RHODE ISLAND MEDICAL NEWS

NEWSLETTER OF THE RHODE ISLAND MEDICAL SOCIETY

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RIMS Raises Storm Warnings on Health Care

The Rhode Island Medical Society is warning state policy makers and the public that a quickly gathering "perfect storm" threatens medical practice in Rhode Island.

The elements of the storm are painfully evident to physicians. Practice expenses are up sharply at the same time that revenues are falling dramatically:

- Liability insurance costs are going through the roof. All Rhode Island physicians are being socked with premium increases that probably average, overall, about 40%. Increases for some practices are as high as 100%. (See Open Letter, p. 6)

- Health insurance premiums are up 20% to 30% and more, — even as health plans are cutting what they pay for the services provided to their beneficiaries and squirreling away millions annually to build up company reserves.

- Medicare payments, which are especially important in graying Rhode Island, were cut 5.4% a year ago and are slated to sink another 4.4% in 2003,— all thanks to what everyone agrees was a technical error, but an error that Congress has still failed to fix. (See story, p. 7)

- The state's dominant health insurer has announced a 7% reduction in selected procedures along with other cut s that will become effective in March 2003. (See story, p. 1)

This "perfect storm" is putting a sudden, harsh squeeze on medical practices, which have already been under increasing pressure here for a long time. The Rhode Island public is already giving up access and quality. The question seems to be, how much loss will the public

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Blues announce cuts

Effective around mid-March 2003, Blue Cross of Rhode Island reimbursement for most procedure codes will decrease by 7% (though no code will sink below 67% of Medicare), and Blue CHiP will eliminate the management fee it pays to primary care physicians ($2.50/member/month) on CHiP's commercial products (only). The management fee under BlueCHiP RIteCare will continue to be paid.

Reimbursements for Evaluation and Management codes will remain unchanged, as will site of service differentials and policies affecting global surgical fees. (Blues spokespersons indicated that the company had considered reductions in these areas as well, but determined that the impact on physicians would be "too great.")

Spokespersons for Blue Cross say they anticipate the overall impact of these changes on medical practices to average a negative 4% or 5%.

Such was the gist of the message that was delivered in person to physicians who attended any of three evening dinner meetings held in December to present the cuts to the community.

By early January, all physicians should have received written notice of the changes from Blue Cross, including a

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The Rhode Island Medical Society, the eighth oldest state medical association in the country, was founded in 1812 to promote the art and science of medicine. In cooperation with the Brown University School of Medicine, Rhode Island Quality Partners, Inc., and the Rhode Island Department of Health, the Society also publishes a monthly magazine, *Medicine and Health Rhode Island.*

Blues pull SHAPE ads in response to RIMS' critique

Calling it "a disservice to Rhode Islanders," RIMS President David B. Ettensohn, MD, told Blue Cross representatives that the company's paid advertising has no factual basis for touting an ample physician workforce for Rhode Island through the year 2006.

In a letter dated December 13, Dr. Ettensohn pointed out that the company's recently released "SHAPE" study ("Statewide Health Assessment, Planning and Evaluation") actually contradicts what the ads say about Rhode Island's physician workforce.

According to what the SHAPE study actually says, "Rhode Island does not have a good understanding of how many of its licensed physicians work in patient care and what percentage of their time is spent seeing patients." The study, conducted over the past year for Blue Cross by Booz Allen& Hamilton and RAND, recommends that more work be done to reduce the "uncertainty about current and future physician supply" in Rhode Island.

In a meeting on December 18, Dr. Ettensohn received oral assurances from Blue Cross that the ads would cease.

Public representations that Rhode Island has plenty of doctors struck a sensitive cord in the medical community. Besides being at odds with the Blues' own SHAPE study, the daily experience of most physicians and patients tends to suggest that Rhode Island already suffers shortages of anesthesiologists, obstetricians, pediatricians, radiological services, psychiatrists, oncologists, general surgeons, and others.

Moreover, physicians see things going from bad to worse as a result of sinking reimbursements from Medicare and Blue Cross and spiking practice overhead expenses. These trends are now so severe in Rhode Island that they call into question the very viability of medical practice in the state, Dr. Ettensohn observed. Many Rhode Island physicians have attested to the fact that recruitment of new physicians to the state has become increasingly difficult. ❖

The New Liability Mess

See page 6 for IBC Board's Open Letter

Medical professional liability premiums are up sharply. This time around, Rhode Island physicians are hard-hit too. The Board of Directors of the RIMS Insurance Brokerage Corporation has written an open letter to Rhode Island doctors about the situation as they see it. The letter is reprinted on page 6 of this newsletter.

Since the impairment and ultimate insolvency of Premier Alliance in 1993/94, the Board of the IBC has monitored market developments and companies doing business in Rhode Island closely. ❖

Physicians are Heroes, but it's a Costly Business

BY DAVID B. ETTENSOHN, MD, PRESIDENT

"We can't all be heroes because somebody has to sit on the curb and clap as they go by." "Being a hero is about the shortest lived profession on earth."

Physicians are heroes. I don't say this because I am one. The thought came to me as I pondered the current state of medicine in Rhode Island. I haven't rushed into any burning buildings lately, nor have I won any professional sporting events. My name is not a household word (yet). I, like you, head to work every day with little expectation that what I do will make any headlines. However, what we do and how we do it makes us heroes.

Perhaps I should define the word hero. It's not as easy as it sounds. Certainly I don't mean hero in the way that the firemen and policemen were heroes on 9-11-01. Their selflessness in a time of crisis would qualify as the epitome of heroism.

There are other definitions of heroism. In American culture, some refer to certain celebrities and athletes as heroes. Are they really? Who are they heroes to? Why do I think physicians are heroes?

When it comes down to the essence of heroism, I think the best definition is one that is offered by Wayne and Mary Soteil, psychologists by trade, based in Winston-Salem, NC, who counsel and advise physicians regarding stress management, among other things. They define a hero as someone who gives "safe space." By this criterion, physicians and firemen qualify as heroes. Celebrities and superstars do not. (The only safe space they provide is for their accountants.)

There is then some degree of selflessness involved in heroism. One might consider a firefighter less heroic if he demanded a large sum of money as a condition for rushing into a particular burning building. While such an individual might provide "safe space" for others, his actions would be tainted enough by mercenary self-interest to disqualify him for full hero status. On the other hand, we do not begrudge a firefighter the normal firefighter's wage; indeed, we would probably agree that the normal wage is low, considering the risks that go with the job.

The definition of a hero, then, includes the willingness to provide safe space unconditionally. By this definition, physicians are truly heroes, — especially in Rhode Island. Physicians' only criterion for seeing a patient is that the patient is seeking medical advice. With rare exception, patients are seen and cared for by physicians without regard to whether they have insurance or other means to pay for their care. Witness the fact that Medicaid patients are well cared for in Rhode Island, yet Medicaid reimbursement does not cover the physician's cost of providing the services.

Physicians are heroes who participate in a centuries-old professional ethic and freely obligate themselves to provide safe space to anyone who is in need of the physician's special skills and training, regardless of whether it makes sense for the doctor in economic terms. In Rhode Island, the economics of medical practice have been making less and less sense for years, and we have arrived at the point where economic realities can begin to render the ethic self-defeating. By that I mean that even heroes can only martyr themselves once. Then they are gone, lost to the community that depended upon them for safe space.

As conditions for medical practice get worse in the state of Rhode Island, we should seek the help of those "sitting on the curb," so that they can write their legislators, talk to their employers, express their outrage at the way their heroes are being treated in Rhode Island.

Chain pharmacies and insurers show their true colors

Contrast the professional ethic and the economic situation of Rhode Island physicians with those of large chain retail pharmacies (e.g., CVS, Brooks) in Massachusetts this past fall. The chains banded together and blocked a reduction in Medicaid payments for prescription drugs to Medicaid recipients. The pharmacy chains were able to retain their higher reimbursements and force the Commonwealth of Massachusetts to find other services to cut (read: provide less safe space). The large retail pharmacy chains demonstrated that they while they are highly successful politically and financially, they are something less than heroic.

Third party payers were originally developed as heroic enterprises. The concept was noble. Instead of pay-as-you-

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President's message
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go, patients could be insured for an annual premium that would cover health related costs. While the initial concept was good, "business" entered into the medical arena, separated patients from their doctors, and introduced in some cases a new boss- the stockholder. Now, there was no longer any direct connection between cause and effect, premium and care. While the story of how we got here is a complex one, the results are much more straightforward. Less of the healthcare dollar actually pays for patient care by a doctor, pharmacist or hospital. Third party payers now look more at the bottom line than at the health of their clients.

The next hit

Starting in March 2003, physicians in the state of Rhode Island will experience a further 7% reduction on procedures from the state's largest third party payer, Blue Cross & Blue Shield of RI, even while health care premiums are increasing by well over 20% for most people. This puts a tremendous squeeze on medical practices that are already stressed. Some Pawtucket physicians had successfully negotiated a mutual consent clause in their contracts, to prevent this exact scenario. The response from BC/BS was to unilaterally not renew those contracts in favor of one that allows BC/BC to pay what they want.

Thus, Rhode Island physicians, who already are among the lowest reimbursed in the country, will absorb another "hit." Most of us cannot realistically afford to shed a payer like BC/BS that commands a virtual monopoly in the state. Even if we did, it would be our patients who take a bigger hit, with diminished access to health care. So we stay "in," try to pay our staffs more as they struggle against the suffocating insurance bureaucracy, and try to deliver safe space to our patients in a hostile environment. Physicians are heroes. They are forced into the hero's role by the myopic and destructive behavior of payers.

What to do.

Who provides safe space for the hero? Your Rhode Island Medical Society, of course. Just two things limit what the Society (or any membership organization of doctors) can do to fight back: available resources and the strictures of anti-trust law.

We can do something about both. If 100% of the doctors who benefit from RIMS' work also shared in the burden as dues-paying members (and we're talking about a dues "burden" of $1.15 a day — the price of a small cup of coffee), RIMS would have more resources. That would help with things like getting RIMS' innovative negotiations bill passed so that doctors could actually negotiate under a "state action exemption" from anti-trust. With RIMS' support, the AMA is always pushing for anti-trust reform at the federal level as well.

Until we have such reform, each of us must decide for ourselves how to deliver care to those in our practices. Some will limit new patients, others will try to see more patients in a shorter time, all will feel the stress of needing to do more with less. Some doctors will relocate to other states where they can satisfy the tenets of the Hippocratic oath without feeling hypocritical.

Another quality of a hero is that he or she tends to try to go it alone. In today's environment we clearly need to be together if we are to fulfill our mission of delivering health care to the state's residents. If you are reading this, you are probably a member- but give this to a colleague and encourage him/her to join.

The Medical Society will be making materials available to make it easy for you to educate your patients about the things that are threatening their relationship with you. We plan to make these materials downloadable from RIMS' website (www.rimed.org) so that you can personalize them for your own practice and patients. In the final analysis, physicians must be rescued by the patients they serve.

It was Will Rogers who said, "We can't all be heroes because somebody has to sit on the curb and clap as they go by." As conditions for medical practice get worse in the state of Rhode Island, we should seek the help of those "sitting on the curb," so that they can write their legislators, talk to their employers, express their outrage at the way their heroes are being treated in Rhode Island.

It was also Will Rogers who said, "Being a hero is about the shortest lived profession on earth." Unfortunately this is an evolving trend across the country, as doctors retire early rather than try to work in an environment where they cannot perform their job. In providing "safe space" for their patients, doctors give up much of their own, frequently in their personal space. For example, while the divorce rate for the average American for first-time marriages is an abysmal at 43%, it is over 20% higher for physicians. We have always paid the price in our personal lives, now we will pay it financially as well.

The message is clear. Physicians are heroes, but it's a costly business.❖

GOOD NEIGHBOR ADVERTISEMENT

The New Medical Professional Liability Crisis

An Open Letter to Rhode Island Physicians from the Board of Directors of the RIMS-IBC

Dear Doctor,

We write to share with you our perspective on what is happening in Rhode Island with regard to medical professional liability insurance.

Along with the rest of the nation, Rhode Island has clearly entered a period when such insurance is becoming both less available and less affordable. In 1999, there were about 10 traditional insurers licensed and / or admitted to do business in RI that included medical professional liability coverage among the lines offered. There were another 10 non-traditional insurers or alternative risk transfer mechanisms providing coverage to the medical profession. The Rhode Island JUA rounded out the list. Since 1999, we've seen some carriers withdraw from our market and some drift into insolvency. Today, there are just 3 insurers that are willing to write any new physician business here at all, and that short list includes the Rhode Island JUA, which by law must take all comers. As underwriting becomes more selective and cautious insurers limit growth to maintain stability, some physicians may be left with only one option.

At the same time, premiums are up sharply for everyone. Many physicians will see their rates rise as much as 80% this year at renewal. The changes vary by carrier, specialty and whether discounts previously offered remain, but the facts are clear: expenses are going up many thousands of dollars for almost everyone.

On average, premiums are likely to increase about 40% for doctors in the state, and we may see the end of the availability of "occurrence" coverage. Nursing homes' premiums are doubling or tripling. All institutional and professional providers already are or soon will be paying sharply more.

Your Rhode Island Medical Society is telling elected officials, regulators and the media that this trend will erode patients' access to care. We encourage physicians to speak with patients about these issues. In combination with other prevailing conditions in the Ocean State, increased liability costs seriously burden the health care system and jeopardize the viability of medical practice. The Medical Society sees the crisis as an opportunity to gain needed reforms. RIMS has identified 9 short-term and 5 longer-term goals that it believes are politically achievable in this environment. You will be hearing about them from RIMS, and we urge you to support your Society's efforts.

Neither RIMS nor the RIMS-IBC will be an apologist for the insurance industry. Here is our take on the facts. While it is true that loss of investment income and the rise of reinsurance costs in the wake of 9/11/01 have cut into the insurance companies' surpluses and increased their operating expenses, the actual impact of those two factors is, in fact, relatively minor, especially for the insurers that serve the Rhode Island market. These insurers are very conservative investors. Because they invest predominantly in high-grade bonds, the tech tumble and even the blue chip slide have limited impact on the portfolios of these insurers. As for the rising cost of reinsurance, that cost is a relatively small proportion of the overhead of the companies that serve most of the Rhode Island market. Therefore, even when those reinsurance costs double or triple, the impact on physicians' premiums is perhaps a few percentage points. (We can speak here only of those entities whose financial position is open to scrutiny; complete and reliable information about hospital off-shore captives, for example, is unavailable.)

The truly important factor behind large premium hikes – and the main factor behind insolvencies, too— is under-reserving. Companies under-reserve for a combination of two reasons: they may be competing for market share and therefore tend to under-price their product for a period of time, and/or they may fall behind the rising curve of settlement costs as a result of bad luck, bad actuarial advice, or mismanagement. It is the resulting "underwriting cycle" (a period of market competition and price stability inevitably followed by a hard market shake-out, insolvencies and sharp premium hikes) that is behind the crisis-proneness of many kinds of insurance, including professional liability.

But it is important to recognize that the underlying curve of rising settlement costs is real, — contrary to the self-serving disinformation that flows from the plaintiff's bar. The roots of the social dynamic that drives litigation trends are open to speculation, but the trends themselves are observable and measurable. We know, for example, that the frequency of suits has been rising at a reasonably predictable rate that parallels the increase in usage of medical services. However, the size of settlements and awards has been growing dramatically in recent years, and this growth is the main driver behind the premium increases we are seeing now.

While none of this is good news, things could be worse. The most positive aspect is that Rhode Island physicians still have solid, if limited, options for coverage. This has not always been the case. Consider:

- In 1975, RI doctors experienced the sudden and complete unavailability of medical professional liability coverage. That led to the emergency creation of the Rhode Island JUA.

- From 1975 until 1994, not a single A.M. Best-rated liability insurance carrier was available to doctors in Rhode Island.

- Between 1987 and 1993, nine different "risk retention groups" (RRG's) sold "bargain" liability policies to hundreds of Rhode Island physicians and then went bankrupt. (Such bankruptcies are especially dangerous because RRG's, like hospital captives, are beyond the reach of Rhode Island regulators and do not have the state insolvency fund as an emergency safety net for policyholders.)

- In 1993/94 RI experienced the "impairment" and insolvency of Premier Alliance, an unrated carrier that had been the only alternative to the JUA for most Rhode Island physicians.

Today, in contrast, we have the following insurers active in Rhode Island:

- Medical Protective, rated A+ ("excellent") by A. M. Best, — although on November 21, Best placed Med Pro's rating under review with negative implications because of large cumulative losses over the past 3 years.

- NORCAL Mutual, rated A ("excellent") by A. M. Best with rating outlook "stable."

- ProSelect, rated A- ("excellent") by A. M. Best with rating outlook "stable."

- Rhode Island JUA, not rated by A. M. Best but structured in such a way that it is extremely safe from bankruptcy.

In addition, we have the Rhode Island Medical Society's 30-year history of vigilance and advocacy in the professional liability arena, and we have the RIMS-IBC supporting the Society's mission and providing knowledgeable service and reliable information to the physicians of Rhode Island.

Signed,

Peter A. Hollmann, MD, President
David P. Carter, MD
Richard Divver
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2003 Medicare Update

Congress still has a narrow window of opportunity to fix the mistake

After a two-month delay, the federal government's "Final Rule" on 2003 Medicare physician payment was due to appear in the Federal Register December 31. As expected, the rule announces a 4.4% reduction in Medicare payment rates. Absent quick corrective action by Congress, this cut will become effective on March 1, 2003 (or possibly somewhat later if CMS further delays publication of its annual "Dear Doctor" letter).

The US Senate chose to leave Washington in December without fixing the flawed formula that generated the cuts. Over 2,500 physicians contacted Congress through the AMA Grassroots Hotline (800-833-6354) in the final days of the 2002 session (see *Rhode Island Medical News*, November 2002). As a result, the House of Representatives responded by twice passing constructive bills to avert a crash. However, the Senate went home without acting. (Physicians can also register their concerns with their Congressional representatives by email through www.ama-assn.org/ama/pub/article/9255-6976.html.)

It remains to be seen whether the fall of Senator Trent Lott and the ascent of cardiac and thoracic surgeon Senator William Frist, MD, as Majority Leader of the Senate may help facilitate the passage of physician and patient-friendly legislation, not only on Medicare issues but on such things as national tort reform as well.

Another concentrated effort is being mounted under AMA leadership to get the Medicare update formula corrected after Congress returns on January 7. All four members of Rhode Island's congressional delegation are on record in support of the needed corrections in the Medicare reimbursement formula.

Update should be +1.6, not –4.4

CMS has announced that if the mistakes in the payment formula were to be fixed, the 2003 update would be +1.6% instead of -4.4%. CMS Administrator Tom Scully said, "We want doctors, and patients, to see Medicare as a trustworthy partner in providing quality services. Fixing the formula to provide an accurate update (which we think should be 1.6 percent for calendar year 2003) is essential to restoring that trust." No doubt that is true, but fixing it now would still not restore the 5.4% hit physicians took in 2002.

Responding to aggressive AMA advocacy on a point originally identified by AMA economists, CMS has finalized its decision to revise a key component of the Medicare Economic Index (MEI), which is the government's measure of medical practice

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Medicare Update
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cost inflation. As a result, the 2003 MEI is 3.0%, the highest the MEI has been in more than a decade. CMS indicates that this change will increase Medicare funding for physician services by $14.5 billion over the next 10 years.

CMS indicates that even though payment rates are scheduled to be reduced by 4.4%, CMS actuaries are forecasting that Medicare spending on physician and health professional services will increase by 2% in 2003. This forecast follows from actuarial assumptions regarding a "behavioral offset," i.e., that physicians will increase the number of services they deliver to Medicare patients sufficiently to offset about 1/3 of the decrease in their payment rates.

Access Concern

CMS is expanding its efforts to monitor beneficiary access to physician services, both nationally and in local markets. CMS admits it "expects the reduced rates to cause fewer physicians to accept Medicare rates as full payment, and also may cause fewer physicians to accept new Medicare patients."

Physicians in several states, including Rhode Island, have little or no choice but to accept Medicare rates; however, physicians in every state are free to limit the portion of their practice they devote to Medicare patients on a fee-for-service basis. (Physicians may find themselves boxed in by "all products" clauses when it comes to Medicare Plus Choice, however.)

Other Issues

A key issue addressed in AMA comments on the proposed rule is the need for CMS to increase Medicare payments for administration of flu and pneumonia vaccine in order for practices to continue to be able to afford to provide this important service to their Medicare patients. In the Final Rule, CMS announced that it has raised Medicare payments for flu vaccine administration to $7.26 from $3.98. ❖

Medicare Participation Options for Physicians

Whenever the 2003 Medicare physician payment schedule is finally published (it was originally due out November 1) and Medicare carriers around the country finally issue their 2003 "Dear Doctor" letters (with information about Medicare's payment rates for 2003 and a "Medicare Participating Physician/Supplier Agreement"), physicians will then have 45 days to make a decision about Medicare participation for 2003. So far, delays at CMS have pushed that 45-day deadline into February. More delays may follow.

To help Rhode Island physicians make informed decisions about their contractual relationships with the Medicare program, RIMS mailed a special advisory to members in early December. What follows is a more complete version of the same information. RIMS is indebted to the AMA for permission to excerpt from AMA's informative *Medicare RBRVS: The Physicians' Guide 2002*. The complete guide is available from AMA Press by calling toll free 800-621-8335. RIMS has enriched and adapted this information below in light of Rhode Island law.

The Rhode Island anomaly

Because of Rhode Island law and Rhode Island's high proportion of elderly, the par/non-par distinction under Medicare is largely academic to physicians practicing in this state. While all American physicians are now limited by federal law (and, in many cases, further limited by state laws) in their freedom to balance-bill for Medicare services, Rhode Island remains one of the few states where balance-billing a

Medicare beneficiary in any amount at all is totally forbidden.

The Rhode Island approach is to regard Medicare balance-billing as "unprofessional conduct" under the medical practice act, which places the physician at risk for sanction by the Rhode Island Board of Medical Licensure and Discipline. The Board, which can tailor its sanctions to fit the offense, has never actually sanctioned a physician for balance-billing a Medicare beneficiary since the law was enacted some fifteen years ago.

Massachusetts became the first state to ban balance billing under Medicare more than twenty years ago. At that time, the Bay State went so far as to make compliance with the new law a direct condition for medical licensure. During the 1980's, the AMA, the Massachusetts Medical Society and other state societies went to court repeatedly and at great cost to test the constitutionality of such state restrictions on a federal program. However, medicine lost those court battles at every turn.

Nothing in state or federal law affects a physician's freedom to accept or not to accept new Medicare patients into a practice.

Special Considerations in the 2003 Participation Decision

For 2003, Medicare officials have announced that there will be an additional payment cut of 4.4% on top of the 5.4% cut that occurred in 2002. The AMA has been leading an aggressive campaign by a broad coalition of physician and other health professional organizations seeking to get legislation enacted before the additional cut goes into effect early in 2003 in order to avert any additional payment cuts and provide an increase in Medicare rates for 2003. The AMA and other physician and health professional groups are preparing a full-court press for Congress to pass legislation to avert the additional 4.4% cut when Congress returns on January 7th. However, this leaves only about a four-week window for congressional action before participation agreements have to be signed.

Once made, Medicare participation and non-participation decisions are binding for the entire year. If the rates change by congressional action during the participation decision period, however, the deadline is likely to be extended further. In addition, physicians who may have already alerted their carrier that they will become non-participating physicians for 2003 may have an opportunity to change their status back to participating if Congress acts to increase the payment rates.

Physicians who are currently participating ("par") and who want to remain par for 2003 do not need to do anything to maintain their current status. Likewise, physicians who are currently non-participating ("non-par") and who want to remain non-par for 2003 do not need to do anything to maintain their current status. To switch from being par to non-par for the coming year, however, or from non-par to par, physicians will likely need to notify their Medicare carrier in writing before about February 15, 2003.

Key decision dates could change if Congress takes action in January that affects the 2003 Medicare payment rates. Physicians can look to RIMS or to the local carrier, Blue Cross, for current information about these dates.

The Three Options

There are basically three Medicare contractual options for physicians. Physicians may sign a par agreement and accept Medicare's allowed charge as payment in full for all of their Medicare patients. Or they may elect to be a non-par physician, which permits them to make assignment decisions on a case-by-case basis. In most states, the non-par option also permits physicians to bill patients for more than the Medicare allowance for unassigned claims, but any such balance-billing is forbidden by Rhode Island law. Finally, there is the third option to become a privately contracting physician, agreeing to bill patients directly and to forego any payments from Medicare to their patients or to themselves.

Physicians who wish to change their status from par to non-par or vice versa will likely need to do so by mid-February, 2003. Once made, the decision will be binding throughout calendar year 2003 except where the physician's practice situation changes significantly, such as relocation to a different geographic area or a different group practice. To become a private contractor, physicians must give 30 days notice before the first day of the quarter the contract takes effect. Those considering a change in status should first determine that they are not bound by any contractual arrangements with hospitals, health plans or other entities that require them to be Medicare par physicians. In addition, Rhode Island's legal prohibition on balance-billing would appear to bar even privately contracting physicians from charging or collecting more than Medicare's allowable. For while the physician may opt out of Medicare, the patient remains a Medicare beneficiary who is free to visit other physicians and have services reimbursed by Medicare. Rhode Island law is focused on the beneficiary and provides that charging or collecting more than the

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RIMS Raises Storm
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and policy makers tolerate before they summon the will to mandate corrective action?

Heavy damage is already evident in the anger and low morale of physicians here, in the reluctance of well-qualified trainees to remain in Rhode Island or to relocate here, and in the strongly negative reputation that Rhode Island now has across the country as an environment that is inhospitable to medical practice.

For example, RIMS has learned that some national consultants who advise young physicians on career choices are now specifically citing Mississippi and Rhode Island as two states that doctors should avoid.

Many Rhode Island physicians who have tried to bring new partners into their practices know first-hand the effects of such negative advertising and the state's undeniably unattractive numbers. The condition of medical economics in Rhode Island is a powerful drag on recruitment and replacement of the physician workforce.

RIMS responds

In response to member inquiries, RIMS issued a special advisory to members in December regarding the particulars of Medicare participation/ non-participation in the context of Rhode Island's peculiar legal environment. (More information is provided on p. of this newsletter.)

Also in response to inquiries, RIMS is preparing for another special advisory for RIMS members on participation/ non-participation in Blue Cross and CHiP.

RIMS is expanding its Health Care Fairness Coalition to support a package of tort reform bills that will be introduced in the new session of the General Assembly that begins January 7.

RIMS has provided advice to Governor-Elect Carcieri's transition team on the urgency of the liability crisis and the other elements of the "perfect storm." RIMS has also carried this message to the Congressional Delegation.

RIMS will be surveying physicians and the public in the coming weeks, both to document the depth of the crisis and to gauge public awareness of the need for meaningful change. Members are asked to watch for the physician survey and to return it promptly to RIMS.

RIMS is asking for more data from members who have specific, recent experience and can provide examples of difficulties in recruitment and other strong anecdotal and statistical information that will help the public understand the special threats that health care is facing in Rhode Island and how these threats affect patients. ❖

Blues announce cuts
(continued)

fee schedule for the 150 top codes in each physician's specialty.

Physicians in attendance at the three meetings held in Providence and Warwick gave strong voice to their anger. They argued that their ability to deliver quality care to patients is severely threatened by economic pressures of rising practice costs and declining revenues.

RIMS President David B. Ettensohn, MD, challenged Blue Cross to postpone any cuts at least until the company had a better understanding of utilization patterns and of the impact that the proposed cuts would have. Spokespersons for the Blues conceded that they imperfectly understand the forces behind their utilization experience and do not know what impact the planned cuts will have.

Many physicians charged that the Blues' company policies are destroying the delivery system that the company and the public depend upon and building up company reserves with misguided haste. (While the Rhode Island Blues have repeatedly claimed that they must reach a reserve level of 22% of premium in order to keep their franchise, the national Blue Cross Association has refused to confirm that such a requirement exists or to comment on the role of overall market share as a consideration in determining appropriate reserve levels.)

"Not the lowest, but pretty close."

Blue Cross is well aware that Rhode Island physicians are under-reimbursed in comparison with their colleagues regionally and nationally. "Not the lowest, but pretty close," conceded one Blues spokesman. The company's own outside consultants have recommended that the Rhode Island Blues must pay better. When asked why they don't, a Blues spokesman cited competition and said, "It's what the market will bear."

In truth, it remains to be seen how much more stress the Rhode Island market can bear. Physicians at the meetings made it abundantly clear that they feel they are being pushed beyond the limit by rising practice expenses (especially liability insurance and health insurance costs for personnel) and long-stagnant or falling reimbursements.

Blue Cross publicly pledged to work with the Rhode Island Medical Society to achieve meaningful tort reform in 2003.

High utilization blamed

What necessitates these painful measures? Blue Cross says the reason is high and rising utilization trends in the state. According to the company, Rhode Island's utilization rates are among the highest in the nation and continue to trend strongly upward. At the same time, however, Rhode Island Blue Cross' data systems lack the analytical capability to identify outliers and other patterns that could suggest less draconian interventions. Blue Cross officials assert that they are asking all parties to share in the pain. As evidence, they site the much higher premiums being charged to employers (including medical practices, of course), and they say they are invoking the company's "most favored nation" clause (a.k.a. "prudent buyer") with hospitals, though confidentiality of individual hospital negotiations bars them from sharing specifics, they say.

Some have suggested that Blue Cross and CHiP are already on the wrong side of the curve and that cutting reimbursements will tend to exacerbate problems, not solve them. Some point to the state's spectacular success with workers' compensation, resulting from the reforms of 1992, as evidence that fair reimbursement is a key to overall savings in health care. ❖

NORCAL ADVERTISMENT

Medicare Participation
(continued)

allowable from any beneficiary is "unprofessional conduct." In that way, Rhode Island restricts the rights of patients as well as doctors.

Participation

Par physicians agree to take assignment on all Medicare claims, which means that they must accept Medicare's approved amount (which is the 80% that Medicare pays plus the 20% patient co-payment) as payment in full for all covered services for the duration of the calendar year. The patient or the patient's secondary insurer is still responsible for the 20% co-payment, but the physician cannot bill the patient for amounts in excess of the Medicare allowance. While par physicians must accept assignment on all Medicare claims, however, Medicare participation agreements do not require physician practices to accept every Medicare patient who seeks treatment from them.

Medicare provides a number of incentives for physicians to participate:

- The Medicare payment amount for par physicians is 5% higher than the rate for non-par physicians.
- Directories of par physicians are provided to senior citizen groups and individuals who request them.
- Carriers provide toll-free claims processing lines to par physicians and allegedly process their claims more quickly.

Non-Participation

Medicare approved amounts for services provided by non-par physicians (including the 80% from Medicare plus the 20% co-payment) are set at 95% of Medicare approved amounts for par physicians. While in most states non-par physicians can charge more than the Medicare approved amount, Rhode Island non-pars may not.

The 95% payment rate for non-pars is not based on whether physicians accept assignment on a given claim, but simply on the fact that they are non-par physicians. When non-par physicians accept assignment, they still receive only 95% of the amount par physicians receive for the same service. In Rhode Island, then, non-par physicians can only end up collecting less for their services than par physicians.

Elsewhere, federal Medicare's "limiting charges" for non-par physicians are capped at 115% of the Medicare approved amount. Obviously, even these capped limiting charges are irrelevant in Rhode Island, but it is interesting to note that in most of the U.S., because Medicare's approved amounts for non-par physicians are 95% of the rates for par physicians, the 15% limiting charge is effectively only 9.25% above the par approved amounts for the services. Thus, physicians in other states who are considering whether to be non-par must determine whether their total revenues from Medicare, patient co-payments and balance billing would exceed their total revenues as par physicians, particularly in light of collection costs, bad debts, and claims for which they do accept assignment. The AMA advises that non-par physicians practicing in states that allow the full federally-set "limiting charges" would need to collect those full limiting charge amounts roughly 35% of the time for a given service in order for the revenues from that service to equal those of par physicians for the same service.

Assignment acceptance, for either par or non-par physicians, also means that the Medicare carrier pays the 80% Medicare payment directly to the physician. For unassigned claims, even though the physician is required to submit the claim to Medicare, the program pays the patient, and the physician must then collect the entire amount for the service from the patient.

Private Contracting

Provisions in the Balanced Budget Act of 1997 give physicians and their Medicare patients the freedom to contract privately to provide health care services outside the Medicare system. Private contracting decisions may not be made on a case-by-case or patient-by-patient basis, however. Once physicians have opted out of Medicare, they cannot submit claims to Medicare for any of their patients for a two-year period.

Private contracts must meet specific requirements:

- THE PHYSICIAN MUST SIGN AND FILE AN AFFIDAVIT AGREE ING TO FORGO RECEIVING ANY PAYMENT FROM MEDICARE FOR ITEMS OR SERVICES PROVIDED TO ANY MEDICARE BENEFICIARY FOR THE FOLLOWING 2-YEAR PERIOD (either directly, on a capitated basis, or from an organization that received Medicare reimbursement directly or on a capitated basis);
- Medicare does not pay for the services provided or contracted for;
- the contract must be in writing and must be signed by the beneficiary before any item or service is provided;

- the contract cannot be entered into at a time when the beneficiary is facing an emergency or an urgent health situation.

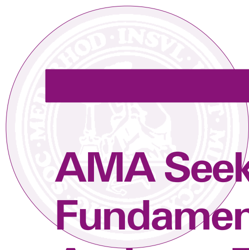
In addition, the contract must state unambiguously that by signing the private contract, the beneficiary:

- gives up all Medicare payment for services furnished by the "opt out" physician;
- agrees not to bill Medicare or ask the physician to bill Medicare;
- is liable for all of the physician's charges, which in Rhode Island may not exceed Medicare's allow able;
- acknowledges that Medigap or any other supplemental insurance will not pay toward the services; and
- acknowledges that he or she has the right to receive services from physicians for whom Medicare coverage and payment would be available.

To opt out, a physician must file an affidavit that meets the above criteria and is received by the carrier at least 30 days before the first day of the next calendar quarter. **There is a 90-day period after the effective date of the first opt-out affidavit during which physicians may revoke the opt-out and return to Medicare as if they had never opted out.** ❖

Example: A service for which Medicare fee schedule amount is $100

Payment Arrangement	Total Payment Rate	Payment Amount from Medicare	Payment Amount from Patient
PAR physician	100% Medicare fee schedule = $100	$80 (80%) carrier direct to physician	$20 (20%) paid by patient or supplement insurance (ie, Medigap)
Non-PAR/ assigned claim	95% Medicare fee schedule = $95	$76 (80%) carrier direct to physician	$19 (20%) paid by patient or supplemental insurance (ie, Medigap)
Non-PAR/ unassigned claim in Rhode Island	95% Medicare fee schedule = $95	$0	$76 (80%) paid by carrier to patient + $19 (20%) paid by patient or supplemental insurance



AMA Seeks Fundamental Shift in Antitrust Enforcement

Raise your hand if you think that the American health care system in the 21st Century is well served by the tenants of Sherman Antitrust Act of 1890. Somehow hospital systems, pharmacy chains and insurance plans manage to work around antitrust law, but the physician voice in health care is effectively stifled by it. Arguably that imbalance is the single greatest root cause of the nation's health care woes. The Rhode Island Medical Society's innovative negotiation legislation (the Health Care Fairness Act, which will be introduced again in 2003) is a remedial approach that does not require a change in federal antitrust law, though change at the federal level remains desirable and necessary.

For years, RIMS and the other states have supported AMA efforts in Congress to gain anti-trust relief for doctors. Last fall, in a Workshop on Health Care Competition Law and Policy, the AMA and state societies got some favorable media attention on the issues that affect physicians and patient care in the current marketplace.

In the context of the Workshop, the AMA and states again called upon federal regulators to take a new took at their approach to physician networks, urging that they be evaluated under a "rule of reason" analysis and not a "per se" analysis. AMA and state spokespersons made the case that many of the options available under the 1996 Guidelines put out by the Justice Department and the Federal Trade Commission are either extremely difficult and expensive for physicians to undertake (clinical integration model) or cumbersome and inefficient (messenger model). They argued that a non-exclusive physician network can be pro-competitive without clinical integration. Further, risk-contracting, which the DOJ/FTC Guidelines of 1996 favor, has proven disastrous for many physician groups, especially on the West Coast, pushing them into bankruptcy and causing severe disruptions in patient care.

The AMA called on the FTC to redirect its healthcare efforts towards health insurers in light of consolidation in the insurance marketplace, which predictably has been followed by increased premiums and increased profits for health insurers. ❖

Rhode Island in Large Cancer Survival Study

Rhode Island has been chosen by the Centers for Disease Control as one of eight states to participate in a large trans-Atlantic study of cancer survival. Data previously collected in cancer registries here and abroad have shown that cancer survival in the USA and Canada is higher than in Europe for many adult cancers. The differences are more marked for elderly patients.

A collaborative study that will measure and attempt to explain these differences. Clinical information will be obtained from the medical records of 500 representative patients in each of the contributing states, provinces, or countries during 1997. Data collection in area hospitals, physician offices and private radiotherapy facilities will continue through September 2004 related to diagnostic work-up, tumor state, treatment and tumor pathology, and the health care system. IRB approvals have been obtained on the state, national, and international level for all data collection and analysis. ❖

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