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Health Care Reform: An Update

Five congressional committees have jurisdiction over various aspects of federal health care reform: House Ways and Means, House Energy and Commerce, House Education and Labor, Senate Health, Education, Labor, and Pensions (HELP), and Senate Finance. All these committees have some health reform activity underway. Both the HELP and Finance Committees met with various members of the health community (largely of consumer and insurance groups) for months to develop compromise legislative packages. No doubt health industry interests, employers, and taxpayers are going to have to make painful concessions to raise the needed $1 trillion to cover a health reform plan of universal access to comprehensive care.

A showdown over a plan likely will surface when the committees start releasing health care reform legislation – to date they have only been dealing with drafts and prospective amendments. Inklings of the funding fight to determine the shape of the reform effort began in March when Congress started the budget resolution proceedings. In the FY10 budget resolution, both the House and Senate rejected President Obama's plan to set aside $634 billion as a "down payment" on his health care reform proposal – an amount that would have covered only about half the plan's expected cost. The rejection took the form of a refusal to commit any dollar amount to health reform.

In April and May, the Senate Finance Committee was the first to release a "trial balloon" version of what might be in its health care overhaul bill. These proposals focused on payment reform, primary care, chronic care management, workforce, health information technology, and care coordination. The Finance Committee now hopes to introduce its bill next week with mark up in mid-July. Finance Committee Chairman Max Baucus (D-MT) wants to get health care reform legislation to the Senate floor before the end of July.

The Senate HELP Committee released a draft (600+ pages) of their health care reform bill – the ***Affordable Health Choices Act*** (Kennedy Bill) – in early June. This legislation addresses access and affordability of health insurance, reforming the health care delivery system, prevention and wellness, and long term supports and services for seriously disabled Americans. For the last two weeks, the Committee marked up the bill completing the sections related to prevention, work-force, quality care, and fraud and abuse with most of the amendments considered negotiated and accepted or voted up or down by the Committee. When the Committee returns from the recess period next week, it will focus on coverage, public plan options, and the employer mandate.

The House committees with jurisdiction over health care reform – Energy and Commerce, Education and Labor, and Ways and Means – released their draft discussion bill on June 19, 2009 (800+ pages). All held hearings on the "Tri-Committee bill" in late June. Mark up of the legislation by these committees is expected to occur in July. During the hearings it was clear that the cost of health care reform and how the country will pay for it will be roundly debated.

The President wants to sign a health care reform bill into law by November. In order to meet the President's deadline, health care reform legislation must move through the committee and floor process in the House and Senate by the end of July with the conference process completed during September/October.

In this issue . . .

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GOP Calls Medical Liability Reform Essential for Health Care Access

During a hearing on access to health care held by the House Energy and Commerce Committee's Health Subcommittee, Republican members pushed for medical liability reform. In opening statements led by ranking subcommittee member Nathan Deal (R-GA) and ranking full committee member Joe Barton (R-TX), the Republican representatives stressed that medical liability reform must be a part of improving access to care. They emphasized that high malpractice insurance premiums were pushing physicians out of practice in some specialties and areas of the country.

One of the witnesses, James Bean, a neurosurgeon representing the American Association of Neurological Surgeons, strongly agreed with the GOP view that liability reform is needed. Bean said that one in three orthopedists, obstetricians, trauma surgeons, ED doctors, and plastic surgeons are sued every year. Bean also acknowledged that the current legal environment is leading to "defensive medicine." That environment, Bean said, also creates disincentives for physicians to report problems, such as preventable medical errors, because of their fear of liability. He proposed that reforming medical liability laws would make physicians more likely to report errors, which could lead to identifying and avoiding these errors. He concluded, "Those at the forefront of health care reform understand that it will do little good to achieve universal insurance coverage – if the doctors who actually supply the care are being driven from business, forced to retire early, or shun potentially risky, life-saving procedures."

Mixed Messages Sent on Changing Medicare's Physician Payment Formula

In President Obama's 2010 budget proposal released on May 7, the budget for the Department of Health and Human Services (HHS) reiterates Medicare cuts the Administration proposed earlier this year to pay for the overhaul of the nation's health care system. It also contains new details on the scheduled cuts in Medicare's payments to doctors and how the cost of legislation stopping those cuts might be reduced.

Tackling Medicare's physician payment system was expected to be one of the most expensive, complex problems in the health care system's reform efforts. The hope was that the efforts would produce a permanent new policy to replace the current system's cost control formula, known as the sustainable growth rate (SGR) and widely regarded as flawed. It appears, however, that a new policy will have to wait.

As for blocking the scheduled cuts called for by the SGR (21% in 2010), the cost is high. Budget documents show that preventing cuts and keeping doctor payments flat over the next ten years – one of the proposals under consideration – would cost $311 billion.

> "We'll patch it up for each of these next three years, but after that we'll let some of the reductions occur. But physicians will be compensated with some of the cost-sharing gains that hopefully will occur with some of these reforms."
>
> **– Senator Max Baucus (D-MT)**
> **Chair, Senate Finance Committee**

The HHS "Budget in Brief" document notes, "As part of health care reform, the administration would support comprehensive, but fiscally responsible, reforms to this payment formula. Consistent with this goal, the Administration will explore the breadth of options available under current authority to facilitate such reforms, including an assessment, both substantively and legally, of whether physician-administered drugs should be covered under the payment formula." The Centers for Medicare and Medicaid Services (CMS) estimates that not including the cost of those drugs in assessing adherence to physician spending targets would lower the 10-year legislative cost of a freeze from $311 billion to $181.5 billion. (In a press release, dated July 7, 2009, CMS announced that it is proposing to remove physician-administered drugs from the definition of "physician services" for purposes of computing the physician update formula.)

In a meeting with reporters, Senate Finance Committee Chair Max Baucus (D-MT) indicated that budget limitations will most likely preclude a permanent new payment policy in any bill produced this year. (Cont'd page 4)

CDC Survey on ED Capacity

The Centers for Disease Control and Prevention (CDC) has completed its latest National Hospital Ambulatory Medical Care Survey (NHAMCS) entitled ***Estimates of Emergency Department Capacity: United States 2007***. Conducted by the CDC's National Center for Health Statistics, NHAMCS was inaugurated in 1992 and is now the longest continuously running nationally representative survey of hospital ED use.

The report notes that, over the last several decades, the role of the ED has expanded from treating seriously ill and injured patients to providing urgent and unscheduled care for Medicaid and uninsured patients with no access to primary care. As a result, EDs are frequently overcrowded, with a common factor contributing to that crowding being the inability to transfer ED patients to an inpatient bed once the decision is made to admit them. "As the ED begins to 'board' patients, the space, the staff, and the resources available to treat new patients are further reduced," the report states. It continues, "A consequence of overcrowded EDs is ambulance diversion, in which EDs close their doors to incoming ambulances. The resulting treatment delay can be catastrophic for the patient."

According to the CDC survey, approximately 500,000 ambulances are diverted annually in the United States. The survey also shows that, while large, metropolitan EDs that serve more than 50,000 patients each year represent just 17.7% of all EDs in the nation, those large EDs accounted for 43.8% of all ED visits in 2007. The implication, according to the report, is that small EDs with annual visit volumes of less than 20,000 patients may not experience crowding.

Other data from the survey show that: one-half of all hospitals with EDs had a bed coordinator or "bed czar"; 58% had selective surgeries scheduled five days a week; and 66% had bed census data available instantaneously. Electronic medical records (EMRs) – either all electronic or part paper and part electronic – were reportedly used in 61.6% of EDs. While the use of basic EMR systems – i.e., those containing patient demographics, problem lists, clinical notes, prescription orders, and laboratory and imaging results – were reported in 14.9% of EDs, CDC could not accurately determine ED use of fully functional EMRs, i.e., those that also include prescription orders sent electronically, warnings of drug interactions or contraindications, orders for tests, out-of-range test levels highlighted, medical history and follow-up, and reminders for guideline-based interventions.

Additional survey data show that:

- EDs with more than 20,000 annual visits comprised more than 70% of EDs in metropolitan statistical areas (MSAs). When compared to EDs in rural areas, EDs in MSAs were more likely to have a bed coordinator in their hospital – 60.7% to 30%, and board patients for more than two hours in the ED while waiting for an inpatient bed – 77.4% to 32.8%.

- More than one-third of the EDs had an observation or clinical decision unit. Admitted ED patients were boarded for more than two hours in the ED while waiting for an inpatient bed in 62.5% of EDs. Among EDs that boarded patients, 14.8% used inpatient hallways or another space outside the ED when it was critically overloaded.

- In the previous two years, 24.3% of EDs increased the number of standard treatment spaces and 19.5% expanded their physical space. Of those EDs that did not expand their physical space, 31.5% plan to do so within the next two years.

- With respect to patient care techniques, 66.1% of EDs used beside registration, 40% used computer-assisted triage, 35.3% used zone nursing, 35.2% used electronic dashboards, 33.8% used a separate fast track unit for nonurgent care, 33.2% used pool nurses, 21.1% used full capacity protocol, and 9.8% used radio frequency identification tracking.

- In comparing large and small EDs based on visit volume and MSA status, large EDs were more likely to: have a bed coordinator in their hospitals – 71.2% to 33.8%; have an observation or clinical decision unit – 53.5% to 32.5%; board patients for more than two hours in the ED while waiting for an inpatient bed – 86.5% to 39%; use bedside registration – 89% to 54.2%; use computer-assisted triage – 62.2% to 24.3%; and use zone nursing – 61.9% to 19%.

GAO Study Finds ED Crowding Continues

According to a Government Accountability Office (GAO) report released June 1, hospital EDs continue to be overcrowded, with lack of access to inpatient beds continuing as the main contributing factor. For this report, GAO was asked to examine information made available since its 2003 report on the issue found that most EDs in metropolitan areas experienced some degree of crowding, and other reports often associated crowded conditions in EDs with adverse effects on patient quality of care.

The information GAO examined included three indicators of ED crowding – ambulance diversion, wait times, and patient boarding – along with the various factors contributing to crowding. In doing so, GAO reviewed national data, conducted a literature review of 197 articles, and interviewed individual subject-mater experts and officials from the Department of Health and Human Services (HHS) and professional and research organizations.

The national data showed that about one-fourth of the hospitals reported going on ambulance diversion at least once in 2006, and that wait times in the ED increased, and in some cases exceeded recommended time frames. According to GAO's analysis of 2006 data from HHS' Center for Disease Control and Prevention's National Center for Health Statistics, the actual wait times and the percentage of visits in which the wait times exceeded the recommended time frames based on patient acuity levels, were as follows:

Immediate – The average wait time was 28 minutes, with 73.9% of patients waiting longer than the one-minute recommended time frame.

Emergent – The average wait time was 37 minutes, with 50.4% of patients waiting longer than the maximum 14-minute recommended time frame.

Urgent – The average wait time was 50 minutes, with 20.7% of patients waiting longer than the maximum 60-minute recommended time frame.

Semiurgent – The average wait time was 68 minutes, with 13.3% of patients waiting longer than the maximum two-hour recommended time frame.

Nonurgent – The average wait time was 76 minutes, with no ED reporting wait times in excess of the maximum 24-hour recommended time frame.

Although national data on the extent to which patient boarding occurs are limited, the articles reviewed by GAO and the experts interviewed reported that the practice is a continuing problem due to the lack of access to inpatient beds. In turn, the lack of access to inpatient beds is due to the competition for available beds between hospital admissions from the ED and scheduled admissions, such as elective surgeries, that can be more profitable for the hospital. Officials from the Society for Academic Emergency Medicine told GAO that, "Because treating surgical conditions is considered more profitable for a hospital than treating emergency medical conditions, hospitals had an incentive to reserve beds for scheduled surgical admissions rather than to give them to patients admitted from the emergency department."

While the GAO found that studies on solutions to ED crowding are limited, strategies have been implemented in isolated cases. One solution found in case studies conducted at several hospitals was to streamline elective surgery schedules, thereby increasing the opportunity for ED admissions. Regarding ambulance diversion, some local communities have established policies that make diversion the last resort for any hospital, as it often leads to critical cases not receiving the immediate care they need. In other instances, either programs were developed that allowed on-call physicians to determine the best ambulance destination for the patient, thereby decreasing the amount of hours of diversion for two hospitals, or state policy was created to prohibit hospitals from going on diversion, unless under inoperable conditions. (Cont'd page 5)

Mixed Messages Sent on Medicare's Physician Payment Formula (Cont'd from page 2)

Instead, Baucus said he is counting on a host of other changes to how the government pays doctors to sidestep problems with the current payment policy.

Under the three-year patch he is proposing, the small increases in physician pay over those three years will eventually lead to future cuts once the patches expire and the Medicare formula kicks back in. Baucus said he is prepared to let those cuts go through, but – in return – physicians will be compensated with new bonuses for providing higher-quality, lower-cost care, along with other savings from government investment in efficiencies. Primary care doctors and general surgeons would also get higher rates as the government refocused the health care system on preventive care and lowering the cost of chronic diseases.

However, a spokesperson for Senator Charles Grassley (R-IA), the senior Republican on the Finance Committee, said that nothing was written in stone on the doctor payment issue. Also, it is unclear how physician-lobbying groups will respond to Baucus's proposals. One group – the American College of Cardiology – already expressed concern with the possible cut in payment rates for specialist physicians in order to boost primary care payment rates, along with eventual future cuts to all physicians.

As for the HHS budget and the proposed Medicare revisions, they include varying payment to hospitals by the quality of care they provide, and an incentive payment that "would link a portion of base operating payments to performance on specified quality measures." Those revisions would contribute $288 billion over 10 years to a reserve fund to help pay for the health care system overhaul. The HHS budget summary states, "The portion of payments linked to performance would be 5 percent in 2011, phasing to 15 percent by 2015. Payments not earned back would be split equally between a pool to fund additional hospital quality incentive payments and the Medicare Trust Fund." CMS estimates savings of $12 billion over ten years as a result. In addition, changes to encourage hospitals to improve quality of care to prevent readmissions would save $8.4 billion over that period.

GAO Study Finds ED Crowding Continues (Cont'd from page 4)

Strategies to decrease ED wait times focused on increasing the speed of laboratory results, accelerating care during the triage process by eliminating some of the administrative work associated with patients entering the ED, and implementing a system allowing nonurgent patients to be treated in less time by having a medical provider other than a physician see them. None of the strategies to address crowding have been assessed on a state or national level, however.

As for other factors contributing to crowding, the report listed the following: lack of access to primary care; shortage of available on-call specialists; and difficulties in transferring, admitting, or discharging psychiatric patients.

For the full report, go to **http://www.gao.gov/new.items/d09347.pdf**.

From the States . . .

California Bill Provides Relief for ED Crowding

The **California** State Assembly recently passed AB 911, a bill aimed at reducing dangerous overcrowding levels in **California** EDs. The bill also would help hospitals plan for and respond to public health crises. The specific provision in AB 911 that would resolve some of the major issues that create congestion in EDs is a requirement that all **California** hospitals create and implement a full capacity protocol. This plan calls for hospitals and EDs to assess the results of their National Emergency Department Overcrowding Scale score every three hours and then provide solutions to each stage of the overcrowding scale.

California is last in the nation when it comes to the number of EDs available per capita, providing only six EDs for every one million residents. Exacerbating this shortage of available facilities is the problematic practice of boarding patients in EDs.

Ohio Joins Other States in Seeking Protections against ED Malpractice Suits

Ohio is the latest state to introduce new legislation that would dramatically increase the legal standard to win a civil suit against a doctor working in an ED. The bill says physicians would have qualified civil immunity while working in EDs and be subject only to lawsuits if they showed "willful or wanton misconduct" – a high standard for liability usually reserved to determine punitive damages. While the bill adds that those protected by the measure are specifically providing services in compliance with EMTALA, some proponents say the legislation is meant to protect all physicians providing ED care.

Following on the enactment of similar laws in Florida, Georgia, South Carolina, Texas, and Utah, the **Ohio** bill is part of a second wave of legislation from other states – including Arizona, Michigan, Minnesota, and North Carolina – seeking such protections as well as special caps on damages in ED civil suits. Proponents promise that the laws will bring an end to the ED doctor shortage and protect physicians from frivolous suits. But, while opponents agree that the laws would protect doctors from ED errors, they also say the laws do little to solve the root problems that contribute to ED mistakes, such as understaffing and overcrowding.

Physicians' groups maintain that the increased threat of lawsuits is behind a shortage of ED physicians and the reason why other doctors resist working shifts in that department. Emergency physicians are fourth out of five practices listed individually in **Ohio**'s Medical Professional Liability Closed Claim Report. In 2007, the most recent year for the closed-claim report, about 11% of claims resulted in judgments against **Ohio** emergency physicians.

Texas credits malpractice reforms in 2003 – including its own emergency physician liability reform – for a resurgence in emergency medicine. According to a report by the state, twenty-four mostly rural counties have added emergency medicine physicians since passage of the legislation. But other factors, such as population growth in areas where new facilities and practices open, also could contribute to more facilities and physicians. And many states, including **Ohio**, which also passed reforms in 2003, have said it is still too early to say how legislation has contributed to change.

Oklahoma Enacts Multifaceted Lawsuit Reform

On May 21, **Oklahoma** Governor Brad Henry (D) signed into law HB 1630, the ***Comprehensive Lawsuit Reform Act of 2009***. The measure, which takes effect November 1, includes requirements for written opinions from qualified experts in medical malpractice cases, limits noneconomic damages in most cases to $400,000, provides for a state reinsurance program to pay for damages in cases where the cap is lifted, and establishes rules governing medical volunteers serving during an official emergency.

The expert opinions requirement specifies that plaintiffs bringing professional negligence actions attach an affidavit stating that they have reviewed the claim with a qualified expert, who has provided them with a written opinion concluding that the facts support a claim against the defendant. The expert's opinion will not be admissible at trial, but plaintiffs must provide the defendant with a copy on request, and must also allow the defendant access to their health records. Unlike a similar law in Texas, which requires that an expert report in a health care liability action be served on the defendant within 120 days of filing suit and provides for dismissal with prejudice if the report is not served or if it is ultimately found inadequate, the **Oklahoma** law requires only dismissal without prejudice if the affidavit is not provided or if the plaintiff does not give the defendant a copy of the report on request.

While economic damages remain unlimited, the new law caps noneconomic damages in all cases involving bodily injury – including, but not limited to, medical malpractice – at $400,000, except in exceptional circumstances. Such circumstances include cases where a jury or judge dealing as a fact finder conclude: that a plaintiff has suffered either "permanent and substantial physical abnormality or disfigurement," or a permanent injury that "prevents them from being able to independently care for themselves"; or that the defendant acted in "reckless disregard for the right of others," was grossly negligent, or acted fraudulently, intentionally, or with malice. Similar standards apply to all tort cases. The jury is not to be instructed about the cap on damages, but must answer certain interrogatories as part of issuing their verdict.

The newly established Health Care Indemnity Fund will be used to pay for damages in cases where the cap on noneconomic damages should be exceeded. The fund, which will not begin to operate until after a task force set up by the statute makes recommendations on how it is to be run, will have $20 million for such damages, and the state will purchase a reinsurance policy to support it. Doctors must have at least $1 million in malpractice coverage to qualify for payments from the fund.

To govern the work of medical professionals working with disaster relief organizations during a declared emergency, the new law establishes a ***Uniform Emergency Volunteer Health Practitioners Act***. This provision establishes a registration system designed to address licensing and credentialing of health professionals. In addition, the law allows doctors from other states to practice in **Oklahoma** during an emergency, and it also protects volunteers from some liability.

Both the governor and the Republican-led Legislature praised the legislation, which reflects compromises on both sides. In a press release issued after he signed the bill, Henry said, "This legislation enacts reasonable and responsible reforms that improve the civil justice system without impairing a citizen's constitutional right to have his or her legitimate grievances appropriately addressed in court."

Short . . .

Online Health Reform Comparison Tool Updated

The Kaiser Family Foundation has updated its health reform gateway page (www.kff.org) to include in the site's side-by-side comparison tool detailed summaries of new comprehensive health reform legislation proposed by the three key House committees (known as the "Tri-Committee" bill) and by the Senate Health, Education, Labor and Pensions (HELP) Committee. With the additions, the interactive online comparison tool now allows comparisons of nine major congressional health reform proposals.

Along with this latest addition, the proposals include those from: the Senate Finance Committee; Senators Tom Coburn (R-OK) and Richard Burr (R-NC) and Representatives Paul Ryan (R-WI) and Devin Nunes (R-CA); Representative John Conyers (D-MI); Representative John Dingell (D-MI); Senator Bernie Sanders (I-VT); Representative Pete Stark (D-CA); and Senators Roy Wyden (D-OR) and Bob Bennett (R-UT). The tool also includes a summary of President Obama's reform principles. The Foundation will continue to update the tool to reflect major new proposals and any significant changes to the plans already introduced.