



News

late-breaking news from your medical association

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STATE

CME Certification

The Medical Board of California changed its CME reporting requirements earlier this year. Physicians are now required to complete 50 CME hours during every two-year licensure period, as opposed to the previous 100 hours every four years. CME is also now calculated based on your personal license renewal date (the last day of the month of your birthday), not the calendar year.

DOI Issues Proposed Reg on Health Insurance Underwriting

The Department of Insurance (DOI) has issued proposed regulations that would impose more stringent requirements for health insurance underwriting in the individual market. The regs are designed to curb rescissions of policies by insurers on the grounds that applicants misrepresented their health status and/or health histories when they applied for coverage. The regs make clear to insurance companies that the DOI will make sure they do all their underwriting before they accept a policyholder and stop the insurer practice of reviewing policy applications for incriminating data once the policyholder becomes sick. A copy of the proposed reg can be viewed at www20.insurance.ca.gov/epubacc/reg/126389.htm.

NATIONAL

New Taxes to Accomplish Health Care Reform

President Obama has stated that he is open to taxing employer provided health benefits to pay for health care reform which is currently excluded from taxation. Such a tax change would raise enormous sums of money (\$518 billion per year) at a time the Administration is struggling to find the \$1-2 trillion needed to pay for such a reform over the next decade. At the same time Congressman Pete Stark has been calling for a 2 percent income tax surcharge. Another funding source to partially pay for this coverage includes ending or capping the income tax deductions that employers now take for the cost of providing health insurance to their employees. Obama continues to support a government-run public health care insurance plan. Something the AMA opposes. Also proposed is to beef up the powers of the Medicare Payment Advisory Commission making it a new federal agency modeled on the Federal Reserve with the power to alter Medicare reimbursement rates. With its expanded powers, MedPAC would address the increasing costs of Medicare.

Patient Education on Differences between Medicare and Medicare Advantage

The AMA has created two new educational resources for current and potential Medicare Advantage beneficiaries. These patient educational resources help educate patients and staff on the benefits and problems associated with participation in Medicare Advantage plans. Visit www.ama-assn.org/go/psa to view and download these patient resources, or call SMCMA.

Demographics of Medical Bankruptcy

A new study published in the American Journal of Medicine found that medical problems contributed to 62 percent of all bankruptcies in 2007 and that between 2001 and 2007, the proportion of all bankruptcies attributable to medical problems rose by nearly 50 percent. Further, 78 percent of those who experienced bankruptcy as the result of an illness were insured, and 60.3 percent had private coverage. Specifically, out-of-pocket medical costs for those experiencing bankruptcy because of medical bills averaged \$17,943 with variation among families based on their insurance plan. Out-of-pocket costs were \$26,971 for uninsured, \$17,749 for those with private insurance, \$14,633 for those with Medicaid, \$12,021 for those with Medicare, and \$6,545 for those with VA/military coverage. The co-author of the study, Harvard-based Himmelstein, compared private insurance to “an umbrella that melts in the rain.”

Bill to Ban Reverse Payments to Delay Entry of Generics

The Commerce, Trade, and Consumer Protection Subcommittee has approved a bill (HR 1706) that would prohibit brand-name drug companies from making payments to generic drug companies to delay the market entry of a generic drug. The bill now moves to the Energy and Commerce Committee. These payments are part of patent settlements between branded and generic drug companies. The legislation would prohibit generic drug companies from receiving “anything of value” from brand-name drug companies for agreeing not to research, develop, manufacture, market, or sell, for any period of time, a generic drug. The legislation also calls for the GAO to conduct a study two years after enactment of the proposed legislation to analyze the impact of the legislation on patent litigation and whether the legislation resulted in earlier or delayed entry of generic drugs to market.

Lack of Access to Beds Key Factor in Emergency Room Crowding

The GAO recently released a report stating that hospital emergency rooms continue to be overcrowded with lack of access to inpatient beds a leading factor. When a bed is not available to ill and injured patients who require hospital admission, the ED may board them and these patients take up extra treatment spaces and ED resources, leaving fewer resources available for other patients. Because of the delays caused by a lack of access to inpatient beds, ambulance diversion continues to happen and hospital wait times increase. The report states that one-fourth of all hospitals went on diversion at least once in 2006. A copy of the report is available at www.gao.gov/new.items/d09347.pdf.

OIG Claims DHHS Loses Billions By Not Acting On Its Recommendations

The Department of Health and Human Services would have saved at least \$7.7 billion as of December 2008 if it had implemented recommendations made by the Health and Human Services Office of Inspector General, according to a new study. In 2008 the OIG claims that one such instance not acted upon was to ensure that Medicare Part D sponsors’ bids and prospective payments were accurate. CMS needs to ensure plan sponsors’ bids accurately reflect their costs to provide the Medicare drug benefit. The OIG also said that in 2007 it determined that Part D sponsors owed Medicare \$4.4 billion for the 2006 benefit year in overpayment that resulted from inaccurate bids. Furthermore, the OIG said 80% of all sponsors owed money back to Medicare for that year. Other recommendations not acted upon included one recommendation to save the Medicaid program \$966 million in additional rebates for generic drugs had CMA pursued legislative changes that would have required rebates for generic drugs to be inflation-adjusted as they are for brand-name drugs.

Expected Out-of-Pocket Spending Increase

Health Affairs Web Exclusive reported that health plans covered slightly fewer expenses in 2007 than in 2004, but out-of-pocket spending grew more than one-third because of growth in overall health spending. For people at 200 percent of the federal poverty level, the percentage spending more than 10 percent of their income out-of-pocket on premiums plus services increased from 13 percent to 18 percent. Expected out-of-pocket spending for all medical services rose for high- and low-cost patients. For all adults, expected spending increased 34 percent, from \$545 to \$729. For the highest-cost 1 percent and 10 percent of adults, expected out-of-pocket spending rose 42 percent and 39 percent, respectively, to \$8,703 and \$3,364. Fifty-seven percent of the increase in workers' out-of-pocket payments was attributable to higher cost-sharing for medical services and 434 percent to higher premium contributions. <http://content.healthaffairs.org/cgi/content/abstract/hlthaff.28.4.w595?ijkey=26lWqhF1By26E&keytype=ref&siteid=healthaff>

EHR "Meaningful Use" HIT Policy Committee Initial Recommendations

The meaningful use workgroup of the HIT Policy Committee has released its initial recommendations for a definition of "meaningful use" of electronic health records. You will recall that under the federal economic stimulus law, providers must meaningfully use EHRs to receive financial incentives from Medicare and Medicaid. While not a formal definition they are the initial recommendations of the functionalities that will be required by 2011 when incentives start. The initial recommendations include 22 objectives for EHRs in 2011. For a copy of the recommendations go to: www.healthdatamanagement.com/news/meaningful_use-38487-1.html

David Blumenthal, the national coordinator for HIT, recently told the WSJ that in defining meaningful use, his office would focus "on performance, rather than any specific technology...We don't care how you accomplish critical tasks, so long as you do so with electronic technology."

How Safeway Cuts Healthcare Costs

Safeway CEO, Steven Burd is utilizing market-based solutions to reduce his healthcare costs. He believes the key to savings is plans that reward healthy behavior. In 2005, borrowing from the auto insurance model, Safeway designed a healthcare plan that capitalizes on two key points: that 70% of all healthcare costs are the direct result of behavior and that 74% of all costs are confined to just four chronic medical conditions. In Safeway's voluntary program, participants are initially tested for chronic medical conditions in order to receive discounts off a base premium for each test passed. If a participant does not pass a test, he or she can be tested again in 12 months, and if progress is made, the company provides a refund equal to the premium difference established at the beginning of the year. Since 2005, Safeway has kept its per capita healthcare costs flat, while most American companies' costs have increased 38% over the same four years.

Higher Hospital Spending Not Linked to Better Quality Care

According to a study of individual hospitals published by Health Affairs Online Journal in May, no evidence was found that hospitals with higher spending provided better care, whether the focus was on all hospitals across the country or limited to academic medical centers or hospitals within a single region. Researchers analyzed end-of-life spending and found that average EOL costs ranged from \$16,059 for the hospitals in the lowest quintile to \$34,742 for those in the highest. The report is available at <http://content.healthaffairs.org/cgi/content/full/>



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NATIONAL

Half of U.S. Hospitals Never Report Sanctions to NPDB

Nearly half of U.S. hospitals have never reported any physician sanctions to the National Practitioner Data Bank. As the only national repository for the records of doctors disciplined for unprofessional conduct, a report compiled by Public Citizen, "Hospitals Drop the Ball on Physician Oversight," suggests that the usefulness of the data bank has been historically handicapped by the failure of thousands of hospitals to report to the NPDB. The report focuses on two causes of under reporting: failure to report and failure to discipline questionable physicians. The report is available at www.citizen.org/publications/

Families Pay \$1,000 More for Coverage to Offset Costs of Uninsured

A study conducted by Families USA reports that American families paid about \$1,017 in additional health insurance premiums in 2008 due to cost shifting by providers to make up for treating the uninsured. Families USA said this "hidden health tax" is the result of the delivery of unpaid medical care totaling \$42.7 billion in 2008. As more people join the ranks of the uninsured, the hidden health tax is growing. The report concluded that due to the economic downturn, with more people losing their jobs and their healthcare coverage, it is highly likely that the hidden health tax for 2009 will be considerably higher than 2008.

MEDICARE

Have You Received a Redetermination Request from Palmetto?

Palmetto has been receiving individual redetermination requests for overpayments containing multiple beneficiaries and/or multiple claims with only one Accounts Receivable (AR)/Financial Control Number (FCN). If you receive a demand letter for an overpayment with multiple beneficiaries/claims and wish to appeal, you must submit the redetermination request as one bulk request, not individual requests for each claim or beneficiary. Include a completed Redetermination Request Form, a copy of the first page of the overpayment demand letter, a copy of the spreadsheet identifying the claims included in the overpayment, and a copy of the medical records for each claim included in the appeal. Do this promptly to avoid your future claims being offset.