California and National Newsbriefs

Court Upholds Right of Non-contracted Physicians Providing Emergency Services to Balance Bill (*Prospect Medical Group v. Northridge Medical Group et al.*): The Second Appellate District, California Court of Appeal concluded that the Knox-Keene Act did not prohibit non-contracted physicians providing emergency services from "balance billing" patients for fees not paid by either the health plan or its contracting IPA. The Court also concluded that such physicians are not required to accept Medicare payment rates as payment in full. As a result, the Court concluded that the IPA in *Prospect v. Northridge* could not sue a group of emergency physicians (EPs) for violating the unfair practices laws for balance billing their patients and could not require that they charge no more than 100 percent of the Medicare rate. The Court did, however, allow the IPA to contest the reasonableness of the EPs' rate, just as physicians have the ability to sue plans and IPAs for the reasonable value of their services in accordance with the *Bell v. Blue Cross* decision. This opinion fully sided with CMA's amicus curiae brief that it filed supporting the EPs. The court held that Section 1379 of the Health and Safety Code did not prohibit EPs from balance billing. This section provides that contracts between a plan and provider shall be in writing and provide that where the plan fails to pay for health care services, the enrollee shall not be liable to the provider for sums owed by the plan.

The Court further declared that Section 1379 refers to and includes within its scope only freely and "voluntarily negotiated contracts" between physicians and plans "based on traditional contractual principles such as a meeting of the minds." The Court rejected the IPA's argument that "implied" contracts based on the parties' conduct or the physicians' obligation to provide EMTALA services could suffice to trigger the balance billing prohibition. The Court reasoned that because the prohibition only applies to "sums owed by the plan," there would need to be a voluntary negotiated agreement "as to how much the plan will pay for a particular procedure in advance of the medical procedure."

The Court also bolstered its argument upon the fact that the Department of Managed Health Care did not adopt a regulation to ban balance billing and gave no weight to a DMHC's attorney letter that balance billing was prohibited. (*CMA Legal Hotlist,* February, 2006.)

Limited English-Proficient Patients: In an effort to improve the delivery of healthcare services to limited-English proficient (LEP) Californians, a

collaborative of 28 physician and medical organizations have created the California Endowment's *Medical Leadership Council on Cultural Proficiency*. This Council will seek out strategies to improve the provision of interpreter and translation services to LEP patients, eliminate racial and ethnic healthcare disparities, improve the quality of care of LEP patients, and consider ways to ensure the healthcare work force represents California's diversity. A 2000 census showed that 40 percent of Californians speak a language other than English at home. Fifty percent (seven million) of these individuals are LEP and would benefit from language assistance—either interpretation (spoken) or translation (written) when accessing healthcare services. LEP hospitalized patients face a greater risk of medical error and misdiagnosis when they are not provided an interpreter. A 2002 report by the Institute of Medicine showed that minorities receive a lower quality of care than whites, even when their insurance and income are the same. A review of over 100 studies during the past decade concluded that these disparities contributed to the higher death rate among minorities from cancer, heart disease, diabetes and HIV infection. The California Endowment (a private, statewide health foundation) was established in 1996 to expand access to affordable, quality healthcare for underserved individuals and communities, and to promote fundamental improvements in the health status of all Californians. See **www.calendow.org** for more information.

Long-Term Health Care and Its High Costs: Sixty-nine percent of all people over 65 will eventually need long-term care, although much of this care may simply involve assisted living tasks easily provided by family or hired help. However, 37 percent of people over 65 will need long-term care in a nursing home or assisted care facility. The average nursing home stay is 30 months, the average yearly cost being $74,000. While most seniors will not incur such large cost, some will, as 11 percent of 65-year-old men and 28 percent of women will need more than five years of care at home or in a facility. Eight percent of claimants on long-term policies with a three-year benefit period exhausted their policy. About 6 percent of seniors who enter a nursing home as a private payer will end up on Medicaid, but under a new federal law, it now has become more difficult to give away assets and thereby qualify for Medicaid-paid nursing home care. As a result, Medicaid eligibility could be adversely affected by gifts made over the period of five years, up from three under older rules, and one cannot qualify for Medicaid if one has a home equity of more than $500,000. Clearly, a small portion of the elderly population will incur massive expenses and potentially use up one's life savings. In order to protect against this scenario, one might consider long-term care insurance. Premiums, however, are expensive, and affordability could limit purchasing of a plan to benefits for only a few years, which, if longevity in a nursing home

does occur, might lead to impoverishment. A possible "solution" might be the purchase of longevity insurance instead of long-term care, or in conjunction with it. This new insurance product that would pay income for life would eliminate the risk of outliving a long-term care benefit. Yet, a drawback even of this type of plan is that the benefits begin at a stated age, such as 85, and if one were to require long-term care before the longevity policy kicks in, then one would have to have planned for enough savings to pay for any long-term-care expenses during the intervening years. (Summarized from an article by Jonathan Clements, *Wall Street Journal,* February 22, 2006.)

Few Healthcare Personnel Obtain Influenza Vaccinations: Seasonal influenza hospitalizes a quarter of a million people in the U.S. and kills about 36,000 Americans yearly, the majority of the most severe cases being in the over-65 population. Yet, less than half of the U.S. physicians, nurses and other personnel get an annual influenza vaccine. This is in the face of the United States Centers for Disease Control and Prevention declaring that vaccinations could help stem outbreaks in health care settings and decrease absenteeism among workers contracting the disease. A CDC study identified only 40 percent of healthcare workers getting regular flu shots, and this figure is thought to be similar in California. As incentives to enhance compliance with their recommendations, CDC is urging healthcare facilities to provide the vaccine free and on-site, and that nasal spray vaccines be offered to certain qualified individuals who would prefer that mode of administration. Moreover, CDC wants healthcare workers to sign a form if they decline the vaccine so as to assist with tracking the disease. California does not track flu vaccinations among its healthcare workers, but individual facilities are being encouraged to keep statistics. It is indeed possible that in the future there will be a mandated vaccination, but this concept has, for the current time, been rejected in Seattle where a federal judge ruled that a hospital could not require its nurses to be vaccinated under the threat of losing their jobs. Kaiser Permanente in Oakland achieved 70 percent compliance among physicians, but only 40 percent among nurses, despite innovative and even generous programs to enhance the rate. Most refusals involve two misconceptions about the vaccine: healthy people don't get the flu, and flu shots can themselves cause illness. Both are myths: healthy people can still spread the illness as infectivity begins 24 hours before clinical symptoms and a contagious state persists for four to five days afterward. Moreover, the vaccine generally only causes minor side effects such as soreness at the site of the injection. Any flu-like illness experienced after the vaccination is a coincidence (non-flu respiratory infections) as the vaccine is not a live virus. The nasal spray vaccine does contain live strains of attenuated virus, and therefore, is recommended only for healthy people ages five to 49. Outbreaks in health facilities are well-documented, with healthcare workers

suspected or identified as the source introducing the virus into the facility. Neither the injection nor the spray is entirely effective as influenza strains constantly mutate, and the strains selected for the following year's vaccines may not fully match the strains of that future time. (Summarized from an article by Deborah Franklin, *New York Times,* February 21, 2006.)

GAO Audit Disputes Veteran Affairs Savings Claims: The Department of Veteran Affairs failed to show that it achieved the $1.3 billion in budget savings that it had claimed in fiscal years 2003 and 2004, according to the Government Accountability Office. The GAO declared that the VA did not have proper documentation for the $1.3 billion it had reported as management efficiency savings. In addition, the VA claimed savings of more than $3 billion from "efficiencies" that reduced overtime and delayed hiring at VA offices, but did not explain how the savings were achieved without a reduction in the quality of service provided. Moreover, during the summer of 2005, the VA reported to Congress its shortfalls totaling $3 billion in its healthcare accounts over fiscal years 2005 and 2006. The VA responded by stating that its accounting practices are in need of improvement, but it denied that it was motivated simply "to fill the budget gap." Members of the Congressional Veterans' Affairs Committees expressed dismay over a VA healthcare budget that "over the past three years has been built like a house of cards" (Senator Daniel Akaka-ranking committee Democrat, Hawaii). (*Congressional Quarterly Today,* February 2, 2006.)

Health Savings Accounts: *Wall Street Journal* commentary praised President Bush's "ambitious and mutually reinforcing set of health reforms" which focus on Health Savings Accounts (HSAs), the tax treatment of health insurance, and increased transparency of health care costs. "The more we look at the fine print in the healthcare reforms President Bush is now stumping for, the more we see the potential for the most sweeping and beneficial changes in half a century." Supercharging HSAs—by making the accounts portable, allowing HSA premiums to be paid from the tax-free savings account, and increasing the allowable contribution limits—could have a profound impact on the economy as "all employees are ultimately less dependent on their employers' coverage and can ultimately buy the kind of insurance that makes better sense for them." (*Wall Street Journal,* February 21, 2006.)

Health Spending Projections Through 2015—Changes on the Horizon: Healthcare spending will consistently grow over the next decade to consume 20 percent of the gross domestic product by 2015, according to economists and actuaries from the Centers for Medicare and Medicaid Services. National health spending is expected to slow to 7.4 percent in 2005,

marking the third consecutive year of slowing growth since 2002. In 2006, Part D Medicare coverage, the new Medicare prescription drug benefit, will produce a dramatic shift in spending across payers, but it will have little net effect on aggregate spending growth. (*Health Affairs Web Exclusive,* February 22, 2006.)

Budget Keeps New Specialty Hospitals on Hold: The debate over physician-owned specialty hospitals is still on hold. In February, President Bush signed into law the federal budget bill, which includes a provision that continues the suspension of new specialty hospitals for another six months or until the Centers for Medicare and Medicaid Services submits a final report on the issue. The Deficit Reduction Act of 2005 charges Health and Human Services with developing a "strategic and implementing plan" regarding physician investment in specialty hospitals. The report must address whether the physician investment in a specialty hospital is proportional, whether the investment is legitimate and whether HHS should require annual disclosure of investment information.

Blood Substitute Research Halted by Feds: The Federal Office for Human Research Protections, charged with protecting patients in medical research, has declared that there are "urgent ethical concerns" about the conduct of a blood substitute study on trauma patients. Two hospitals participating in the study have suspended their investigations. The Federal Drug Administration has overseen Northfield Laboratories, Inc. research and granted permission to conduct the study without obtaining patients' consent. The investigation involves the blood substitute PolyHeme, which is being used to treat hemorrhagic trauma patients, half receiving the PolyHeme, the other half saline. This is done without informed consent, which, of course, may not be a feasible process in critically ill patients. Blood is then administered in the hospital only to the saline-infused patients. The ethical dilemma arose with an older study in which PolyHeme was administered to patients undergoing aneurysm surgery and in which 10 of 81 patients had myocardial infarctions, while none of the 71 patients receiving standard therapy suffered from such. This study was suspended without completion. The FDA permitted the new study without informed consent because of its belief that new therapies that hold promise for improved outcomes in trauma cannot practically be tested if physicians must first obtain traditional informed consent. The question arises as to whether it is ethical to withhold donor blood from the PolyHeme patients when the substitute's efficacy is scientifically uncertain. Allegedly, there also is the failure to adhere to an FDA criterion for a non-consent trial, which is that standard therapy must be "unproven or unsatisfactory." Northfield contends that donor blood "may not be the optimal treatment for the early care of trauma patients, and PolyHeme is being evaluated as a potential better alterna-

tive," and that the study was "on strong scientific, legal and ethical ground." (*Wall Street Journal,* Article by Thomas Burton, March 10, 2006.)

Methicillin-Resistant *Staphylococcus Aureus*—Factoids: According to the U.S. Centers for Disease Control and Prevention, each year virulent bacteria afflict two million patients (one in 20 hospital admits), causing half of all major complications and 90,000 deaths. Though rates of MRSA infection in many hospitals in Europe have declined to almost undetectable levels, multi-drug-resistant *S. aureus* is widespread in the U.S. and a reflection of the way medicine is practiced. One reason that hospital-borne *S. aureus* strains have evolved to greater virulence is their durability in the external environment, surviving for days to weeks on fomites such as computer keyboards and telephones. They are carried among patients by unaffected medical personnel and even visitors. Some strains are now resistant even to common hospital detergents. Vancomycin now is the drug of last resort, but resistance to it is increasing.

The only way to defeat this epidemic is to interrupt the chain of transmission within the hospital. Since the 1970s, a strict, no-tolerance policy has decreased infection rates in much of Europe to very low levels. Patients are tested to determine if they are harboring MSRA strains. Even those who have only transient MSRA in their nasal passages are isolated in single rooms, or in double rooms with another MSRA patient, and visitors must be gowned and masked. Healthcare professionals who come in contact with affected patients are constantly monitored through nasal swabs. The single most important way to stop bacterial spread is by healthcare workers being required to wash their hands often and to use alcohol-based sanitizers, which are more effective than soap and water, and easier on the hands. Floors and surfaces are disinfected frequently. Intravascular catheters coated with antibiotics, gloves that release disinfectants, diagnostic tests that rapidly identify bacteria, and microbe-resistant bed sheets and lab coats are now available. Over-prescription of antibiotics is not the main culprit of this epidemic, but it does lead to resistant strains. New strains even have been found outside hospitals, and community-based MRSA in the U.S. now account for a fifth of the *S. aureus* strains causing skin infections. The CDC is planning to launch a web-based reporting tool to enhance its existing voluntary infection-reporting system. Last year, infections consumed $9 billion hospital profits from the costs of longer hospital stays, and private and public insurers paid $11.5 billion in reimbursement to hospitals relating to complications of infections. (Compiled from *Proto,* Massachusetts General Hospital, Winter 2006, and *Wall Street Journal,* March 8, 2006.)

California Medical Marijuana Identification Card Program: In 1996, California passed Proposition 215, also known as the Compassionate Use Act,

which gave seriously ill people the right to possess and use marijuana (cannabis) for medical purposes, when they have a recommendation from a physician. Prop 215 gives the patient's primary caregiver (the person who has assumed responsibility for the housing, health and safety of the patient) the right to cultivate and possess cannabis for the patient. To assist law enforcement in identifying Californians who were protected by the Act, and to provide patients and their caregivers with a form of identification that would protect them against wrongful arrest and prosecution, Senate Bill 420 was passed in 2003. SB 420 required the Department of Health Services to establish a medical marijuana identification card and registry program; hence the Medical Marijuana ID Card Program. Participation in this MMICP is voluntary for patients and primary caregivers, and the card gives the holder authorization to process, grow, transport and/or use the marijuana. However, this card does not protect individuals from seizure of plants or from federal prosecution under the federal Controlled Substance Act. A serious medical condition is defined in SB 420, and includes, among others, AIDS, anorexia, cachexia, cancer, chronic pain, glaucoma, multiple sclerosis, seizures, nausea, migraine, arthritis, and any other chronic or persistent medical symptom that limits a person's ability to conduct major life activities as defined in the Americans With Disabilities Act. (From the County of Santa Clara Public Health Department.)

Medical Student Debt: In March 2005, the Association of American Medical Colleges issued "Medical Educational Costs and Student Debt," a report of a national working group that catalogued the rising debt levels of medical students, residents, and young physicians. Graduates of private medical schools in 2003 averaged an overall debt load of about $120,000, while those of public schools was about $80,000. With no tuition increases, an unlikely scenario, 2007's graduates can expect average debt of approximately $160,000 (private) and $120,000 (public). If educational debt continues to rise at current rates and physicians' income continues to barely keep pace with inflation, then there is realistic concern for the future affordability of medical education. The debt load and tuition for medical students has risen at much higher rates (5 percent to 7 percent per year) than have physician salaries (flat for past five years). Currently, medicine still is economically a relatively good bargain, as on the average it takes 8 percent of a physician's after-tax income to pay off educational debt if they consolidate their loans over 30 years. But, 20 years from now, if the current paradigm is not changed, it will take 50 percent to 60 percent of after-tax income, an untenable amount. Ultimately, students without family or personal resources to pay for medical school, or the ability to garner sufficient need-based grants and scholarships, may choose another career path, one with lower tuition rates and fewer years of costly education

and low-paying specialty training. Those who continue to pursue medicine will find themselves with little choice when it comes time to decide where and how to practice. (*P&S,* Winter 2006: Debt's Rising Tide: A Threat to Young Physicians and to a Career Choice, authored by Gina Shaw.)

Nursing Educators in Short Supply: It is much more difficult to recruit a registered nurse as a nursing school instructor than it is to recruit an R.N. for clinical practice in Silicon Valley. The pay differential is as much as $30,000, a significant deterrent to prevent an R.N. from entering teaching. As a result of the dearth of instructors, nursing schools have insufficient faculty numbers and have to turn away would-be nurses from their programs. This only adds to the exploding national shortage of R.N.s. As a potential solution, the San Jose Silicon Valley Chamber of Commerce is attempting to bring hospitals and nursing schools together with the following caveat: hospitals provide R.N.s to serve as nursing instructors, and students agree to work for one of the cooperating hospitals. Currently, there are about 14,000 unfilled nursing positions in California, but this is likely to grow to 100,000 by 2030! California's share of federal work-force grants could be one source of funding teaching programs, as could Governor Schwarzenegger's announcement of a $90 million program to encourage public-private partnerships to expand nursing education. Other areas that the Chamber has identified for work-force development include police, firefighters and data security engineers.

CSA House of Delegates May 20, 2006

CSA governance is at the heart of our member-driven organization. All members are invited to attend the CSA House of Delegates meeting on Saturday, May 20, 2006, from 1:30-4 p.m., at the Rancho Las Palmas Marriott Resort and Spa in Rancho Mirage, Calif. Consider making a day of it and getting some CME credits before the meeting.

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