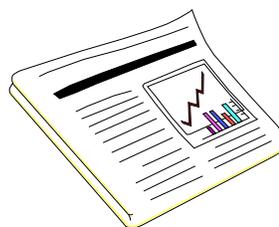


California and National News



AMA Survey Forecasts Medicare Access-to-Care Crisis if Physician Rates are Cut:

The looming Medicare physician payment cuts will hurt access to care for America's seniors and disabled, according to an AMA survey released this week. If Congress fails to fix the flawed sustainable growth rate (SGR) formula, physicians will face reimbursement cuts totaling 26 percent over six years beginning in 2006. The 2005 Medicare Trustees report indicates that practice costs will go up 15 percent during that same time period.

The projected cuts are an unintended consequence of an unsound SGR formula. The formula allows Medicare spending on physician services to grow at the rate of the gross domestic product (GDP), but it actually penalizes physicians because the cost of physician services rises more rapidly than the GDP.

Unfortunately, CMS must as a matter of law apply the SGR formula when calculating Medicare fees. CMA believes that SGR should not be used to update physician fees because it is based on GDP, not medical inflation.

"Physicians are sensitive to the budgetary challenges facing Congress, but if something isn't done to fix the broken SGR formula, physicians will not be able to afford to treat Medicare patients," says CMA CEO Jack Lewin, M.D. "Our House of Delegates said that fixing the SGR must be CMA's top federal legislative priority. We will continue to work hard to make this happen before the cuts take effect next year."

Congressional intervention in 2003 and 2004 staved off two previous rounds of cuts, turning projected cuts into small increases. AMA and CMA continue to advocate for a long-term legislative solution.

"Medicare payments to physicians already seriously lag behind the increasing cost of providing medical care. If Congress and the Administration fail to act soon, physician payment cuts of 26 percent over six years will be devastating to the foundation of Medicare," says AMA President-Elect J. Edward Hill, M.D. "According to AMA's survey, 38 percent of physicians will decrease the number of new Medicare patients they accept due to the first Medicare payment cut scheduled to take place in 2006. And that is just the tip of the iceberg, as the vast majority of cuts are scheduled to come after 2006."

Sixty-one percent of physicians who responded to the survey said that they will defer purchase of new medical equipment if Medicare reimbursement is cut as scheduled in 2006. Fifty-seven percent will reduce time spent with Medicare

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patients, 54 percent will defer purchase of information technology, 52 percent will begin referring complex cases, and 49 percent will stop providing certain services. And if the cuts continue through 2013 as scheduled, 71 percent of physicians surveyed say they will reduce time spent with patients or stop providing certain services, and 47 percent said they will retire. Contact: Elizabeth McNeil, (415) 882-3376 or emcneil@cmanet.org. (From *CMA Alert*, April 7, 2005.)

CMA Releases 12th Health Plan Expenditures Report; Blue Cross Again Spends Least on Patient Care: CMA released its 12th annual “Knox-Keene Health Plan Expenditures Summary,” detailing the financial status of California’s HMOs. This year’s report shows that in 2003-2004 Blue Cross of California again continued to spend less than 80 percent of each premium dollar on medical care. Just 79.9 percent of its revenue went to patient care, with 20.1 percent going to administrative costs and profit.

“Once again this year, these numbers are staggering,” said CMA president Robert E. Hertzka, M.D. “Health plans should be spending their dollars treating patients, not lining the pockets of their shareholders with patients’ premiums.”

Blue Cross is the only large health plan that has consistently spent less than 80 percent of revenue on medical care since CMA issued its first report in 1994. Blue Cross again this year registered the highest executive compensation among publicly traded health plans. Leonard Schaeffer, CEO of Blue Cross parent company Wellpoint Health Networks, received more than \$11 million in total stock, salary and other compensation.

Other plans that trail their competitors and spend the least on medical care are Aetna (80.9 percent), Blue Shield (81.5 percent), and Great West Healthcare (81.8 percent). In what has proven to be an embarrassment to the insurance industry, they refer to the percentages as the “medical loss ratio.”

Plans with the highest “medical-loss ratios”—those spending the most on medical care—are Alameda Alliance for Health (99.6 percent), CalOptima (97 percent), Partnership Health Plan (95.1 percent), and Kaiser Foundation Health Plan (92.8 percent).

Blue Cross last year merged with Anthem, creating the nation’s largest health plan. CMA opposed this mega-merger, calling upon state regulators to approve the deal only if patients were guaranteed substantial protections. CMA told regulators that such protections should include a requirement that the newly merged company spend at least 85 cents of every premium dollar on patient care. CMA also asked that regulators block the egregious spending of up to \$360 million on golden parachutes for executives, urging that the funds instead go to trim soaring premiums in California.

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State Insurance Commissioner John Garamendi, who called the proposed merger “one lousy deal for California health care consumers,” later approved it after the companies agreed to invest at least \$265 million in various health care programs around the state. Commissioner Garamendi agreed with CMA that the new plan must devote more premium dollars to patient care. To ensure this happens, Garamendi has created a “medical care ratio” index that he will use annually to audit the new health plan. Contact: CMA Media Relations, (916) 444-5532 or leginfo@cmanet.org. (From *CMA Alert*, March 17, 2005.)

Profits and Revenues of Major Health Plans: The numbers here are taken from September 30, 2004 10Q SEC Filings.

Profits of Major Health Plans

Health Plan	3Q 2004 Profit	3Q 2003 Profit	% Increase
Aetna	\$302,300,000	\$215,900,000	40%
Blue Cross (Wellpoint)	\$315,058,000	\$246,219,000	28%
Cigna	\$206,000,000	\$116,000,000	78%
HealthNet	\$42,604,000	\$234,030,000	(82%)
Pacificare	\$303,000,000	\$243,000,000	24%

The number reported here for Aetna does not include a one-time \$99 million profit that Aetna showed from discontinued operations.

Increase in Premium Revenue

Health Plan	3Q 2004 Revenue	3Q 2003 Revenue	% Increase
Aetna	\$3,786,600,000	\$3,301,700,000	14.7%
Blue Cross (Wellpoint)	\$5,463,223,000	\$4,763,859,000	14.6%
Cigna	\$2,776,000,000	\$3,068,000,000	(10%)
HealthNet	\$9,560,244,000	\$9,093,219,000	4.8%
Pacificare	\$12,188,000,000	\$10,937,000,000	10.2%

(From Santa Clara County Medical Association, May 13, 2005.)

Health Net Settles RICO Case with CMA and 900,000 Physicians Nationwide: CMA and more than a dozen other state medical associations agreed this week to a settlement with Health Net, one of six remaining health plan

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defendants in the RICO class action lawsuit pending before U.S. District Judge Federico Moreno in federal District Court in Miami. The suit alleges that the health plan defendants violated federal law by using coercive, unfair, and fraudulent means to control physician-patient relationships. Health Net is the third defendant to settle.

The settlement provides improvements to physician-related business practices as well as cash payments to physicians in accordance with specific terms set out in the agreement. The settlement will also enhance communication between physicians and Health Net, reduce administrative complexity in claims payment and improve the quality of the health care delivery system. These changes are expected to result in increased predictability and speed of claims payment, creating significant value for physicians by reducing time-consuming and costly administrative burdens and giving physicians more time to focus on their central mission—providing health care to patients.

Health Net has agreed, among other things, to:

- Redefine medical necessity so physicians can expeditiously get their patients the care they need,
- Abide by fair and transparent payment and contracting rules,
- Use AMA’s CPT codes for patient care and billing, which will end most claim “bundling and downcoding,” a practice used by many insurance companies to cut medical costs and underpay physicians,
- Pay capitation from day of patient enrollment and provide physicians with periodic reports on projected cost and utilization information,
- Speed up payments to physicians, with electronically submitted claims paid in 15 days and paper claims in 30 days.
- The settlement provides major protections both for fee-for-service PPO physician practitioners and for medical group and IPA physicians who contract with Health Net.

“This settlement provides significant gains for physicians and patients,” says CMA CEO Jack Lewin, M.D. “We hope it puts leverage on the other health plan defendants to move ahead and resolve this suit without the need for a protracted trial. Most important, settling the suits means we can spend our time and resources working together on quality of care, patient safety, and expanding access together—and that’s where we need to be.”

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The settlement agreement would also require Health Net to pay \$40 million to physicians as redress for past grievances and another \$20 million for legal fees. Officials estimated the prospective relief through improved claims and payment procedures to be worth \$300 million in the next several years.

“CMA began the battle against California’s largest for-profit health plans—Blue Cross/Wellpoint, Health Net, and PacifiCare—five years ago, when it became obvious that insurance companies were promising patients one thing to sell a policy and then doing the opposite when it came time to deliver health care,” says CMA President Michael Sexton, M.D. “This is a victory for physicians and patients. It is a shame that other health plans are still delaying doing what is right for patients.” Contact: CMA’s legal information line, (415) 882-5144 or legalinfo@cmanet.org. (From *CMA Alert*, May 5, 2005.)

CMA and DMHC Tell Court that Physicians Must Be Allowed to Sue HMOs for Fair Payment: In an appeal of a physician-unfriendly trial court ruling, CMA last week filed a brief arguing that physicians must be allowed to take legal action against health plans that refuse to reimburse them fairly for emergency services provided to plan enrollees. The trial court in this case, *Bell v. Blue Cross*, ruled that noncontracting physicians cannot sue health plans for the reasonable value of emergency services provided to plan enrollees. The trial court’s ruling, if allowed to stand, allows health plans to systematically underpay California’s safety-net providers and unnecessarily involves patients in billing disputes between their physicians and their health plans.

Blue Cross claims that the Knox-Keene Act does not require that health plans make patients financially “whole” in emergency cases, and therefore the plan has no responsibility to reimburse physicians for the reasonable value of emergency medical services provided to its enrollees. Blue Cross also claims that neither patients nor physicians have a right of action in such cases and that only the Department of Managed Health Care (DMHC) has the authority to enforce the provisions of the Knox Keene Act.

“The law leaves no room for debate that plans must pay reasonably for emergency services provided to their enrollees by noncontracting physicians,” wrote CMA legal counsel Astrid Meghrigian in the brief that was filed with the Second District Court of Appeal in Los Angeles. “HMOs are not free of judicial scrutiny and cannot not absolve themselves of this responsibility.”

DMHC also filed a brief in this case, demanding that the appeals court overturn the lower court’s ruling. “The fundamental flaw in the trial court’s ruling is that it allows a health plan to unilaterally determine the level of reimbursement for noncontracted emergency providers without further recourse,” wrote DMHC

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attorneys in the brief. “If providers are precluded from bringing private causes of action to challenge health plans’ reimbursement determinations, health plans may receive an unjust windfall and patients may suffer an economic hardship” when providers bill patients to recover the difference between the health plan’s payment and the provider’s billed charges. Contact: CMA’s legal information line, (415) 882-5144 or legalinfo@cmanet.org. (From *CMA Alert*, April 7, 2005.)

The Medicalization of Torture: The revelation of torture and prisoner abuse in Iraq has led to the Army’s Fay Report and the independent Schlesinger Report. Some of the findings indicate the complicity of American physicians, nurses and medics in torture, not only in Iraq, but also in Afghanistan and Guantanamo Bay. There are three prominent ways in which physicians, historically, have been involved with atrocities. First, they have not reported injuries that are consequences of abuse. Second, they have given medical reports to interrogators who might then use this knowledge of physical or psychological vulnerabilities. Third, physicians have been complicit in the falsification of documents that assign an ordinary cause of death to a decedent who actually perished from torture.

Notorious physician violators of the Hippocratic oath included Nazi physicians who conducted atrocious medical experimentation on prisoners; Soviet psychiatrists who put dissidents in mental hospitals; South African physicians who falsified medical reports on blacks who had been killed or tortured; and Iraqi surgeons, who, under Saddam Hussein’s orders, cut off soldiers’ ears as punishment for desertion.

There are inherent conflicts between the Hippocratic oath and the exigencies of military combat. In military situations, the environment generates powerful psychological pressures toward killing and harming others. In both Vietnam and Iraq, these conditions were a part of a counter-insurgency war in a hostile setting, amid a largely nonwhite population, where soldiers faced a dangerous enemy who is extremely hard to locate, and even found it difficult to ascertain whom the enemy actually was.

Dr. Lifton, author of the *NEJM* article, believes that military conditions create a “conflict between humane professional and legal perspectives and the realities of insurgency, where there are nasty forces at play,” where physicians’ adherence to the Hippocratic oath can be offset by the “pressures of a military group.” Yet, while acknowledging that medical professionals are capable of complicity in torture, he does not believe that atrocity-producing situations are powerful enough to override all of our human instincts. “There’s still a basic distinction between someone who has engaged in such behavior and someone who might.” (From the *New England Journal of Medicine*, Volume 31, 2004, pp 415-416, and *Harvard Magazine*, November/December, 2004.)