

California and National News

Health-Care Tab Hits \$1.7 Trillion: Health-care spending in the U.S. grew to an estimated \$1.7 trillion in 2003—more than \$5,800 for every American—but the pace of growth was slower than in recent years. Health care also for the first time was projected to make up more than 15 percent of the national economy last year, the federal Centers for Medicare and Medicaid Services (CMS) said. Government spending on Medicaid and Medicare rose in 2003, but more slowly than in 2002, helping contain the overall increase in spending, CMS said. The CMS report, released on the Web site of the journal *Health Affairs*, said that health-care spending grew a projected 7.8 percent in 2003, down from 9.3 percent in 2002.

Health-care spending, however, is expected to outpace growth in the rest of the economy for the next 10 years, CMS said. By 2013, annual spending on health care is expected to reach \$3.4 trillion and be more than 18 percent of gross domestic product. The projections didn't include the anticipated effects of the new Medicare prescription-drug law, which will offer seniors prescription-drug coverage beginning in 2006. CMS officials said they expect a shift in who pays prescription-drug bills rather than a significant increase in spending on drugs.

“Our story, with or without the legislation, doesn't change much,” said Stephen Heffler, CMS's deputy chief actuary and lead author of the report. Prescription-drug spending, however, will continue to outpace the rest of health care for the next 10 years, Mr. Heffler said at a conference about the report. Dan Crippen, the former director of the Congressional Budget Office, said that huge changes in health-care spending lie just beyond 2013, the end of the period covered in the report, when baby boomers start reaching retirement age. (From *The Wall Street Journal*, February 12, 2004.)

Court Dismisses Challenges to Cigna's Settlement With Doctors: A federal appeals court dismissed challenges to a \$540-million settlement between Cigna Corp. and thousands of doctors who claimed the health insurer systematically underpaid them. The bulk of the nation's doctors, some 700,000, have signed on to a massive racketeering lawsuit against the managed-care industry, charging the insurers with breaching contract terms by shortchanging them on payments and curtailing necessary patient care. Philadelphia-based Cigna won approval for its settlement in February, but a small group of doctors disagreed with the settlement and attempted to derail the deal through the courts.

Cigna said the dismissal of those appeals cleared the way for implementation of the settlement, which would end Cigna's part in the lawsuits filed by doctors in the late 1990s. Under the settlement, Cigna agreed to spend \$400 million to improve its billing systems and pay about \$70 million to doctors in addition to \$55

News–Cont’d

million in attorneys’ fees. The insurer also agreed to spend \$15 million to create a healthcare foundation and to establish an advisory committee. A spokesman for Cigna could not be reached for comment.

Cigna was the second major managed-care company to reach a deal in the massive lawsuit. Last May, Aetna Inc. and the doctors settled for \$470 million. A trial for the remaining defendants has been set for June in Miami. They include Humana Health Plan, PacifiCare Health Systems, Prudential Insurance Co. of America, United HealthCare, WellPoint Health Networks and Foundation Health Systems. (From the *Los Angeles Times*, April 23, 2004.)

Canada Plans Changes to Health-Care System: The Canadian government plans to tackle the long wait lists for medical treatment that have plagued the country’s universal health-care program in recent years, Health Minister Pierre Pettigrew said. In a speech billed as an outline for the future of Canada’s health-care system and aimed at setting the tone for talks with the 10 provincial governments, Mr. Pettigrew said the federal government is committed to making the national program financially sustainable and more accessible. “Wait times have become the lens through which Canadians evaluate their system,” he told reporters.

At the same time, the federal government aims to cover more services, such as home care and prescription-drug plans, which now aren’t core parts of the national insurance system. “These are the new frontiers of the health-care system, and pharmaceuticals is the fastest-growing area of provincial health spending,” Mr. Pettigrew said. He didn’t say how the government plans to address treatment delays or how much additional funding it plans to inject into the system. Federal officials already have started private discussions with the provincial governments, which are responsible for administering health care. Prime Minister Paul Martin is expected to meet with provincial premiers this summer to discuss program details. The provinces long have complained that federal-government funding has slipped, and at the same time they fiercely resist efforts by the federal government to control how they spend their health-care dollars.

Opposition politicians say Mr. Martin’s government has failed to make specific commitments. “This is the same rhetoric,” said Conservative Party health critic Rob Merrifield of Mr. Pettigrew’s speech. Mr. Martin’s Liberal government, Mr. Merrifield said, has failed to make good on commitments to health-care reform made by outgoing Liberal Prime Minister Jean Chr tien last year. (From *The Wall Street Journal*, April 21, 2004.)

News–Cont’d

CMA Seeking Statewide Fix for Medicare Payment Formula: A *CMA Alert* article (April 29) on Medicare’s geographic payment formula was interpreted by some readers to mean the CMA is seeking only a four-county solution to this problem. That is not accurate. CMA is examining possibilities for a statewide fix for Medicare’s geographic payment formula. In the long term, our goal is to replace the entire Geographic Practice Cost Index (GPCI) system with something that is fair and more reflective of real geographic differences. That will be a tough thing to accomplish, since other states are focusing their efforts on getting the sustainable growth rate (SGR) formula fixed, and have not yet turned their attention to the shortcomings of the GPCI system. CMA believes that **both** formulas need to be reconsidered.

In the short term, however, CMA is looking to bring *new additional federal dollars* to California for as many locality 99 counties as possible. As directed by the House of Delegates, the Board of Trustees will review the issue in detail and seek a more global solution than the one rejected by the House. CMA feels that such a solution may be doable for as many as nine counties, where the federal difference between the Geographic Adjustment Factor (GAF) rating and actual practice costs is significant enough to have a demonstrably negative effect on access. To succeed in any such proposal, CMA will need to back up our claims of adversity with data. We encourage physicians to forward to their county medical societies any data that illustrates the unfair disparity between Medicare payment levels and actual practice costs. Please also forward a copy of this data to Elizabeth McNeil at CMA so that a comprehensive proposal can be formulated and discussed by our trustees. No action would take place without trustee approval.

In assessing the impact of the Medicare payment formula on California, it is key that physicians be educated about the adverse impact the formula has nationwide. Our locality 99 payments, as frustratingly low as they may be, are higher than in Washington, D.C., and many other expensive urban areas. Overall, California benefits the most of all states from the payment formula. Our problem is the inequities between counties, even though **all** counties in the state are above the national average. The *Alert* article should have been more carefully worded. Some readers understood it to mean that CMA is focusing only on a specific fix for the four counties. Again, that is not accurate. CMA seeks *new dollars* to fix inequities in *all California counties* that can demonstrate with data that they have unfair payment levels when compared to practice costs.

Any new federal funding strategy would be vetted with our county partners before we go forward to the trustees with a proposal. The article was an effort to put those current issues on the table in anticipation of that discussion. Contact:

News–Cont’d

Elizabeth McNeil, (415) 882-3376 or emcneil@cmanet.org. (From *CMA Alert*, May 6, 2004.)

CMA and Coalition Press Ahead with ER Ballot Initiative: The California Medical Association remains committed to the emergency room and trauma care ballot initiative and is moving ahead with coalition partners to win its passage in November. Contrary to some recent rumors and a few press reports, CMA never withdrew support for this important initiative, which would raise \$600 million to fund emergency and on-call care in California. The initiative would also provide funds for 911 emergency dispatch and community clinics. CMA and the other members of the Coalition to Preserve Emergency Care (CPEC) are continuing the ballot campaign to ensure Californians have access to high-quality emergency care no matter where they live or where they travel in the state.

Unfortunately, the California Healthcare Association (CHA), the trade association for the state’s hospitals, recently dropped its support for the initiative. CHA also withdrew its financial commitment and, despite a plea from coalition partners, its board recently voted to take a “neutral” position on the measure. A CHA press release resulted in several stories that misconstrued CMA’s position. CMA and the remaining members of the coalition are extremely disappointed with CHA’s decision. The state’s hospitals and its patients would benefit greatly if the measure passes.

In addition to funding for emergency rooms, trauma centers, and emergency doctors and specialists, the ballot measure would provide money for community clinics to pay for urgent and primary care services that reduce the flow of patients to overcrowded hospital emergency rooms. CMA still needs to raise \$300,000 to meet its fund-raising goal of \$900,000. While this is a lot of money, the benefit to physicians and patients will be great. The initiative is expected to raise about \$600 million annually to ensure access to trauma and emergency services, with about \$200 million spent to reimburse emergency and on-call physicians for care provided to uninsured and underinsured patients. Contact: Dustin Corcoran, (916) 444-5532 or dcorcoran@cmanet.org. (From *CMA Alert Special* April 26, 2004.)

Health Care Largely Spared in Governor’s Revised Budget: Governor Schwarzenegger yesterday unveiled his much anticipated revised budget proposal. The \$103 billion spending plan contains significantly fewer cuts to health and welfare programs than had been proposed the January budget, and it does not include any tax increases.

The governor eliminated the 10 percent cut to physician reimbursement that he had proposed in January, thanks in large part to the preliminary injunction won

News–Cont’d

by CMA in federal court in December. That injunction blocked the 5 percent cut that was passed by the Davis Administration in 2003. In granting the preliminary injunction, U.S. District Judge David Levy said the state of California failed to consider how it would affect access to care for the more than 6 million poor, disabled, elderly, and children whose health care is provided by Medi-Cal. The state has appealed the injunction. CMA is confident, however, that the appeal will fail and that there will be no cuts to physician reimbursement.

The revised budget also eliminates proposals to require copayments for health and human services programs, cut the funding for in-home care, and cap Healthy Families enrollment.

The proposal would, however, increase monthly premiums for Healthy Family enrollees with family incomes above 200 percent of the federal poverty level (\$2,544 a month for a family of four). The monthly premiums would be increased beginning in 2005 from \$9 per child to \$15 per child.

The governor delayed until August 2 the release of his plan to dramatically transform the \$33 billion-a-year Medi-Cal program and rein in the program's costs. In order to implement such an overhaul, the state will first need to request a waiver from federal regulatory and statutory mandates. The governor will ask the legislature to approve a plan to redesign Medi-Cal by the end of the year. Contact: Heather Campbell, (916) 444-5532 or hcampbell@cmanet.org. (From *CMA Alert Special* May 14, 2004.)

ERs Getting Faked Out: Uninsured Who Can't Afford to Pay Falsifying Identities: Coloradans are increasingly using fake names when they show up in emergency rooms because they can't afford their medical bills. At Centura St. Anthony Central Hospital, 11.3 percent of the bills sent to ER users are returned because there is no such person or address. Two years ago, the rate of returned mail was just 4 or 5 percent. Since then, the number of uninsured people seen in the emergency department has skyrocketed. Now, one in three is uninsured, having neither private insurance nor Medicaid or Medicare.

A group of emergency specialists gathered recently to say that emergency rooms are stretched thin and about to snap, overwhelmed by the 720,000 Coloradans who don't have health insurance. Nationwide, an estimated 44 million are uninsured. The American College of Emergency Physicians joined sponsors of Cover the Uninsured Week in calling for universal health care coverage. They unveiled a national survey of 2,000 emergency doctors in which respondents reported that the uninsured are delaying care, showing up in emergency rooms sicker, and dying sooner because they lack access to regular treatment. The doctors attributed

News–Cont’d

the rising number of uninsured to the loss of employer-based health insurance and to higher unemployment.

Ten years ago, 20 percent of St. Anthony Central’s patients lacked private or government health insurance. Now, the number is 50 percent. Colorado’s hospitals lost \$3.2 billion two years ago in charity care expenses, bad debt, unpaid bills and the lower-than-cost reimbursements from Medicare and Medicaid. That’s \$3.2 billion out of the \$13 billion in total hospital charges that year. If everyone were insured, the number of people getting treated at the \$600-per-hour emergency room rate would plunge, people wouldn’t delay care and everyone’s premiums would drop by about one-third. (From *Rocky Mountain News* May 14, 2004.)

**Reclaiming the Heart & Soul of Medicine:
A CME Workshop for Physicians**

with Rachel Naomi Remen, M.D.

September 10-11, 2004

**Acqua Hotel, 555 Redwood Highway
Mill Valley, California**

“The process by which we are trained to professional expertise often wounds our hearts and souls and diminishes our wholeness. But meaning is a function of the heart and not the mind. It is not surprising that so many physicians report losing a sense of meaning and satisfaction in their work.

This workshop will enable physicians to explore the deeper meaning of their work and live closer to their authentic values. Through the use of small group discussions, journals, reflections, experiential exercises, storytelling, imagery and poetry, Dr. Remen will enable us to begin to heal the wounds of our training, gain a fresh perspective on our daily work and reclaim a sense of aliveness in our service. Be prepared to connect with your colleagues in new ways, and remember why it is that we have all chosen this work in the first place.”

For registration information, go to www.rachelremen.com/workshop.html, or contact Corrie at (707) 575-6801. The sponsor of this meeting is The Institute for the Study of Health and Illness at Commonweal.