

4.4% Cut for Medicare Physician Payments Goes into Effect January 1st

Due to procedural issues in the House and Senate, Congress failed to prevent the Medicare physician payment cut before its first session came to a close on Thursday, December 22, 2005. Although the conference report on S.1932 – *Deficit Reduction Omnibus Reconciliation Act of 2005* – was passed by the Senate December 20 by a 51-50 vote, Senate Democrats used a parliamentary procedure to send the measure back to the House for a second vote. The House had approved the conference report in the early morning hours of December 19 by a 212 to 206 vote.

In a December 22 letter to House Speaker Dennis Hastert (R-IL), the Minority Leader Nancy Pelosi (D-CA) told Hastert that she would not allow budget reconciliation legislation containing \$11 billion in Medicare and Medicaid spending reductions to be considered via unanimous consent. House Democrats are objecting to the conference report because of the increases to Medicaid co-payments and premiums that are contained in it.

The House unofficially wrapped up its business for the year earlier this week with the majority of members returning to their home districts for the holidays. Only a handful of members were available for a pro forma session yesterday to consider measures that can only be passed by unanimous consent or a voice vote.

The House is now faced with bringing the House back to vote on the measure before the end of the year, early in January, or when it is scheduled to reconvene on January 31. Pelosi told Hastert House Democrats would cooperate in pulling out numerous provisions from the conference report and passing them as separate legislation, such as a Medicare payment increase for physicians and funding for state high-risk pools under Medicaid. Under current law, Medicare payments to physicians will be reduced 4.4% effective January 1, 2006. The conference report eliminated the cut and replaced it with a 0% update in payments.

New Study Points to Compromised Access to Emergency Care

According to a study released November 18, 2005, by the Center for Studying Health System Change (HSC), converging pressures in hospital EDs – ranging from persuading specialists to provide on-call coverage to dealing with the growing numbers of patients with serious mental illness – have the potential to compromise access to

emergency care and aggravate already rapidly rising health care costs. In its report, *Rising Pressure: Hospital Emergency Departments as Barometers of the Health Care System*, HSC, a nonpartisan policy research organization funded principally by The Robert Wood Johnson Foundation, found that the rising pressure in EDs is a systemic issue that includes financial incentives that reward specialist physicians for performing more procedures outside general hospitals; diminishing access to primary care; declining funding for community-based mental health services; and financial pressures on hospitals to pursue business strategies of seeking higher-paying patients and services. (Cont'd page 3)

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Third Meeting of EMTALA Tag Held

At its meeting held on October 26-28, the EMTALA Technical Advisory Group (TAG) discussed the problems general hospitals have in providing on-call emergency services, and how EMTALA regulations might apply to physician-owned, specialty hospitals. Representatives of national hospital associations told the group that physicians practicing in specialty hospitals should be required to provide support for on-call services in the EDs of their local community hospitals.

In written testimony to the group, Federation of American Hospitals (FAH) Vice President and General Counsel Jeff Micklos stated that physician-owned, limited service hospitals can have a negative impact on the ability of a community to treat emergency patients, because many specialty hospitals do not have an ED. As a result, Micklos said, "physicians who have transitioned their practices to those limited service facilities are often no longer available to the community for purposes of providing on-call coverage to the community hospital's emergency department."

Charles Hart, President and CEO of Regional Health, who testified on behalf of the American Hospital Association (AHA), characterized community hospitals' decreasing ability to maintain the physician capacity necessary to provide emergency services as a "constant threat of an EMTALA violation." Hart recommended that specialty hospitals be required to have a pre-existing agreement with community hospitals on which they intend to rely for emergency back-up services. The agreement should address provisions to support the full-time, emergency capacity within community hospitals, including on-call coverage.

In a previous letter to the TAG dated March 30, the American Medical Association noted that providing on-call emergency services was a problem that preceded specialty hospitals. The physician group said, "Emergency departments have become this country's health care for the uninsured and it is extremely difficult for either hospitals or physicians to finance this growing level of uncompensated care."

The TAG also examined whether specialty hospitals should be federally required to maintain an ED, and whether they are subject to EMTALA requirements under which a Medicare-participating hospital with specialized capabilities or facilities may not refuse to accept an appropriate transfer of a patient in need of such capabilities or facilities. Both the FAH and the AHA argued against requiring specialty hospitals to maintain an ED, because they generally do not have the capability to provide service in all emergency situations. While both associations agreed that EMTALA requires specialty hospitals to accept patients transferred to their facility when they have the capacity to treat them, Hart said, "It is unlikely, however, to have much of an effect on emergency access to specialty services." He maintained that the most important issue is the on-call requirement for specialty hospital physicians.

HHS Releases Pandemic Flu Strategy

On November 2, the Department of Health and Human Services (HHS) released the medical and public health component of the Bush Administration's pandemic flu strategy – a [400-page plan](#) detailing the agency's guidance to national, state, and local policy makers and health departments to help speed preparations for a possible avian flu outbreak. The HHS plan specifies four major components of preparedness and response to a flu pandemic:

- T** Intensifying surveillance and collaborating on containment measures, both international and domestic;
- T** Stockpiling of antivirals and vaccines, and working with industry to expand production capacity;
- T** Creating a seamless network of federal, state, and

local preparedness, which includes increasing health care surge capacity; and

- T** Developing education and communications efforts to keep the public informed.

The plan also offers guidance in a variety of areas, including staffing and supplies required for a surge in patients, and distribution of vaccines and antiviral drugs – particularly when they are in short supply. It also outlines the roles and responsibilities of community decisionmakers, and suggests measures to control infection and limit the spread of disease.

HHS Secretary Mike Leavitt said, "An influenza pandemic would test our nation's health care ([Cont'd page 3](#))

HHS Releases Pandemic Flu Strategy (Cont'd from page 2)

system as never before, and this plan anticipates the specific problems we will face and recommends solutions to better protect the American people." He added, "The preparations we make for a pandemic today will have lasting benefits for public health and for our ability to be better prepared for any emergency, whether it's a deadly virus or another public health emergency."

As for funding, Bush asked Congress for \$7.1 billion. His request included \$6.7 billion in additional 2006 appropriations for HHS, of which approximately \$4.7 billion would go toward investments in creating vaccine production capacity and stockpiles, \$1.4 billion toward stockpiling antiviral drugs, and \$555 million toward surveillance and public health infrastructure and communications. The latter amount includes \$100 million for state and local preparedness.

New Study Points to Compromised Access to Emergency Care (Cont'd from page 1)

Numerous reasons were cited for specialist physicians' waning interest in taking ED on-call coverage: the perceived higher risk of malpractice litigation, lack of reimbursement for uninsured patients, opportunity costs in terms of time of a physician's obligation in return for hospital admitting privileges, and as specialists provide more services outside general hospitals, they are less dependent on having privileges at general hospitals," said HSC Senior Researcher Ann S. O'Malley, M.D., co-author of the study.

EDs serve as the care provider of last resort for insured and uninsured patients alike who cannot access care elsewhere. They are the one place in the U.S. health system where people cannot be turned away regardless of their insurance status or ability to pay. In the face of these pressures, ED visit rates continue to grow steadily. During the past decade, the number of ED visits nationally rose 26% – from 90 million to 114 million in 2003 – much faster than the 11% growth in the U.S. population during the same period.

January Report Warns Nation Unprepared for Medical Disaster

Following the hurricanes that hit Florida in 2004, Tom Ridge, then-Secretary of the Department of Homeland Security (DHS), called for a review of the nation's medical preparedness. St. Louis transplant surgeon Jeffrey Lowell conducted that review. His report, *Medical Readiness Responsibilities and Capabilities: A Strategy for Realigning and Strengthening the Federal Medical Response*, was issued on January 3, 2005 – some eight months before hurricanes Katrina and Rita hit. It warned that the nation was woefully unprepared for a medical disaster and lacked a coherent plan for taking charge of mass casualties.

The report noted the difficulties government medical teams had in coordinating and delivering help during the 2004 hurricane season, and concluded that the planning for dealing with a surge of patients during a disaster such as a biological or nuclear attack would be inadequate. It also called for a uniformed medical reserve corps, including specialists, fashioned after the National Guard, and said, "The nation's medical leadership works in isolation, its medical response capability is fragmented and ill-prepared to deal with a mass casualty event and . . . DHS lacks an adequate medical support capability for its field operating units." (Cont'd page 4)

"I thought it (the report) was a great place to start. Most people in the medical community who are concerned about readiness, preparedness, disaster medicine and so forth felt pretty much the same way. . . . There are parts of that report that are absolutely unanimous with what the (medical) community has been saying, and other parts of the report that are very specific organizational things that are not really what Secretary Chertoff has in mind."

– Dr. Jeffrey Runge, Chief Medical Officer, DHS

January Report Warns Nation Unprepared for Medical Disaster (Cont'd from page 3)

Other conclusions contained in the report were:

- < National Disaster Medical System teams often are deployed without full preparation for the disaster they are handling. "Recent deployments to Florida following the 2004 hurricanes confirmed critical shortfalls in doctrine, training, logistics support and coordination."
- < It is "imperative" that DHS realign its resources and create the job of an assistant secretary of medical readiness.
- < Conflicts in legislation, a presidential directive, and the National Response Plan must be reconciled to eliminate overlapping responsibilities and authorities and questions about who takes charge. "Politically adversarial turf wars between (Homeland Security) and (Health and Human Services) and similar battles between organizational units within DHS threaten DHS' ability to lead effective medical response in the event of a national medical event."
- < The government's lack of a single coordination point for local emergency medical services in communities is cause for "significant concern."
- < The nation lacks a "systemwide strategy" for handling a massive surge of patients. "The ability to provide care to large numbers of casualties following a

major incident remains one of the greater challenges and vulnerabilities."

- < DHS officials said the problems identified in the report were in the process of being addressed when this year's hurricanes hit. They noted that Secretary Michael Chertoff, who took over a month after the report was issued, was reorganizing DHS and had created two new positions: an undersecretary for preparedness and a chief medical officer to take the lead on preparedness.

Lowell, however, does not believe DHS has implemented enough changes yet. He said that the current system of volunteer disaster medical teams was "pretty much shot" when called upon to respond to a second disaster after Katrina. He revealed that Mike Brown, then-Federal Emergency Management Agency chief, had strongly rejected the report, but that Ridge had heartily welcomed its conclusions and recommendations. In urging that more recommendations be implemented, Lowell said, "If people want to tweak it (the report), great. Let's get on with this and move forward quickly."

AHIC's Focuses on Public Health Threats and Records Access

The new federal advisory panel created to recommend specific actions to foster development of a secure, interoperable electronic health information system agreed to initially focus on a handful of specific projects, including rapidly improving biosurveillance for public health threats. The American Health Information Community (AHIC), as the 17-member panel comprising private and public sector officials is called, also agreed to consider ways of using technology to secure quick improvements in the monitoring and treatment of patients with chronic diseases, as well as patients' access to and use of their own medical records.

HHS Secretary Michael Leavitt, the AHIC Chair, told the panel that he wants it to recommend innovations that can be adopted quickly. He also said he wants the panel to move the nation toward President Bush's goal of widespread adoption of interoperable electronic medical records by 2014. Leavitt and David Brailer, the National Health Information Technology Coordinator, presented AHIC with 13 "potential breakthroughs" covering three categories. The breakthroughs are intended as core building blocks from which AHIC can select pathways for rapid progress.

The breakthroughs in the first category, **consumer empowerment**, help individuals manage their health care and advocate for themselves as they use health care services. Examples are personal medical records and an electronic medical/registration process for doctors' offices and hospitals. Under the second category, **health improvement**, the breakthroughs help physicians and hospitals deliver safe and informed medical care, such as electronic health records giving clinicians direct access to a person's medical history. In the third category, **public health protection**, the breakthroughs allow for almost instantaneous awareness and informed medical response (Cont'd page 5)

AHIC's Focuses on Public Health Threats and Records Access (Cont'd from page 4)

to episodic and unexpected threats, ranging from ED visits after accidents and natural disasters, to the public health threats of bioterrorism and the potential bird flu pandemic.

Secretary Leavitt said he hopes that AHIC will find ways to combine the market power of the federal government, which spends more than \$100 billion on health care annually, with the market innovation of the private sector. He also emphasized his desire for quick successes, such as having patients assemble and "own" their health records. The panel had a range of opinions on this and other issues. As for the practicality of asking individual Americans to become personally accountable for their medical records and prescription data, the roadblocks cited ran the gamut from the sheer volume of paper records, to the confidentiality of medical records, to the lack of health literacy on the part of many Americans. Leavitt said a working group will look at the problem and offer potential solutions, and perhaps suggest a business model.

At its next meeting, AHIC will examine the status of electronic prescription programs and consider the challenging issues of acquiring useful data for improving health care quality and disseminating it to patients and those paying for health care. For more information about AHIC's meetings, go to www.hhs.gov/healthit/ahic.html.

The States: Medical Malpractice Update

T FL Court Seeks Rules on Waiving Fee Caps

The **Florida** Supreme Court has asked the **Florida** Bar to draft rules that would enable lawyers to continue to bypass a state constitutional amendment that limits their share of medical malpractice awards. The justices have not made a final decision on the issue, but on December 14 unanimously ordered the bar to propose a procedure for clients to waive the fee limitations. In ordering the bar to draft proposed rules, the justices suggested it include oversight or reviews by judges to ensure clients' rights are protected.

The amendment, approved by voters last year, was initiated by the **Florida** Medical Association as a way to reduce malpractice costs. Amendment 3 limits lawyers to no more than 30% of the first \$250,000 of an award and 10% of anything above that amount.

Lawyers have been avoiding the caps by getting clients to sign waivers of their rights under the amendment. The Medical Association responded by asking the Supreme Court to adopt a professional rule that would require lawyers to abide by the amendment's limits.

The **Florida** Justices appeared deeply skeptical about the doctors' requests, which suggest that any citizen has a right to waive a constitutional right.

Justices also questioned why the **Florida** Bar, which is responsible for regulating attorneys, had not submitted guidelines for medical malpractice cases when professional rules cover other contingency fees, including procedures for waivers.

T Hawaii Considers Doctor-Apology Law

The **Hawaii** State Bar Association and the Honolulu County Medical Society have recommended that the state enact a law to allow physicians and hospitals to apologize for medical errors without increased liability risk. The groups plan to form a committee to examine similar laws in other states, such as Arizona, Colorado, Florida, Illinois, Missouri, North Carolina, and Oregon. The **Hawaii** Medical Claims Conciliation Panel has offered to help the two groups draft the proposed legislation.

T Caps off the Table in Iowa

According to members of a legislative panel studying **Iowa's** malpractice system, lawmakers will not be spending time next session debating whether to impose limits on damages that can be collected by injured patients. Explaining his opposition to such limits, Senator Keith Kreiman (D-Bloomfield) said, "They don't lower the cost of malpractice insurance, and they take away the rights of injured Iowans." On the opposite side, Senator Bob Brunkhorst

(R-Waverly) favors setting the limits, but he acknowledged that the votes to make such a change simply are not there. Both sides agreed that, while lawmakers are likely to debate other medical malpractice issues when the Legislature convenes in January, capping damages will not be part of that debate.

Other proposals recommended by the panel for the Legislature's consideration include: prohibiting the use of physician apologies for medical errors as evidence in malpractice lawsuits; requiring medical experts to confirm the validity of malpractice lawsuits earlier in the litigation process; providing state funds to help specialists cover the cost of malpractice insurance; and requiring physicians and hospitals to report medical errors to the public.

T Kentucky Governor Calls for Medical Malpractice Reform

Kentucky Governor Ernie Fletcher (R) has stated that he will push for a constitutional amendment on medical malpractice lawsuits as part of his 2006 legislative agenda. Although attempts at offering voters a proposed constitutional amendment have failed in previous attempts, Fletcher said it is necessary to help keep doctors in Kentucky. He has not offered any specifics for his plan.

T Oregon Bill Clarifies Malpractice Reporting Requirements

Oregon State Senator Ginny Burdick (D-Portland) and Representative Wayne Krieger (R-Gold Beach), leaders of the Interim Judiciary Committee, are preparing a bill clarifying that malpractice claims against all **Oregon** doctors must be reported to the state. The bill is in response to a series of articles published in *The Oregonian* that described how Kaiser Permanente Northwest and **Oregon** Health & Science University (OHSU) avoided reporting malpractice claims for more than a decade.

Kaiser and OHSU argued that existing reporting requirements did not apply to them. Now, however, both are turning over to the **Oregon** Board of Medical Examiners the records of past malpractice claims against their doctors, helping fill a gap of

more than 10 years in the state's ability to track malpractice records. Malpractice reports triggered about one in 10 of the Board's 313 investigations of doctors last year. Such reports accounted for less than 3% of disciplinary actions.

T Tennessee to Conduct Pretrial Assessments of Expert Witness Testimony

Under a pilot program, sponsored in part by BlueCross-BlueShield of **Tennessee** and Unum-Provident, judges in the state's malpractice lawsuits can select independent experts to conduct pretrial assessments of planned expert witness testimony. The purpose of the program is to determine whether such assessments can reduce unfounded expert witness testimony. In accordance with rules agreed to by the Medical Society of Chattanooga and Hamilton County and the Chattanooga Bar Association, judges in malpractice lawsuits with conflicting testimony from expert witnesses will ask a panel of physicians to recommend several independent experts from other states. The judges will select one of the recommended independent experts, and – provided that attorneys for both sides agree to the selection – that expert will assess the expert witness testimony and testify at an admissibility hearing two months before trial. Supporters, who include past presidents of the American Bar Association and the American Medical Association, maintain that the program could help reduce the number of malpractice trials and related legal costs.

T Virginia Lawsuit Data

According to data released this month by the **Virginia** Bureau of Insurance, about three-fourths of malpractice lawsuits filed in the state over the past three years resulted in no payments to plaintiffs. With more than 1,200 claims filed against physicians annually, payments to plaintiffs in malpractice lawsuits over the past three years totaled \$70 million annually. The average malpractice settlement among all physicians totaled about \$22,000; and the average settlement among obstetricians and general surgeons totaled \$383,500 and \$391,000, respectively. The amount malpractice insurers paid to plaintiffs over the past three years totaled \$221 million, although 60% of those payments totaled less than \$600,000 and only 33 totaled more than \$1 million.

T WA Voters Reject Malpractice Initiatives

In a bitterly rancorous campaign leading up to the November 8 election in **Washington**, doctors and trial lawyers spent a record \$14 million attacking each other over their competing medical malpractice initiatives. Voters, however, were not persuaded by either group; they resoundingly defeated both the doctors' initiative, I-330, and the lawyers' initiative, I-336.

I-330 would have limited plaintiffs' attorney fees and capped pain-and-suffering awards in medical malpractice cases at \$350,000. It also would have allowed providers to deny treatment to patients who refuse to sign agreements to resolve malpractice claims through arbitration rather than in court. I-336 would have revoked the license of doctors who lost three malpractice verdicts in 10 years and required public hearings on malpractice insurance rates.

Some see the defeat as a mandate for a legislative fix, and House and Senate Democratic leaders said they will try another run at an alternate plan they floated earlier this year. Their proposal includes pieces from both of the initiatives, with a heavy emphasis on provisions aimed at improving patient safety. It does not include any damage caps or limits on attorney fees, which may be a stumbling block for the two groups' reconciliation. While the doctors have said that such elements must be part of any compromise, the trial lawyers have made it clear that they will continue to fight any push for damage caps.

T Caps Bill Passes Wisconsin Legislature – Veto Stands

In **Wisconsin**, the Assembly and the Senate passed AB 766, a bill that would cap noneconomic damages in malpractice lawsuits at \$450,000 for adults and \$550,000 for minors. The bill also would require that recommendations be submitted every two years on how those limits should be increased. But because the state Supreme Court ruled in July that a similar law enacted in 1995 was unconstitutional, Governor Jim Doyle (D) vetoed AB 766 on December 2.

Wisconsin first established a limit on damages in malpractice lawsuits in 1975, when the state enacted a \$1 million cap on noneconomic damages. That cap expired in 1991, and in 1995 the state enacted a law that treated both adults and children the same and called for a \$350,000 cap to be adjusted annually for inflation. In July 2005 the state Supreme Court struck down the current cap which – with the annual adjustments – had risen to \$445,755.

In commenting on AB 766 and the Court's ruling, Dan Leistikow, spokesperson for the Governor, said, "It's pretty hard to imagine how \$450,000 is constitutional." He added that Doyle had wanted to work with legislators on a better solution to the problem, but "it doesn't look like they have done that." Since the Senate's party-line vote on AB 766 (all 19 Republicans voted for the bill and all 14 Democrats voted against it) is short of the two-thirds majority required to override a veto, Doyle's veto will likely stand, and it appears that the whole debate on caps will have to start over.