Dear Colleague,

National Health System Reform was signed into law earlier this week amid much confusion and divided opinion. What is certain is that most people speaking about it know very little about the final product. The vociferous reactions expressed by many physicians are likely echoes of what happened when Social Security and Medicare were signed into law by earlier generations. One of the key reasons for introduction of this legislation had been universal access. The law has certainly improved access for many. Some estimates are that 75% of the 48 million uninsured will now have access to health care coverage. There is no question that this will mean more work for physicians of all specialties. However, some of the coverage for the newly covered could still be
quite expensive so patients may still be making difficult decisions. Illegal immigrants will remain outside the system. Although not the plan of the House of Representatives, these patients will likely still receive uncompensated care by physicians and institutions as they are today. Unfortunately when care is delivered late it is often more expensive than it need be. A second certainty is that many of us will pay more for our health care coverage or pay more in taxes to support the system.

But there is also much uncertainty. There are more than 2000 pages in the law and this is going to take time for even a rudimentary understanding and implementation by all stakeholders. This is the process to which we must now turn our attention. Much of the battle will occur during this rule making period. In addition it is inconceivable that this Congress or future Congresses will refrain from tinkering with health care. Careful monitoring of these dealings is essential. All of these interactions will have impacts on our clinical practice and the quality of medicine that we provide in United States. It is perhaps now more important than ever that we are engaged in that process. Coverage policy, beneficiary rights, technology expansion, comparative effectiveness, end-of-life care, and pilot projects of CMS will all be discussed and impact all of us in the years to come. Organized medicine at the local and national level remains key spokesmen for us in this process. There could not be a better time to become involved in these issues. I encourage you to consider joining with your colleagues in playing a role.

Michael X. Repka, MD

From the Statehouse Jay Schwartz, Esq.

This week brought no further developments concerning bills that have been of interest to MSEPS. All these bills have been successfully amended or are about to be defeated.

While this has been a quiet legislative session for bills dealing with ophthalmology, such is not the case with bills dealing with organized medicine. It is virtually certain that legislation to increase the caps on medical malpractice cases will not be acted upon favorably after strong opposition from MedChi and the hospital industry. This means that the relative stability in medical malpractice rates will continue and perhaps improve in light of the apparent decline in the number of cases being filed against doctors in recent years. At the time of the Special Session on Medical Malpractice in December 2004, MedMutual reported there were 95 cases per year for every 1,000 insured physicians; the number has now dropped to 73 cases per 1,000 insured physicians.

Following is the weekly report given to the MedChi Board of Trustees on issues of importance to organized medicine for the week ending Friday, March 26th.
Nurse Practitioner

MedChi has reached agreement with the nurse practitioners for an amended bill which simplifies the procedures in obtaining approval of collaborative agreements. However, the compromise bill maintains the requirement that a nurse practitioner must have a collaborating physician and disallows independent practice by nurse practitioners. These amendments were worked out in a series of negotiating meetings between MedChi lobbyists Pam Kasemeyer and Steve Wise and representatives of the nurse practitioners. It now appears that a properly amended bill will pass the Senate and be accepted by the House HGO Committee.

Assignment of Benefits

The Assignment of Benefits (AOB) battle continued on Tuesday, March 23rd before the Health Subcommittee of the House HGO Committee. The Chair of the House Committee (Delegate Peter Hammen) attended the Subcommittee meeting which involved presentations by MedChi and allied physician groups, the insurance industry led by CareFirst CEO Chet Burrell and representatives of the Maryland Hospital Association. Presentations and detailed questions and answers were presented to all parties at the Health Subcommittee meeting which was also attended by MedChi Component Executives Mary Morin, Susan D’Antoni and Neilson Andrews. The bill faces tough sledding in this particular committee because of the opposition of Chair Peter Hammen and Vice Chair Shane Pendergrass. Opponents continue to insist upon rate caps on physicians (particular hospital based physicians) who elect to receive an Assignment of Benefits. The Senate bill already contains a rate cap on "on call specialists" and the insurance industry would like to extend that cap to hospital-based physicians.

It is possible that a compromise could be reached before the General Assembly adjourns on April 13th although MedChi has made it quite clear that a "rate cap" is not an acceptable compromise. Since the principal objection to legislation is that patients will be "balance billed" in far greater numbers than at present since doctors will no longer have an incentive to stay within networks once the insurance check is received directly by "non par" doctors. MedChi has proposed that the bill be amended to reflect Colorado law which has the insurance company responsible for any "balance bill." CareFirst argues that such a provision will increase health care costs and drive up premiums.

While the passage of the AOB law appears bleak, there is still a considerable amount of time and pressure is building on the House HGO Committee to do something with the issue. Jay Schwartz had a private conversation with Chair Pete Hammen on Tuesday evening where Hammen continued to argue for some sort of a pilot project where hospital based docs would be paid a fair rate and governmental bodies such as the HSCRC which presently sets hospital rates. Delegate Hammen indicated that he would like to call a meeting for further discussions on the AOB bill to involve his Committee leadership as well as the CareFirst CEO, MedChi and the Maryland Insurance Administration. It is expected that this meeting will occur next week.

False Claims

Jay Schwartz met Delegate Joseph Vallario who is the Chair of the House Judiciary Committee on Monday to discuss proposed amendments to
the False Claims bill. The Administration continues to argue for "no further amendments" because of the "consensus" amendments adopted by the Senate in exchange for the Maryland Hospital Association's support. MedChi, the pharmaceutical industry and the business community remain opposed and are seeking four amendments (proper definition of intent to defraud, elimination of attorney fees award, elimination of retroactivity and an elimination of the qui tam private lawsuits).

It appears that the retroactivity amendment will be successful in light of recent Advice of Counsel issued by the Attorney General's office indicating that provision of the bill is likely unconstitutional. In addition, it appears that several House members and particularly, Delegate Mary-Dulany James, are interested in pursuing the other amendments rather than accept the Senate bill as passed. DHMH Secretary John Colmers indicated to Jay Schwartz this week that other amendments may be possible but it appears that the Administration will only agree to the critical amendments if the House Judiciary Committee balks at the Senate bill.

MedChi Update - Protecting quality care in Annapolis

Dear Editor:

The Congressional process with regard to health system reform is completed with the passage of legislation the other night. Yet, the challenge of quality care for our citizens is far from resolved. On April 1, 2010, Maryland physicians face an across-the-board cut of 21.2% to Medicare reimbursements. More cuts in upcoming years are likely to follow. Given the current precarious state of the health care delivery system, a jolt of that magnitude will send it into shock. Its been documented in Maryland and across the country, a 21% cut in Medicare reimbursement will create huge shortages in physician access. The tragedy: all this pain suffering can be avoided by eliminating a flawed formula theoretically developed to create efficiencies.

For the past 13 years, The Sustainable Growth Rate (SGR) formula has hung over Medicare like Damocles’ Sword. While well intentioned when it was included in the Medicare reimbursement formula back in 1997, it has never been implemented. Congress has passed legislation every year since 1997 to avert the cuts that SGR mandates. The reason was simple: Congress understood that cuts in compensation for care would reduce access to care and put more patients in harms way.

SGR implementation would be ruinous to our health care delivery system. Medicare payments currently cover over 51% of
physicians' direct practice costs. Medicare payments today are only 1% higher than they were in 2001. Over the same period of time, physician practice costs increased 22%, as measured by the Medicare Economics Index. If physician fees are cut by 21%, it will bankrupt physician practices. A 21% cut in Medicare payment translates to $220 million a year in cuts for the care of the elderly, the disabled and the 58,763 employees, 644,028 Medicare patients and 238,777 TRICARE patients in Maryland. No industry in this state can sustain a pullback of that magnitude and delivery service at the same level.

It is time for the federal government to stop relying on the budget gimmicks and temporary measures used in the past that have only raised the cost of implementing a permanent solution. Congress has to eliminate the SGR if it is sincere in providing access to quality health care for all citizens. If SGR is not repealed, and the cuts are implemented this year, how many Maryland seniors and veterans will be without a doctor?

Sincerely,

Gene M. Ransom III, Esq.

Gene Ransom is the CEO of MedChi, the Maryland State Medical Society.

Save the Dates

April 21, 2010 - AAO Congressional Advocacy - Washington, DC

April 22-24, 2010 - AAO Mid-Year Forum - Washington, DC

May 7, 2010 - MSEPS Annual Scientific Assembly - Hilton BWI