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## All Hands to Battle Stations

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The most important outcome of the 2007 regular and special legislative sessions in Sacramento was to make abundantly apparent that 2008 could be the most monumental and therefore contentious years for shaping health policy in California history since the passage of MICRA during the medical malpractice crisis in the 1970s. Voters are demanding universal access to care; legislators understand that constituents will hold them accountable if health access is not addressed urgently, and Governor Schwarzenegger is staking his gubernatorial legacy on tackling the health care crisis in California. The momentum for change is here, and health care reform has already become a driving force in the national presidential debate. Now is the time for all Emergency Physicians to lead the charge in protecting and expanding our patients' right to access quality emergency medical care while defending the ability to practice medicine without the unfair gamesmanship of insurance companies. Two key issues for Emergency Physicians that will be addressed during the coming session are the Democratic health care reform proposal and the Fair Payment (a.k.a. Balance Billing) debate.

### ***Democratic Health Care Reform Proposal***

The new Democratic bill ABX1-1 (Nuñez/Perata) passed the Assembly Health Committee and will likely face a floor vote by the end of this year. Specifically, the new healthcare plan establishes an individual mandate for most Californians, but exempts people who cannot afford to purchase insurance. Affordability is met when the total cost of health insurance is 6.5% or less of a family income.

- Covers all children and parents up to 300% of the federal poverty line. [\$61,950 for a family of four]
- Covers all single adults through Medi-Cal up to 250% of the federal poverty line. [\$25,525 for an individual]
- Provides individuals with incomes 250-450% of the federal poverty line who are not eligible for public programs with an advanceable[sic], refundable tax subsidy to help purchase coverage.
- Ensures that nobody earning between 0-150% of the federal poverty line will be required to pay premiums, co-payments, or deductibles.
- Requires the Managed Risk Medical Insurance Board (MRMIB) to establish the minimum benefits package suitable for coverage in California.
- Contains significant cost-containment measures, including expanding scope of practice of allied

health providers, allowing the state to pursue bulk purchasing of pharmaceuticals and requiring transparency from hospitals.

In addition to cost-containment measures, the bill is financed through a combination of fees and taxes, including:

- A \$2 per pack increase in the tobacco tax.
- An employer fee assessed on a sliding scale. Employers with payrolls up to \$100,000 would be expected to contribute at least 2% of payroll. Employers with payrolls from \$100,000 to \$250,000 would be expected to contribute at least 4% of payroll. Employers with payrolls above \$250,000 would be expected to contribute at least 6.5% of payroll. In addition, employers would be expected to either offer insurance to part-time employees or contribute to the public purchasing pool for those employees.
- A hospital fee assessed at 4% of revenue.<sup>1</sup>

Although many groups have expressed support for the proposal with some relatively minor amendments, this proposal continues to lack strong "buy-in" from key groups including many labor organizations. This proposal also includes expansion of nurse practitioner/ physician assistant scopes of practice and relaxes the requirements for physician supervision. This portion of the proposal represents a deal-breaker for physicians as well as nurses. Although this new proposal does make some concessions to Governor Schwarzenegger's earlier objections to AB 8, the broad exemption from requiring that all California residents have health care coverage is a deal-breaker for the administration. This bill, similar to AB 8, which was vetoed by the Governor, will clearly lack the supermajority vote needed to overcome executive veto. Still, the political gain to the governor and the Democratic leadership from reaching a deal is enough to keep the debate moving toward consensus.

### ***Fair Payment (Balance Billing)***

SB 389 (Yee), or a similar bill, is also likely to reemerge during the next legislative session. In short, this bill seeks to protect insured patients from unexpected, unpaid bills resulting from non-contracted "hospital-based physicians when the patient's health plan contracts with the hospital in which the physician has privileges to practice." Prohibiting full payment disincentivizes insurers from contracting with emergency physicians while also giving insurers *carte blanche* to continue shortchanging emergency doctors for their

services. In the event of a dispute, the physician would be required to initiate a claim with the Department of Managed Health Care's industry-friendly "independent dispute resolution process" (IDRP). Although on its face, eliminating patients from the payment dispute seems beneficial, this mechanism actually *interferes* with meaningful change within the insurance industry. When the insured consumer is deliberately removed from the consequences of choosing a particular insurance plan or company, the incentive for the insurance companies to provide more extensive coverage is eradicated, while the business incentive to "discount" emergency services is powerful.<sup>2</sup> Further, the consequences of enforcement by the Department of Managed Health Care (DMHC) are minor and fail to deter unfair business practices.

### Price Capping

Adding a layer of complexity to the Fair Reimbursement issue is SB 981 (Perata). This bill would also prohibit direct billing of patients for services not covered by a patient's health plan and require physicians to file a grievance with the DMHC's IDRP. However, Senator Perata's plan would "require that payment for each coded and charged covered service rendered by that non-contracting, hospital-based physician be made at the lesser of the physician's full charge or [some yet-to-be-determined] interim payment standard."

This proposal is potentially disastrous for emergency doctors. In effect, an "interim payment standard" could ultimately serve as the *de facto* cap on compensation for emergency services as no health plan need ever pay more than the standard established by this bill.

In short, significant health care reform is coming. It is up to us as doctors, as Emergency Specialists, and as patient advocates to be active members of both our specialty and the House of Medicine at large. Now is our time to reshape how access to care is provided. To make positive change, all physicians need to have one resounding, unified voice. Now more than ever, our patients are depending on us to lead the discourse on healthcare reform and establish meaningful access to healthcare.

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