

AMA Releases Its Health Insurer Code of Conduct

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The American Medical Association has called on U.S. health insurance companies to adopt its just-issued code of conduct.

The Health Insurer Code of Conduct Principles evolved from a resolution that was unanimously adopted by the AMA House of Delegates at its 2008 Interim Meeting. The New York Delegation



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DR. ROHACK

called on the association to develop such a code, get insurers to sign on, and come up with a way to monitor compliance. The code has been endorsed by nearly every state medical society as well as 19 specialty societies, according to the AMA.

The last time the insurance industry issued any kind of internal standards was 15 years ago, said the AMA, which added that the industry has had a "questionable" record of compliance with those standards, known as the Philosophy of Care.

"The health insurance industry has a crisis of credibility," Dr. J. James Rohack, AMA president, said in the statement. "With the enactment of federal health reform legislation, it's time for insurers to re-commit to patients' best interests and the fair business practices necessary

to re-establish trust with the patient and physician communities."

Americas Health Insurance Plans, the industry trade organization, did not directly address the AMA code. But spokesman Robert Zirkelbach said many of the principles are covered under the health reform law (Affordable Care Act).

"Health plans have pioneered innovative programs to reward quality, promote prevention and wellness, coordinate care for patients with chronic conditions, streamline administrative processes, and provide policyholders with greater peace of mind," he said. "We will continue to work with policy makers and other health care stakeholders to improve the quality, safety, and efficiency of our health care system."

The code's principles address topics including cancellations and rescissions; medical loss ratios and calculating fair premiums; open access to care, including transparent rules on provider networks and benefit limitations; fairness in contract negotiations with physicians; medical necessity and who can define it; and a call for more administrative simplification, fewer restrictions on benefits, and better risk adjustment mechanisms for "physician profiling" systems. Physicians should also have more opportunity to review and challenge their ratings in those systems, according to the principles.

The AMA said it has written to the eight largest health insurers seeking their pledge to comply with the code. ■

For more information, visit www.ama-assn.org/ama/pub/advocacy/current-topics-advocacy/private-sector-advocacy/code-of-conduct-principles.shtml.

Temporary Rules Outline HIT Certification, Meaningful Use

The federal government has published regulations that will allow for temporary certification of electronic health records—the first step aimed at helping physicians and other providers get the software and hardware required to be eligible for bonus payments under federal health programs.

According to the Office of the National Coordinator for Health Information Technology (ONC), the rule "establishes processes that organizations will need to follow in order to be authorized by the National Coordinator to test and certify [electronic health record] technology."

"We hope that all [health information technology] stakeholders view this rule as the federal government's commitment to reduce uncertainty in the health [information technology] marketplace and advance the successful implementation of EHR incentive programs," said Dr. David Blumenthal, the national coordinator for health infor-

mation technology, in a statement.

Certification of electronic health records means that the electronic health care package has been tested and includes the required capabilities to meet the "meaningful use" standards issued by ONC.

Under this system, hospitals and physicians will have the assurance that the certified EHRs can help them improve the quality of care and qualify for bonus payments under Medicare or Medicaid.

The incentive payments were authorized by the Health Information Technology for Economic and Clinical Health Act, part of the Recovery Act.

The rule was for a temporary certification program.

A final rule on permanent certification of EHRs will be issued in the fall. ■

For more information about the temporary certification program and rule, please visit <http://healthit.hhs.gov/certification>.



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APA Says BP Should Pay

The American Psychiatric Association wants the administrator of the \$20 billion Gulf oil-spill compensation fund to pay for the mental health care of affected individuals. Attorney Kenneth Feinberg has been charged with determining payouts for the fund, which was established by oil company BP at the request of the White House. Although the fund was largely envisioned as a way to compensate Gulf Coast residents for financial losses, the state of Louisiana has sought reimbursement from BP for mental health care it has delivered. Mr. Feinberg recently testified before a House committee that he was unlikely to approve payouts solely for mental health claims. The APA and other mental health groups objected.

Spill Health Effects Tallied

Meanwhile, researchers at Columbia University's Mailman School of Public Health in New York have estimated the oil spill's long-term physical and mental health effects in a survey of 1,200 adults who live within 10 miles of the Louisiana and Mississippi coasts. The survey was conducted in late July, after the Deepwater Horizon well was capped. About 43% of adult respondents said they had direct exposure to the spill or the cleanup effort, and 39% of that group reported physical symptoms. About one-third of all parents said their children had physical or mental health effects or both. The spill seemed to hit low-income households hardest. Those with annual earnings less than \$25,000 were more likely to say they had lost income since the spill. The school's National Center for Disaster Preparedness will follow 1,000 adults and children in the area to determine the continuing physical and mental health effects of the spill. The survey was conducted in collaboration with the Children's Health Fund and the Marist Poll of Poughkeepsie, N.Y.

\$200 Million Settles Drug Claims

AstraZeneca said in early August that it would settle about 17,500 lawsuits related to the antipsychotic Seroquel (quetiapine) for about \$200 million. Plaintiffs have alleged that use of the drug causes diabetes. According to "The Pink Sheet" newsletter, AstraZeneca has thus done away with the bulk of cases against the drug, although another 176 cases (representing 3,661 plaintiffs) had been filed but not served on the company. As of late June, AstraZeneca had already spent about \$711 million defending Seroquel tort claims.

Hypomania Isn't Uncommon

As many as 40% of people with major depressive disorder may have sub-

threshold hypomania, a new survey revealed. The study was part of the National Comorbidity Survey Replication, a federally sponsored nationally representative survey of Americans that was conducted between February 2001 and April 2003. Subthreshold hypomania is a discrete period of increased energy, activity, euphoria, or irritability that does not interfere with daily activities. The subgroup of people with a history of major depression and subthreshold hypomania were younger at onset and had more depression episodes than did those without a history of hypomania. In a statement, lead author Kathleen Merikangas, Ph.D., of the National Institute of Mental Health said that recognizing hypomania in major depression "is important in determining the future risk for the development of bipolar disorder, and should be considered in treatment decisions among people with major depression." The study was published online Aug. 16 in the American Journal of Psychiatry.

Deals Keep Generics Off Market

Branded- and generic-drug manufacturers have made at least 21 deals so far this year that potentially delay the production of cheaper, generic versions of brand-name drugs, the Federal Trade Commission said. In three-quarters of the settlements, the drug makers came to terms without money changing hands. The FTC, which is attempting to crack down on "pay-for-delay" deals, told congressional lawmakers that generic- and branded-drug manufacturers inked 19 such deals in 2009 and 16 in 2008.

Generics Saved Nearly \$1 Trillion

Use of generic drugs saved the U.S. health care system more than \$824 billion in the decade 2000-2009, according to a report commissioned by the Generic Pharmaceutical Association and conducted by research firm IMS Health. Drugs for conditions of the cardiovascular system, the nervous system, and metabolism accounted for three-quarters of the savings. In 2009, generics saved \$139.6 billion. The savings are expected to grow as 6 of the 10 largest-selling brand-name drugs will lose patent protection by 2014.

Part D Premiums Edge Up

Medicare beneficiaries can expect their monthly Part D prescription drug premiums to rise next year, but only by about \$1, to an average of \$30 per month, according to the Centers for Medicare and Medicaid Services. CMS Administrator Donald Berwick said during a press conference that premium rates will remain relatively steady in 2011 because minor cost increases for the Part D plans have been offset by increased use of generic drugs.