflict of interest."

Article 13 of the Code states, in its entirety:

“No grants, scholarships, subsidies, support, consulting contracts, or educational or practice related items should be provided or offered to a healthcare professional in exchange for prescribing products or for a commitment to continue prescribing products. Nothing should be offered or provided in a manner or on conditions that would interfere with the independence of a healthcare professional’s prescribing practices.”

Resolution 207-04, Managed Care Organization Credentialing Process & Timelines for Acting on the Physician’s Application for Participation in the Network: LSMS seek regulation which would require all managed care organizations to develop a uniform platform, (such as a password-protected website) which would allow physician applicants the ability to immediately assess the status of his/her application for participation in the panel, ...”

Reason: COL & DGA are coordinating with several other health care provider associations and interested groups to introduce broad legislation with shall address this issue and many others. This LSMS policy shall be included in this proposed 2009 legislation.

Resolution 202-07, HIV Testing Policy: LSMS is to seek and/or support legislation or repealing RS 40:13.13 [**Please, note: no such statute exists; the LSMS COL & DGA presumed this reference was intended as La R. S. 40:1300.13, relative to “HIV-related testing”**] and any other legislation treating HIV testing in a different manner than other similar infectious disease testing.

Reason: Passage of Act 153 of 2007 amended certain Sections of Title 40, relative to “venereal disease” and “HIV-related testing”, including La R. S. 40:1300.1, which states, in part, “...Consent HIV testing shall be incorporated into the patient’s general informed consent for medical care on the same basis as are other screening or diagnostic tests; a separate consent form for HIV testing shall not be necessary.”

Resolution 207-07, Health Insurance Preauthorization: LSMS will seek and/or support through legislation and/or regulation to require health insurance companies which operate in Louisiana to guarantee payment to a medical provider if preauthorization has been approved, regardless of any other contract provision, (1st Resolve)

Reason: Passage of Act 575 of 2008, amended Louisiana’s Insurance Code’s Sub-part entitled Standards for Health Insurance Coverage (the prompt pay statute) establishing “limitations on retroactive denial and recoupment”, which states, in part, “...for health care services rendered in good faith and pursuant to the benefit plan, no health insurance issuer shall retroactively deny payment or recoup any monies paid beyond ninety days from the expiration of the allowable thirty-day period for the payment of any claim...”

RESOLUTION 202

SUBJECT: Proposed Strengthening of La. R.S. 9:2794 to eliminate “Non Delegable Duty”; “Negligence Per Se” and Captain of the Ship Doctrines

INTRODUCED BY: Jefferson Parish Medical Society

1 **WHEREAS**, Louisiana Revised Statute 9:2794 requires a finding that a physician
2 breached the standard of care and caused damages in order to establish liability for medical
3 negligence; and
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5 **WHEREAS**, in violation of La. R.S. 9:2794, the Louisiana Courts of Appeal have
6 adopted the “non-delegable duty doctrine” which imposes liability on physicians even where the
7 jury finds the actual negligence was committed by a third party, not employed by the physician or
8 under the physician’s control or supervision; *See e.g. McLin v. Breaux*, 2005-1911(La. App. 1st
9 Cir. 11/3/06) 950 So.2d 711 (in which the Court of Appeal reversed a jury finding in favor of the
10 physician in a retained sponge case and imposed liability despite the clear evidence that the
11 physician complied with the standard of care while the hospital staff admittedly did not follow
12 protocol); and
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14 **WHEREAS**, the Courts of Appeal’s adoption of the “non delegable duty” and “per se
15 negligence” doctrines amounts to an adoption of the Captain of the Ship Doctrine to impose
16 liability in medical malpractice actions on physicians for the care and treatment provided by
17 hospital employees; *See e.g. McLin v. Breaux*, supra; *Romero v. Bellina*, 01-0274 (La. App. 5th
18 Cir. 9/25/01), 798 So.2d 279, writ denied 01-2852 (La. 1/11/02), 807 So.2d 237; *Johnston v.*
19 *Southwest Louisiana Assoc.* 96-1457 (La. App. 3rd 4/2/97) 693 So2d 1195, and
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21 **WHEREAS**, the Louisiana Courts of Appeal have issued decisions imposing liability on
22 physicians for acts of negligence committed by third parties, not under the employ of the
23 physician or under his control or supervision, be it therefore
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25 **RESOLVED**, that the LSMS seek and/or support legislation to amend and strengthen
26 Louisiana Revised Statute 9:2794 to legislatively overrule the *Grant v. Touro Infirmary* line of
27 cases which holds that a physician has a non delegable duty in the case of retained foreign bodies
28 and to further require specific proof of negligence by the physician in all medical malpractice
29 cases. *See e.g. McLin v. Breaux*, 2005-1911(La. App. 1st Cir. 11/3/06) 950 So.2d 711; *Romero v.*
30 *Bellina*, 01-0274 (La. App. 5th Cir. 9/25/01), 798 So.2d 279, writ denied 01-2852 (La. 1/11/02),
31 807 So.2d 237; *Johnston v. Southwest Louisiana Assoc.* 96-1457 (La. App. 3rd 4/2/97) 693 So2d
32 1195; *Grant v. Touro Infirmary* 254 La. 204, 223 So.2d 148 (La. 1969), and be it further
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34 **RESOLVED**, that the LSMS seek and/or support legislation to amend and strengthen
35 Louisiana Revised Statute 9:2794 to confirm that the doctrines of “Captain of the Ship”, “Non
36 delegable duty” or “Negligence Per Se” are not the law of this state and to confirm that no
37 physician shall be held liable for acts of negligence by a hospital employee.
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RESOLUTION 203

SUBJECT: Ethical Conflict of Interest for Preferentially Compensated Physicians

INTRODUCED BY: Marcus L. Pittman, III, MD, Delegate
St. Tammany Parish Medical Society

1 **WHEREAS**, Louisiana Governor Bobby Jindal has recognized the importance of ethics
2 reform in the State of Louisiana, and

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4 **WHEREAS**, in the HEALTH CARE QUALITY IMPROVEMENT ACT OF 1986
5 (HCQIA), Congress created the National Practitioner Data Bank “to improve the quality of
6 medical care” and “to restrict the ability of incompetent physicians to move from State to State”
7 by creating “effective professional peer review”, and

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9 **WHEREAS**, over the last two decades, managed care strategies have resulted in a large
10 number of physicians having their medical practice subsidized through hospital and/or hospital
11 contracted entities, and

12
13 **WHEREAS**, such physician subsidies can be used as leverage in patient care issues and
14 peer review actions, creating an inherent conflict of interest, and

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16 **WHEREAS**, the AMERICAN MEDICAL ASSOCIATION recognizes that: “The
17 potential for abuse of peer review exists. Personal agendas, competition or other reasons
18 unrelated to quality care must not be the motivation for peer review actions” (Letter dated March
19 1, 2002 from Timothy T. Flaherty, MD, Chair, AMA Board of Trustees; and Michael D. Maves,
20 M.D., MBA, AMA Executive Vice President), and

21
22 **WHEREAS**, the LOUISIANA STATE BOARD OF MEDICAL EXAMINERS
23 (LSBME) “may refuse to issue, or may suspend or revoke any license or permit, or impose
24 probationary or other restrictions on any license or permit issued” for “unprofessional conduct”
25 (LA Medical Practice Act, La. Rev. Sta. §1285.A.13), be it therefore

26
27 **RESOLVED**, that, in keeping with Governor Jindal’s attempt at ethics reform, that, as the
28 “premier advocate for patients and physicians”, the Louisiana State Medical Society should
29 communicate with and urge action by the Louisiana State Board of Medical Examiners to
30 consider that physicians who are preferentially compensated by a hospital or a by competing
31 hospital, and who hold medical staff office or participate in medical staff peer review oversight
32 should be considered to be in violation of the Louisiana Medical Practice Act provision on
33 “unprofessional conduct” (LA Medical Practice Act, La. Rev. Sta. §1285.A.13).

Attachment: Letter dated March 1, 2002 from Timothy T. Flaherty, MD,
Chair, AMA Board of Trustees;
and Michael D. Maves, M.D., MBA,
AMA Executive Vice President

American Medical Association

Physicians dedicated to the health of America

515 North State Street
Chicago, Illinois 60610

312 464-5000
312 464-4184 Fax



Memo to: Executive Directors
State Medical Associations
National Medical Specialty Societies
Hospital Medical Staff Presidents and Chiefs of Staff

From: Timothy T. Flaherty, MD, Chair, Board of Trustees
Michael D. Maves, MD, MBA, Executive Vice President

Handwritten signatures of Timothy T. Flaherty and Michael D. Maves.

Date: March 1, 2002

Subject: Compliance with the Health Care Quality Improvement Act (HCQIA)

The American Medical Association supports peer review by physicians and protection of peer review documents and proceedings. The AMA also discourages involvement in peer review proceedings by physician panel members who are economic competitors of the peer reviewed physician and discourages medical testimony by economic competitors when the proceedings may result in termination of the affected physicians privileges, AMA Policy H.375-983. (Attachment)

Peer review by physicians is essential to ensure and improve quality care for patients. It should be performed by physicians. However, absent immunity, some physicians may be unwilling to participate in this responsibility of their profession. The Health Care Quality Improvement Act of 1986 (HCQIA) was enacted to encourage physicians to participate in peer review by providing limited immunity from money damages. To qualify for immunity, peer review action must meet specific criteria. (Attachment)

The potential for abuse of peer review exists. Personal agendas, competition or other reasons unrelated to quality care must not be the motivation for peer review actions. Peer review that is not fair or objective can undermine patient care, patient access as well as a physician's reputation. Failure to adhere to a fair peer review process can erode public confidence in the ability of the medical profession to adequately monitor itself.

In order to ensure quality patient care and to assure fairness to all physicians, the AMA urges all medical staffs to adopt and implement medical staff bylaws that comply with AMA policy and HCQIA.

We hope that physicians continue to remain tireless advocates for their patients by continuing to pursue high quality care. By ensuring that medical staff bylaws conform with HCQIA requirements and AMA policy, patients, the public and physicians will all benefit.

Attachments

RESOLUTION 204

SUBJECT: Federal Health Care Funds for Areas Affected by Hurricanes
Katrina and Rita

INTRODUCED BY: Jefferson Parish Medical Society

1 **WHEREAS**, providing care to the patients formally served by the Louisiana public
2 hospitals in the areas affected by Hurricanes Katrina and Rita has created serious financial stress
3 on Louisiana's hospitals and physicians, and
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5 **WHEREAS**, the Federal Omnibus Reconciliation Act appropriated funds to Louisiana to
6 relieve the financial distress created by providing care to uninsured patients post Katrina and Rita;
7 and
8

9 **WHEREAS**, the State of Louisiana has failed to disperse or account for the federal funds
10 received by the state since Hurricanes Katrina and Rita; and
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12 **WHEREAS**, the federal funds received by the State of Louisiana are essential to the
13 stability of the healthcare system in the hurricane affected regions; therefore, be it
14

15 **RESOLVED**, that the LSMS request a report or accounting from the State of Louisiana
16 regarding the amount of federal funds designated for health care that have been received by the
17 state since Katrina and Rita and to whom the funds have been disbursed.
18

RESOLUTION 205

SUBJECT: Immediate Financial Relief for Hurricane Affected New Orleans
Area Hospitals

INTRODUCED BY: Orleans Parish Medical Society
Jefferson Parish Medical Society

1 **WHEREAS**, five hospitals, East Jefferson, West Jefferson, Ochsner, Tulane, and Touro,
2 remained open or quickly reopened in the immediate post Hurricane Katrina period, providing
3 healthcare to all residents of the hurricane affected region; and
4

5 **WHEREAS**, no public hospital was open in the immediate period after Hurricane
6 Katrina, nor is a full service public hospital scheduled to open in the hurricane affected region for
7 at least seven more years; and
8

9 **WHEREAS**, providing care to the patients formally served by the Louisiana public
10 hospital by the five referenced hospitals has now created serious financial stress on those five
11 hospitals, and
12

13 **WHEREAS**, the Federal Omnibus Reconciliation Act appropriated funds to Louisiana to
14 relieve the financial distress in those five referenced hospitals created by providing care to
15 uninsured patients in the post Katrina period; and
16

17 **WHEREAS**, the State of Louisiana has yet to disperse those appropriated funds to the
18 five institutions for which it was intended; and
19

20 **WHEREAS**, this failure of the State of Louisiana to distribute those appropriated funds
21 has exacerbated the financial distress experienced by the five referenced hospitals; and
22

23 **WHEREAS**, continued operation on those five referenced hospitals is essential to the
24 stability of the healthcare system in the hurricane affected regions; therefore, be it
25

26 **RESOLVED**, that the Louisiana Sate Medical Society seek and/or support legislation,
27 regulation, federal waiver, and/or other proposal that would provide immediate financial relief to
28 the five hospitals, East Jefferson, West Jefferson, Ochsner, Tulane, and Touro, for the financial
29 distress created in those institutions by the provision of medical care to the patients in the
30 Hurricane Katrina affected region who did not possess adequate health care coverage
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RESOLUTION 206

SUBJECT: Physician-Insurer Contracting

INTRODUCED BY: Shreveport Medical Society

1 **WHEREAS**, there remains an urgent need to affect positive changes to contracting
2 between health insurers and physicians, and

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4 **WHEREAS**, recently Colorado (2007) followed by Ohio (2008) and possibly Florida
5 (2008) have led the way in successfully addressing the issues of “Transparency” and “Fairness”
6 in contracting reforms through their respective state legislatures, and

7
8 **WHEREAS**, the Colorado and Ohio state medical societies were the principal leaders in
9 forming statewide coalitions of physicians and provider groups to advocate successfully for
10 passage of contracting reform bills despite strong opposition from the insurance and business
11 community, therefore be it

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13 **RESOLVED**, the Louisiana State Medical Society evaluate the successful efforts of the
14 Colorado and Ohio state medical societies’ contracting reform models, and establish a statewide
15 coalition of physician and provider advocacy groups for the purpose of introducing and/or
16 supporting legislation in 2009 to achieve the following reform objectives in contracting between
17 insurance companies and physicians:

- 18
- 19 ▪ a requirement that each insurer provide contracting physicians with a copy of the
20 insurer’s payment rates to ensure physicians know the terms and conditions of the contract
21 in advance;
 - 22
 - 23 ▪ a prohibition barring insurance companies from selling or renting a physician’s
24 contract to another company unless the rental is disclosed to the physician and all of the
25 original contract terms between the physician and the insurer are honored;
 - 26
 - 27 ▪ restriction of “all products” clauses, which often force physicians to accept all of an
28 insurance company’s products such as workman’s compensation business added to the
29 contract without their knowledge after they have signed the contract;
 - 30
 - 31 ▪ a provision prohibiting insurers from using predatory clauses in their contracts with
32 physicians – these clauses can force physicians to provide services at a lower rate than
33 originally stipulated in the contract;
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 - 35 ▪ disclose in plain language the terms of payment, the duration of the contract, the
36 identity of the person responsible for processing the physician’s claims, and the
37 mechanism to resolve disputes;
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 - 39 ▪ define the method used to calculate fees, such as relative value unit, percentage of
40 Medicare payment, or percentage of billed charges;

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- provide the fee schedule for codes reasonably expected to be billed by physicians under the contract and, on request, for other codes that may be used by physicians; and
- give physicians advance notice of contract changes.

LSMS related policies:

140.94 Contracting and the Physician's Ethical Duty: The LSMS opposes agreements or clauses in participating physician contracts which unreasonably restrain the physician from providing information to the patient about policies and decisions of the insurer or other contracting entity. These provisions constitute an unacceptable restriction on the physician's ethical duty to act as the patient's advocate. (R511-93, reaffirmed R101-03)

165.82 Patient Protection Act: The LSMS supports the following patient and/or physician protections:

(1) Health plans be required to provide prospective enrollees/patients with information regarding:

- a. coverage provisions and exclusions;
- b. prior authorization or other review requirements;
- c. financial arrangements that would limit the services offered, restrict referral options, and establish incentives not to deliver certain services;
- d. plan limitations and the impact of any limitations upon an enrollee; and
- e. enrollee satisfaction statistics.

(2) Patients have a choice of physicians and at least three different types of health plans:

- a. a traditional insurance plan (with copayments and deductibles)
- b. an HMO or PPO
- c. a benefit payment schedule plan.

(3) Patients have the right to change physicians.

(4) Patients of managed care plans can submit an appeal on cases where they object to medical decisions regarding their health care.

(5) Patients who choose a plan that restricts access to physicians may purchase a point of service option to see any physician outside the plan.

(6) Plans be prohibited from terminating physicians *without cause* and must provide physician applicants with all reasons for denial of an application or nonrenewal of a contract. A due process appeal containing the precise mechanism outlined in the Health Quality Improvement Act of 1986 must be accorded. Procedures that ensure confidentiality of provider and individual medical records must also be followed.

(7) Plans must establish credentialing criteria to allow physicians within the plan's geographic service area to apply for credentials. Credentialing would be based on standards of quality. Criteria and profiles must be available to physicians.

(8) Plans must establish a mechanism under which physicians in the plan can provide input into the plan's medical policies.

(9) Plans must allow for physician input pertaining to their participation in managed care plans by:

- a. permitting physicians to negotiate with the managed care organizations on the terms and conditions of their participation; and
- b. requiring managed care organizations to disclose all participation requirements and selective contracting criteria to applying physicians; and
- c. expanding the concept of physician governance of managed care entities by requiring they establish self-governing medical staffs similar, if not identical, to those in hospitals that function under the principles of self-government.

91 Appropriate utilization review criteria must be established. These should include but
92 not be limited to:

93 (1) A plan model in which a medical director is responsible for all clinical decisions of
94 the plan;

95 (2) Screening criteria, weighting elements, and computer algorithms used in the review
96 must be based on sound scientific principles, developed with physicians having an
97 essential role, and released to physicians and the public;

98 (3) Only a physician of the same specialty as the practitioner who provided a service
99 would be permitted to recommend denial of coverage or payment;

100 (4) The plan would be required to provide to participating physicians the names and
101 credentials of those who conduct medical necessity or appropriateness review; and

102 (5) Patient or physician requests for prior authorization of a service must be answered
103 within two business days, with personnel available for same day responses regarding
104 questions of medical necessity.

105 The Patient Protection Act shall require that medically indigent patients dependent on
106 publicly funded programs be given a schedule of their entitlements including their right
107 to select either a public or private sector physician for their health care.

108 Long-standing LSMS support for the option of Medical Savings Accounts (MSAs) is
109 affirmed and vigorously advocated. (SR211-94, reaffirmed R101-04)

110 **180.89 Any Willing Provider:** The LSMS supports laws and/or regulations that would
111 prohibit a health insurance issuer from refusing to allow a physician, who is located
112 within the coverage area of the health insurance issuer and is willing to accept the
113 contract terms and conditions of participation, to join the panel of the issuer as a
114 participating provider. (R206-03)

115 **185.91 Insurer Explanation of Benefit Forms:** Insurance carriers should provide an
116 explanation of medical benefits (EOMB) to health care providers whenever the carrier's
117 reimbursement differs from the amount billed by the provider. The EOMB must be
118 provided with the reimbursement check.

119 (1) The EOMB must contain appropriate identifying information so the provider can
120 relate a specific reimbursement to the applicable claimant, the procedure billed, and the
121 date of service.

122 (2) The carrier shall use the provider's listed EOMB CPT codes and descriptors to
123 demonstrate how each charge has been reduced or disallowed.

124 (3) The EOMB shall specify what underlying managed care organization's contractual
125 fee schedule is used for determining reimbursement and/or applicable discounts.

126 (4) The EOMB shall clearly identify the insured's remaining financial responsibility
127 under the contract. (R207-96, reaffirmed R101-06)

128 **185.89 Patient Eligibility for Medical Services:** The LSMS encourages all managed health
129 care companies in Louisiana to provide reasonable and adequate 24 hour a day access to
130 determine eligibility of patients, names or approved network hospitals and names of
131 approved physicians. If patient eligibility information is not readily available, it can be
132 assumed that a patient with a managed care identification card is eligible for services at
133 the facility to which he/she has presented. The LSMS believes that managed health care
134 companies should be required to pay for any appropriate services rendered to patients
135 when hospitals or physicians have made reasonable efforts to determine eligibility.
136 (R208-97, reaffirmed R101-06)

137 **185.88 Health Plans Publish Health Plan Rules:** Each health insurance payor be required to
138 disseminate its DOI-approved plan to all individual providers enrolled in the plan.
139 (R217-01, reaffirmed R102-06)

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141 **185.87 Inclusion of Payment Schedule in Managed Care Contracts:** Each third party payor
142 attach a complete payment schedule which is updated whenever the payment schedule is
143 altered but at least yearly to the physician contract. (R218-01, reaffirmed R102-06)

144 **185.86 Health Plans Publish Explanation of Benefits (EOB):** Third-party payors operating in
145 Louisiana be required to provide to the plan's beneficiaries an Explanation of Benefits
146 after each claim has been adjudicated. (R222-01, reaffirmed R102-06)

147 **265.93 Non-Compete Clauses in Contracts:** The LSMS opposes non-compete clauses that limit
148 the privilege of a physician to practice medicine. Any non-compete clause excessive in
149 geographic scope or duration, or any non-compete clause between a physician and non-
150 physician that restricts the physician's privilege to practice medicine is unacceptable. (R409-
151 03)

152 **285.99 Managed Care Consumer Protection Laws:** Insurers should disclose, upon request, to
153 employers, patients and physicians, the contractual financial incentives and controls
154 affecting patients' access to health care. (R205-96, reaffirmed R101-06)

155 **285.98 Fee Schedules in Managed Care Organization Contracts:** The LSMS supports
156 efforts to ensure that patients, or their designee, have disclosed upon their request the
157 exact dollar amounts of allowed fees/coverages, when considering undergoing medical
158 services that may result in an obligation for a copayment based on those coverage
159 amounts. (R208-96, reaffirmed R101-06)

160 **285.97 Gag Orders:** The LSMS opposes managed care companies imposing any form of gag
161 clause that prevents a physician from discussing quality of care issues and treatment
162 options with their patients. The LSMS is opposed to managed care companies
163 terminating physicians without cause and provide physician applicants with all reasons
164 for denial of an application or renewal of a contract. A due process appeal containing the
165 precise mechanism outlined in the Health Care Quality Improvement Act of 1986 must
166 be accorded. (R211-96, reaffirmed R101-06)

167 **380.96 Right of Physician and Patient to Privately Contract:** The LSMS holds inviolate the
168 constitutional right of citizens to enter into private contracts, such as between physician
169 and patient, and the right of the physician to directly bill the patient for services
170 rendered. The LSMS unalterably opposes any legislation that (1) interferes with the
171 right of private contract between citizens; (2) prohibits a private physician from billing a
172 private patient; (3) mandates physician acceptance of assignment; (4) pays the hospital
173 instead of the private physician for services of private physicians to hospitalize private
174 or public patients; and (5) treats private physician or medical staffs as virtual employees
175 of hospitals or government. The LSMS unalterably opposes the proposed Mandatory
176 Assignment and Hospital Enforcement amendment or any similar legislation which
177 would change Medicare into a second-rate, no choice welfare, Medicaid-type program
178 and thus force private hospitals and physicians to refuse Medicare patients. The LSMS
179 urges the AMA to take the same position. (R20-84, reaffirmed R101-03)

180 **380.95 Regulation of Physician Charges:** Attempts to regulate charges of physicians who do
181 not accept assignment, but who bill their patients directly, is a violation of the
182 constitutional right of the physician to contract for services with his or her private
183 patients. (R16-86, reaffirmed 1996, reaffirmed R101-06)

184 **385.96 Payment of Claims By Health Insurers:** Insurers should make payments to physicians,
185 hospitals and other health care providers, as well as to the patients (insured) in
186 accordance with laws related to assignment of benefits within 30 days of receiving proof
187 of claim, or to be subject to penalty of double the amount of benefits due under the
188 terms of the policy or contract, together with court approved attorney fees. (R52-89,
189 amended R101-99, reaffirmed R101-06)

RESOLUTION 207

SUBJECT: Revision of Act 817 and Medical Malpractice Reform

INTRODUCED BY: Council on Legislation

1 **WHEREAS**, Act 817 of the 1975 Legislative session was one of the first professional
2 liability reform packages passed in the United States and has withstood the tests of time as a solid
3 framework of liability protection for health care providers in Louisiana, and
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5 **WHEREAS**, one of the most important protections of Act 817 is its limitations on
6 liability, particularly the limit on total liability, and
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8 **WHEREAS**, numerous challenges have been launched against the constitutionality of
9 various provisions of Act 817, and in recent years those challenges have focused more on the
10 limitation on liability, and
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12 **WHEREAS**, the most serious challenge to Act 817 is now pending before the Louisiana
13 Supreme Court in the form of the Arrington/Taylor cases. The current cap values have not
14 changed since passed in 1975 and these cases focus on the assertion the caps do not provide equal
15 protection because their dollar value is significantly less today given the increases in the costs of
16 health care and individual earnings over the past 33 years, and
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18 **WHEREAS**, a decision by the Supreme Court to declare the limits on liability in Act 817
19 unconstitutional, or the entire Act for that matter, would create a major crisis in health care access
20 and delivery in Louisiana far greater than that of 1975. Health care providers and insurers in our
21 state recognized this potential crisis and have been working for over two years in a proactive
22 manner to develop legislation to address the current challenge and remedy the arguments for
23 changing and/or eliminating Act 817, therefore be it
24

25 **RESOLVED**, the LSMS House of Delegates reaffirms policy 435.88, including a cap on
26 total damages, as the principle policy for developing a legislative reform agenda to address
27 challenges to and the preservation of Act 817, and be it further
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29 **RESOLVED**, as a part of its legislative agenda to preserve important provisions of Act
30 817, LSMS policy is to support and work for the passage of a state constitutional amendment to
31 establish the authority to limit damages for medical malpractice awards.
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34 **Related LSMS Policies:**

35 **265.92 Proportionate Fault of a Tortfeasor:** In matters of tort litigation each tortfeasor shall pay
36 only for the portion of the damage that he/she has caused, and the tortfeasor shall not be
37 solidarily liable with any other person for damages attributable to the fault of that person.
38 (R112-04)
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- 1 **270.98 Medical Malpractice Laws:** The LSMS House of Delegates gives authority to act
- 2 swiftly and decisively on any legislation introduced that improves or gives stability to
- 3 the medical malpractice laws of Louisiana to the Council on Legislation and the
- 4 Department of Governmental Affairs in concert with the LSMS Executive Committee
- 5 and the LSMS Executive Vice President. (R211-02. reaffirmed R101-07)
- 6 **435.90 Solidary Liability:** The LSMS opposes any attempt to reinstitute solidary liability in
- 7 Louisiana. (R112-04)
- 8 **435.89 Physicians’ Testimony in Malpractice Trials:** The LSMS opposes any state law which
- 9 allows attorneys to mandate physicians to testify as to the standard of care in a medical
- 10 malpractice case. (R216-96, reaffirmed R101-06)
- 11 **435.88 Limitations on Malpractice Recovery:** The LSMS is committed to preserving a cap
- 12 on medical professional liability damage awards paid by or on behalf of health care
- 13 providers in Louisiana and supports other changes in the medical professional liability
- 14 statutes that enhance affordability and availability of medical professional liability
- 15 insurance.(R203-01, amended R102-06)
- 16 **435.86 Loser Pays Rule in Civil Litigation:** The LSMS supports a loser pays rule in civil
- 17 litigation. (R208-04)
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RESOLUTION 208

SUBJECT: Truth in Advertising by Physicians

INTRODUCED BY: St. Tammany Parish Medical Society

1 **WHEREAS**, physicians have an ethical and professional responsibility to practice in a
2 manner that is in their patient's best interests, and

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4 **WHEREAS**, physicians have an obligation to practice in a manner that is commensurate
5 with their education and training, and

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7 **WHEREAS**, patients rely upon physicians to provide information about known facts,
8 risks, and side effects of medical procedures based on the physicians professional education and
9 experience, and

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11 **WHEREAS**, misleading and deceptive statements regarding a physician's education and
12 training undermine patient trust in physicians, and

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14 **WHEREAS**, these statements pose a significant risk to quality medical care by confusing
15 or misleading patients about the care they are receiving, therefore be it

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17 **RESOLVED**, that the Louisiana State Medical Society strongly encourage the Louisiana
18 State Board of Medical Examiners to enforce all current regulations regarding advertising and
19 establish new regulations, if needed, to prevent and penalize physicians from advertising
20 themselves as specialists in fields in which they are not board certified or eligible in that specialty
21 as established by the American Board of Medical Specialties or Board of Osteopathic Specialties.
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