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"Doc Fix" Still Under Consideration

On July 18, Representative Michael Burgess (R-TX) introduced a bill that would give Congress a quick-and-dirty option for averting a 27% cut in Medicare pay for physicians in January. The ***Assuring Medicare Stability and Access for Seniors Act of 2012*** – H.R. 6142 – would freeze Medicare rates at their current level through 2013, thus postponing a cut until January 1, 2014.

Of the three bills floated this year to deal with the Medicare reimbursement issue, the legislation from Burgess appears to be the most passable. A more ambitious bipartisan bill introduced in May would scrap the sustainable growth rate (SGR) formula that Medicare uses to set physician pay, phase out fee-for-service reimbursement, and replace it with a system that rewards physicians for high-quality, low-cost care. The high price tag of the bill – the ***Medicare Physician Payment Innovation Act of 2012*** – makes passage unlikely in an election year.

A bill from Senator Rand Paul (R-KY) also would eliminate the SGR formula and give physicians Medicare annual raises equal to increases in the Consumer Price Index, up to 3%. Paul proposes to offset the cost of his bill, which he puts at $440 billion, by repealing Medicaid expansion and premium subsidy payments under the ***Patient Protection and Affordable Care Act*** (PPACA). This bill also has dim prospects because Democrats who control the Senate have vowed to protect the PPACA from wholesale gutting.

Representative Burgess is on record stating that his bill would cost roughly $20 billion. It does not offer any "pay for" to make it budget neutral, but Burgess has stated that a deficit-reduction bill passed by the House in May and now awaiting Senate action would free up enough money to fund H.R. 6142.

Burgess introduced his legislation with the goal of passing it before the November general election. Otherwise, the effort to stave off a 27% pay cut could take a back seat to a set of more pressing issues facing Congress at the end of 2012: the expiration of the tax cuts enacted during the George W. Bush administration, $1.2 trillion in automatic spending cuts mandated by last year's debt-ceiling deal, and the need to raise the debt ceiling again.

Study Finds Similar Patterns of ED Visits by Medicaid and Insured Patients

Contrary to popular belief that Medicaid patients often use EDs for routine care, a study by the nonpartisan Center for Studying Health System Change released July 11 found the majority of patients visit EDs for symptoms that suggest emergent or urgent medical problems. The study, ***Dispelling Myths About Emergency Department Use: Majority of Medicaid Visits Are for Urgent or More Serious Symptoms***, funded by the Robert Wood Johnson Foundation, examined the ED visits of Medicaid patients from birth to age 64, as well as the visits of those with private insurance.

The study showed that slightly more than half of Medicaid and private insurance visits to EDs in 2008 **(Cont'd page 2)**

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were categorized as emergent or urgent. Specifically, 5l.5% of the visits by Medicaid patients were categorized as emergent or urgent. The rest of their visits were classified as semi-urgent needing care in two to 24 hours (22.6%), nonurgent (nearly 10%), or unknown/no triage (15.8%). As for the ED visits by patients with private insurance, 54.9% were for emergent or urgent care, while 7% were for nonurgent, routine care.

Although the study concludes that many of the concerns of policymakers and providers that Medicaid patients' heavy reliance on EDs is a problem that contributes to crowding, long waits, high costs, etc. are misconceptions, it also shows that non-elderly Medicaid patients do use EDs at higher rates than non-elderly privately insured patients. Non-elderly Medicaid patients' ED visits accounted for 45.8 visits per 100 enrollees, while the visits by non-elderly privately insured patients accounted for 24 visits per 100.

To reduce overall ED use, the study suggests that policymakers consider how to encourage development of lower-cost alternative care settings that can "provide prompt care for urgent cases and have appropriate services and equipment to diagnose and treat minor cases."

The study can be found at **http://www.hschange.org/CONTENT/1302/**.

Congressional Report on 'Gray Market' Released

According to a congressional report released July 25, a growing number of prescription drugs in short supply are being sold to hospitals at extreme price markups. When providers are unable to obtain drugs directly from manufacturers or authorized distributors, they sometimes purchase them from "gray market" vendors at much higher prices.

The report by congressional staff, ***Shining Light on the "Gray Market,"*** was released during a Senate Commerce, Science and Transportation Committee hearing. It reviewed 300 drug distribution chains and found that prescription drugs leaked into the gray market through pharmacies more than 69% of the time, often being bought and sold multiple times before reaching a hospital or other health care facility. The report noted that many hospitals and other stakeholders expressed concern about the safety of drugs purchased from gray market companies because they did not understand how gray market vendors obtain short-supply prescription drugs.

The hearing and report are part of an ongoing bicameral investigation into why hospitals and other health care providers are having difficulty obtaining prescription drugs they need to treat patients with cancer and other life-threatening conditions. The report was prepared for Senators John D. Rockefeller IV (D-WV) and Tom Harkin (D-IA) and Representative Elijah E. Cummings (D-MD).

During the hearing, Harkin said the report "makes clear that there are weaknesses in our drug supply chain that allow some bad actors to obtain shortage drugs through highly questionable methods and to charge hospitals exorbitant prices for critical drugs." Rockefeller noted that lawmakers and investigators are not sure about everything that happens to the drugs while they are being passed "from hand to hand" in the gray market. "But here's one thing we do know—every company in the chain charges a big markup. By the time the gray market has done its work, a cancer drug that originally cost $10 or $12 has become a drug that cost $500 or even $1,000. This kind of price gouging is disgusting and indefensible."

According to the report, price gouging occurs in the gray market primarily because of drug shortages, which have been concentrated primarily in the area of generic sterile injectable drugs. When drugs are not available, providers sometimes are forced to delay treatments or procedures, or to attempt to use an (Cont'd page 2)

Congressional Report on 'Gray Market' Released (Cont'd from page 2)

alternative treatment that may be potentially less effective.

The House Oversight and Government Reform Committee in June released a report that said enforcement activities by the Food and Drug Administration were largely to blame for shortages. In a July 23 letter released by Democrats on the House committee, however, the FDA responded to the report and said it is not to blame for drug shortages. The agency said more than half of all shortages in recent years were a result of manufacturing problems, including quality issues and delays.

During the Senate hearing, stakeholder groups and providers decried the gray market price gouging practices. David Mayhaus, chief pharmacy director at Cincinnati Children's Hospital Medical Center, said how important it was to ensure adequate supply of medications for pediatric patients. "It is a daily reality that the buyers in our division receive emails and phone calls from alternative wholesalers," Mayhaus said. He also noted that the calls increase when a new or critical drug goes into a shortage situation. Since the drugs are critical, the hospital often has no choice but to pay sometimes up to 35 times the normal pricing.

John Coster, senior vice president of government affairs for the National Community Pharmacists Association, told the committee of recent "troubling reports" of shell pharmacies established for the sole purpose of buying medications in short supply in order to resell them to secondary wholesalers.

Patricia Earl, an industry analyst with the National Coalition of Pharmaceutical Distributors, however, told skeptical lawmakers that the fake pharmacies and gray market markups were an "anomaly," and that the pricing process of certain drugs is more complicated than it may initially appear. The price markup "is not all profit," she said.

The report can be found at **http://democrats.oversight.house.gov/images/stories/7.25.12%20Staff%20Report%20Shining%20Light%20on%20the%20Gray%20Market.pdf**.

FDA's letter about the earlier report is at **http://democrats.oversight.house.gov/images/stories/2012-5778.Cummings.drug%20shortages.response.final.pdf**.

From the States . . .

Medical Malpractice Bills Introduced in Michigan

Michigan Senate Bill 1110 and House Bill 5579 have recently been introduced by Senator Roger Kahn (R) and Representative Kenneth Horn (R), respectively, to restrict medical malpractice lawsuits against ED physicians to cases of gross negligence.

Introduced by **Michigan** Senator Arlan Meekhof (R), Senate Bill 1116 would establish "the exercise of medical judgment" as a valid defense in medical malpractice cases, defined as a "reasonable and good-faith belief that the person's conduct is both well founded in medicine and in the best interests of the patient." This would be a "question of law" for the courts to decide.