Westchester Physician

October 2009 Vol. 20 No. 2

The Health Care Reform Issue

By John J. Stangel, MD, WCMS President

At this moment, perhaps the most crucial debate in the history of American medicine is taking place. The debate is about health care reform. The reforms, whatever they are, have the potential to forever affect our ability to make decisions on how to treat our patients and the future of our profession. To offer you an opportunity to process the information that is constantly released by Washington and to help you act in a way that you feel is best for you, your patients, and your profession, we have done something very unusual. For the first time since publishing the Westchester Physician, we have devoted the entire issue to a single subject, Health Care Reform. We, the WCMS, are your advocate as well as your portal for information. To provide this necessary information, we have assembled the following articles by a distinguished panel of physicians.

Dr. Robert Lerner reviews the single payer model of health care. It is the historical beginning of the health care proposals of today. The evolution of the model is critical to understanding current discussion. Dr. Michael Rosenberg summarizes the AMA's position on HR 3200. Many members of the Society have expressed frustration with the AMA's response to the Administration's health care proposals. But these outcries have often made without really understanding the AMA position. We need to have an unbiased review of the recommendations the AMA has made. This is the center of the whole discussion. Dr. Rosenberg has presented this review.

The term "quality care" has been used a lot recently. What does it mean and how is it measured? Dr. Abe Levy provides us with an understanding of the definition, the method of measuring it and its impact on us. This is the first discussion of the criteria used to determine quality of care that I have read. Washington has relied on the Medicare/Medicaid model for its health care proposals. What if the model to which they refer is flawed? That is the subject of Dr. Amy Newburger's article. It questions the basis of the entire health care reform proposals.

Dr Joseph Tartaglia's article summarizes the errors of information given by Washington and, most important, what you can do. This article pulls the previous discussions together. Brian Foy, our new Executive Director, follows. In his article he suggests exactly how you can impact the evolution of health care legislation right now regardless of your position in the debate.

We, the Westchester County Medical Society, are your definitive source of reliable information. Whether it is the health care reform debate or the H1N1 Virus, we will provide insight unique to Westchester physicians. The Society is now readying two systems that are crucial in today's environment. We have set up a blast email system to supply information to our members in a virtually instantaneous way. Receiving information is only half the story. Physicians need a way to share their information and their views, positive or negative, with their colleagues, political representatives and the public. To accomplish this we have set up a forum, essentially a group of blogs, on our website by which our members may communicate with the world. The website will be a source of constantly updated information, opinions and videos that are necessary to your practice and your patients' care. We also plan to be part of an extensive lobbying effort to communicate the position of our members to our legislators.

Express yourself. Be a true part of the health care discussion. We have provided the means. It is up to you to provide the action. ✦

A Look Inside . . .

The Westchester Physician
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Westchester County Medical Society

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Mark Your Calendar

October 21, 2009
WAM Pediatric Section Meeting
NYMC, Valhalla, NY

October 28, 2009
Fourth Annual Massachusetts
General Hospital Lecture Series
Mount Kisco Medical Center

November 12, 2009
WCMS Board Meeting - 6:30 pm
WCMS Offices

December 11, 2009
Annual Holiday Party & Silent Auction
6:00 - 10:00 pm
Pleasantville Country Club, Pleasantville, NY

March 9, 2010
MSSNY State Legislative Day
Albany, NY

Member News

New Members

Jeffrey D. Altholz, MD
(Internal Medicine)
Elmsford, NY

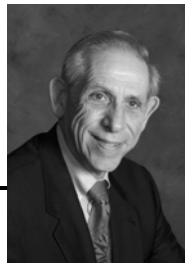
Kausik Kar, MD
(Internal Medicine)
Valhalla, NY

Life Members

Michael David Sparago, MD
WCMS member for 39 years

J. William Silverberg, MD
WCMS Member for 52 years

Why is the Move for Single-Payer Health Care Failing?



By Robert G. Lerner, MD

As I write this on September 16, 2009, the public is viewing the political debate about health care reform with varying mixtures of confusion, hope, anxiety, disappointment, despair, disgust and elation. Certainly the proponents of a single payer system and the majority of the general public agreeing with them in surveys are disappointed at the very least. They are not turning out like the opponents of the current proposals screaming at Town Hall meetings. Nor are they gloating and preparing for celebration as the executives of the health insurance industry must be at this time. How did this happen once again just as it happened in the past? Did President Obama make strategic errors? Does the public really not want Medicare for all? Did the health insurance industry pay off venal and corrupt legislators? Is our political system structured to give undue influence to the wealthy and big business? Is single payer failing because we really can't afford it? Will the profit motive drive the health insurance industry to such extremes that there will be catastrophic failures in health care just as the unregulated pursuit of profit brought down our financial system?

First, let's look at the string of past failures to address health care reform and provide universal health care in the United States. This has gone on for a century but we can focus on recent history. How did the Clinton administration fail? The fact that the proposal was created in secret with minimal input from the physician community certainly contributed to the failure. Harry and Louise misled the public on behalf of the health insurance industry. That certainly contributed to the failure. However, Vicente Navarro, MD, PhD, professor of Health Policy at The Johns Hopkins University and Editor-in-Chief of the International Journal of Health Services believes there is a more fundamental reason. He believes that there is a need for a "left" proposal to be in the discussion so that a more central proposal can succeed and that Clinton's proposal became the "left" proposal because single-payer was left out of the discussion. Did President Obama make the same error? After all, he said in the past that he was a proponent of a single payer health care system.

> *"So the challenge is, how do we get federal government to take care of this business? I happen to be a proponent of a single payer health care program. I see no reason why the United States of America, the wealthiest country in the history of the world, spending 14% of its Gross National Product on health care cannot provide basic health insurance to everybody. And that's what Jim is talking about when he says everybody in, nobody out."*
>
> *"A single payer health care plan, a universal health care plan. And that's what I'd like to see. And as all of you know, we may not get there immediately. Because first we have to take back the White House, we have to take back the Senate; we have to take back the House." (Barack Obama in 6/30/2003 before the Illinois AFL-CIO)*

In February 1974, President Nixon sent a message to the Congress that the time had come for universal health care. He said:

> *"Three years ago, I proposed a major health insurance program to the Congress, seeking to guarantee adequate financing of health care on a nationwide basis. That proposal generated widespread discussion and useful debate. But no legislation reached my desk."*

How did he change and what resulted? He gave in to the insurance industry and made them an integral part of the program.

> *The measure I am recommending today therefore contains a number of proposals designed to contain costs, improve the efficiency of the system and assure quality health care. These proposals include:*

(continued on page 4)

Why is the Move for Single-Payer Health Care Failing?

(continued from page 3)

> ***1. HEALTH MAINTENANCE ORGANIZATIONS (HMO'S)***
> *On December 29, 1973, I signed into law legislation designed to stimulate, through Federal aid, the establishment of prepaid comprehensive care organizations. HMO's have proved an effective means for delivering health care and the CHIP plan requires that they be offered as an option for the individual and the family as soon as they become available. This would encourage more freedom of choice for both patients and providers, while fostering diversity in our medical care delivery system.*
>
> *My proposed plan differs sharply with several of the other health insurance plans which have been prominently discussed. The primary difference is that my proposal would rely extensively on private insurers.*

We all know what happened. The HMO'S did what every shareholder owned for-profit company is supposed to do. They concentrated on profit maintenance instead of health maintenance. It reminds me of the fable of the scorpion and the frog. A frog agrees to let a scorpion ride on his back to cross a river; while crossing the river, the scorpion stings him, dooming the two of them. When asked why, the scorpion explains, "I'm a scorpion; it's my nature." We should expect such behavior from insurance companies; it's their nature.

Even today as I write this, Senators Baucus and Grassley, each representing sparsely populated states but both top recipients of "campaign contributions" from the health insurance industry, are trumpeting their views of how to keep the private health insurance industry heavily involved. Their proposals both leave out any mention of a "public option" to the House of Representatives legislation.

What are the advantages of a public option? It is clear that a single payer system could eliminate an enormous burden of administrative cost and the 30% overhead imposed by the private health insurance industry. Many think that those savings alone could pay for providing health insurance coverage to the currently uninsured. A single administrative structure would also facilitate introducing evidence-based efficiencies and even make tort reform a more easily achieved target. With "everyone in" to share the risk we would not see exclusion of pre-existing illness or people being dropped by health insurance companies because they need care. We wouldn't see the threat of medical bill bankruptcy added to the burden of serious illness. We would have efficient ways to negotiate drug costs with the pharmaceutical industry. However, others see that as too much strength on one side of the negotiating table with a threat to physician's autonomy and income.

So, did President Obama make strategic errors? Many people think so, including Dr. Navarro. He believes that stressing cost containment comes across as a threat to cut back the benefits that the Medicare population already has in order to provide insurance to others. Another error he mentions is a failure to address the fear of bankruptcy for people underinsured by their employer-based policies. The fragmentation of the plan based upon income comes across as taxing "me" to pay for "them" rather than a plan to benefit everyone. Leaving out the single payer option is an error not only because it removes the "left" option but it also antagonizes all those voters who supported it.

Does the public really want single Medicare for all? Yes, of course, it is not failing because the public doesn't want it. Multiple surveys confirm this; even a majority of physicians want it. (Kaiser Health Tracking Poll July 2009, Physicians' Beliefs and U.S. Health Care Reform —A National Survey NEJM Sept 14, 2009) In the NEJM survey,

> "...a large majority of respondents (78%) agreed that physicians have a professional obligation to address societal health policy issues. Majorities also agreed that every physician is professionally obligated to care for the uninsured or underinsured (73%), and most were willing to accept limits on reimbursement for expensive drugs and procedures for the sake of expanding access to basic health care (67%)."

Did the insurance industry pay off corrupt and venal legislators? I am willing to accept that most legislators are good people making an honest effort on behalf of the American people. However, I am also convinced that our system of campaign finance leads to wealthy corporations having undue influence on legislation.

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Why is the Move for Single-Payer Health Care Failing?

(continued from page 4)

Is single payer failing because we really can't afford it? Certainly not, this is irrational considering the huge amounts we continue to spend compared to countries that provide universal health care for far less expenditure.

Will the profit motive drive the health insurance industry to such extremes that there will be catastrophic failures in health care just as the unregulated pursuit of profit brought down our financial system? Unfortunately, that seems to be the scenario that is playing out. Unless the health insurance industry is brought under control by a single payer system, or a public option or effective regulatory legislation they will continue to behave like the scorpion according to their true nature.

Stay involved and keep abreast of developments. We are not going to get a perfect health program. We should support the best reform we can get. ✦

Drs. Ehrlich and Finegold Join WESTMED Medical Group

The medical practice of James B. Ehrlich, MD and Jonathan Finegold, MD, formerly known as Gastroenterology of Westchester has become part of the Westchester Medical Group, which just recently changed its name to WESTMED Medical Group.

Dr. Ehrlich is a Board Certified Gastroenterologist and is Section Chief and Attending Physician in the Division of Gastroenterology at Lawrence Hospital Center in Bronxville. Dr. Finegold is also a Board Certified Gastroenterologist, received his medical degree from the University of Miami and completed his residency and a fellowship in Gastroenterology and Advanced Endoscopy at New York Columbia Presbyterian Medical Center.

Both physicians are members of the Westchester County Medical Society and the Westchester Academy of Medicine.

- Mark Your Calendar -

WCMS/WAM Annual Holiday Party & Silent Auction

Pleasantville Country Club
Friday, December 11, 2009
6:00 - 10:00 pm

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MSSNY, the AMA and HR 3200

By Michael Rosenberg, MD, Past President
WCMS and MSSNY

There is a lot of misinformation being disseminated to physicians and the public regarding HR 3200, and the position your medical society has taken with regards to this bill and the ongoing healthcare reform debate in general. HR 3200 is not perfect. However, it is a starting point of discussion and we are committed to staying at the table until all of our issues have been heard.

The day before President Obama's speech to the joint session of Congress on healthcare reform, AMA President Jim Rohack, MD, sent a letter to the President and all members of Congress emphasizing the following seven critical elements necessary for health system reform:

1) Provide health insurance coverage for all Americans;
2) Enact insurance market reforms that expand choice of affordable coverage and eliminate denials for pre-existing conditions;
3) Assure that health care decisions are made by patients and their physicians, not by insurance companies or government officials;
4) Provide investments and incentives for quality improvement, prevention and wellness initiatives;
5) Repeal the Medicare physician payment formula that will trigger steep cuts and threaten seniors' access to care;
6) Implement medical liability reforms to reduce the cost of defensive medicine;
7) Streamline and standardize insurance claims processing requirements to eliminate unnecessary costs and administrative burdens.

These seven core principles were and remain the position that the medical society, based on policies approved at the House of Delegates, has advocated for throughout this debate. Currently, there are several issues that affect us all:

- Providing anti-trust protection to physicians so that together, we can negotiate with health insurers on a level playing field.
- Ensuring that any proposed public plan option will not default into a single payer, government-run health care system in the future.
- Ensuring that the "Pay-Fors" in the bill do not unfairly injure small businesses and middle-class Americans.

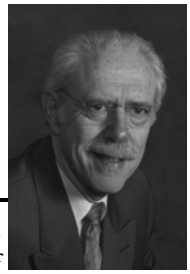
To set the record straight on some of the latest misinformation, the AMA contacted White House staff to again express strong concerns with some recent medical treatment examples used by President Obama. It was made clear that physicians are extremely dedicated and focused—first, foremost and always—on providing care that best serves their patients.

A statement the AMA released on August 12 stated, "We agree with President Obama on the importance of prevention. However, a recent example used to illustrate his important point was misleading. Surgeons are not paid $30,000 to $50,000 to amputate a diabetic's foot. Medicare pays a surgeon, on average, from $541.72 to $708.71 for one of two procedures involving a foot amputation. It is possible that the total bill, hospital stay, rehabilitation, prosthesis, etc. may approach the larger amount mentioned." These types of examples create the wrong impression — that physicians are motivated by payment levels rather than what is best for patients.

Foremost, the AMA and MSSNY will consistently stress to our elected leaders that physicians are dedicated to putting patients first and optimizing health care quality.

We know that HR 3200 is not the full remedy for the nation's flawed health financing system, nor **will** the current version **be** what will eventually become law. The Senate Finance Committee, which has released the Baucus proposal, is more likely to have greater control of the final version as it relates to financing of Medicare, Medicaid expansion, and there is no public option plan currently being put forward in the Senate. Both HR 3200, and the evolving Senate Finance Committee plan, have many objectionable items that we as physicians, and our AMA and MSSNY, must oppose for the good of our patients and our profession. What the AMA and MSSNY have decided strategically is that the best way for us to achieve our advocacy goals is to be supportive of the overall concepts, and fight in the trenches for the details. *(continued on page 9)*

The Difficulty in Measuring Quality of Care



By Abe Levy, MD

Phrases like *Quality of Care, P4P, PQRI, HEDIS, NCQA, and outcome measures* have entered our vocabulary and become accepted in such a way as to obscure the difficulty of measuring the quality of medical care.

In addition, some have brought patient satisfaction into the discussion even though measuring this is even more vague and unscientific.

Even such long-standing quality indicators as the use of beta blocker pharmaceuticals after a myocardial infarction have recently been questioned and indeed removed, as it has become apparent that certain sub-sets of patients with heart failure may be harmed by these medications.

Intensive blood glucose control in the ICU and in the hospital has also recently been found to harm some patients. We know that aspirin can prevent heart attacks and strokes, but increase the risk of gastro-intestinal bleeding.

Nevertheless, the use of objective quality indicators, such as hemoglobin A1c control in diabetics, LDL control in coronary artery disease and diabetes, immunization percentages in children and adults, and mammography or colonoscopy percentages in middle age, can validate the quality of the medical care being provided either by an individual physician or a group.

The electronic entry of laboratory and imaging orders as well as prescriptions by the physician also increases the accuracy, and hence the quality, of these components of a patient's medical care. They also allow for decision support to take place in real-time.

As Medicare and other carriers begin to reimburse more for these "quality of care" measures, their usage is certain to increase. Despite the inherent arbitrariness of trying to measure the quality of medical services and their lack of statistical significance for any one physician, our efforts should be focused on making sure that the measures used are as objective and scientific as possible. ✦

MSSNY, the AMA and HR 3200

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Our AMA had two options, one of which was to oppose this legislation, and die on our sword, unless every component of AMA policy was incorporated into the bill. The other was to support the bill for the very good things that are in it, including revision of the flawed Medicare SGR formula and provision of coverage to our 46 million uninsured patients, and to continue to work with Congress to amend the objectionable parts. We also continue to argue as forcefully as possible that there can be no real healthcare reform with tort reform.

By choosing the latter strategy, our AMA Board feels, and our MSSNY Executive Committee agrees, that we will be in a better position to influence the final outcome. Even if this comprehensive legislation fails, and it may, we will still need to address the projected 20% decrease in Medicare reimbursement scheduled for January 1, 2010, and we will be talking to the same legislators for that!

I share the concerns many of you have expressed about the proposed legislation, and I recognize that many do not agree with the position that the AMA and MSSNY have taken. Express your position, join the debate and discussion, but do so recognizing the truth about the actions that the AMA and MSSNY have taken to date, rather than the hyperbole.

Advocating for the seven core principles of our AMA and MSSNY regarding healthcare reform, genuine progress is being made in this regard. I urge all of you to express your concerns to your Congressional representatives, and to our two Senators.

We owe that to our patients and to the next generation of physicians in America. ✦

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Medicare is 45 Years Old! Can it Survive Middle Age?

By Amy E. Newburger, MD
Immediate Past President, WCMS

Medicare is held up as a model for health care coverage because of its lower overhead, compared to private, for-profit insurance. Most of us have not been on the scene long enough to remember the details surrounding the start of Medicare.

In 1965, half of all seniors lacked medical insurance. Medicare was enacted by Congress to provide a comprehensive medical program to ease the financial burdens of senior citizens who were in need of health care. Those individuals who had paid payroll taxes for at least 10 years were eligible, as were their spouses.

The benefits of Medicare included coverage of in-patient costs of hospital, skilled nursing facility, hospice in-patient care, as well as home health services and rehabilitative post-institutional care (Part A, or hospital insurance, HI). Coverage has been extended to include physical therapy, speech therapy, chiropractic treatments and hospice benefits. These costs are paid from general governmental revenues, as well as almost half from a 2.9% tax on earnings. This accounts for 40% of Medicare spending.

Additionally, there is the option of purchasing supplemental medical insurance (Part B, or SMI) which pays for outpatient physician visits, diagnostic tests, durable medical goods and home health services. Coverage of some screening studies such as routine mammography was added in 1988. Part B has deductibles and co-payments also. Currently, the average premium is $96 but is tied to income, and can be as high as $308 monthly.

Eligibility in Medicare was extended in 1972 to cover permanently disabled persons under the age of 65 and those with renal disease.

Enrollment in Part C, Medicare Advantage, includes Medicare Part B and other out-patient services such as dental, vision, and prescription care. The premium is directly paid to private health insurers which are vetted by the government which administer these for-profit plans.

Another component of SMI, Part D, began in 2006 and principally provides access to prescription drug coverage through private insurance plans. More than half of all Medicare beneficiaries are enrolled in a Part D Prescription Plan at this time. This benefit has a deductible, a 25% co-payment, and this is where the "donut hole" is to be found. The donut hole occurs when the beneficiary has spent $896 in true out-of-pocket expenses until $4350 is reached, when the drug coverage resumes, with no co-payment.

This was a significant endeavor, and did not seem to be fiscally challenging or unsound. In 1965 there were 18 million citizens aged 65 or older, constituting 12% of the population. In 1965 the average life expectancy was 72 years. In 1965, Medicare accounted for 0.6% of the Gross Domestic Product spending.

In contrast, now we have 43 million senior citizens, and the elderly population is increasing rapidly, so that by 2030 one in five Americans will be over the age of 65. Currently 13% of the population is over 65 years.

In 1950, 46% of men over the age of 65 still worked. Now the average age upon retirement is 62. Although 62 year olds are not generally eligible for Medicare, having fewer workers is significant, because payroll taxes contribute to the Medicare fund, regardless of the age of the employee. Since the beginning of the recession in December 2007 the number of unemployed persons increased from 7.6 million to 15.1 million, and payroll employment has declined by 7.2 million jobs. In fact, health care employment is one of the only sectors in which there is an increase in employment, with 559,000 new jobs.

Thus, since its inception, more services and goods are offered and covered by Medicare benefits, and the population of subscribers has increased, while its funding sources are declining. The Medicare Trust Fund is projected to run out of money by 2017. Medicare funding relies basically on a pyramid scheme, but the pyramid is becoming top heavy and will topple unless there is a broader base of support.

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Medicare is 45 Years Old! Can it Survive Middle Age?

(continued from page 12)

Physician participation in Medicare has endured because the lower payments to the physician can be offset by cost shifting to private plans and private self-pay patients. In the tri-state area more physicians, both generalists and specialists, are no longer accepting new Medicare patients. A colleague in gastroenterology related that his standard fee for colonoscopy is $1000, which he gets from his private self-pay patients. He gets $600-700 from managed care plans, and $200 from Medicare. If all his patients paid $200 he would not be able to continue offering the procedure.

In order to survive, costs must be controlled and this can only occur if there are changes in the entire health care delivery algorithm. Several innovative approaches have been proposed. In a recent NEJM article online*, some useful measures for reducing costs by hands on case management are discussed, which also improve the patients' functional health status. But this approach can only work if there is a change in the way payments are made for services and goods.

Historically, most private insurers have resisted underwriting preventative measures and screening tests, despite clear evidence that they can detect systemic diseases and malignancies earlier. One insurance company executive explained to me that whereas these costly tests do improve health over the long haul, the payoff of less utilization of insurance subsidized care in later years has a 10+ year lag. He stated that, on average, individuals change their private insurance plans every three years, so that his company would probably not be the one to reap the benefit of a healthier subscriber in later years. He noted that his business had to be profitable and could not make that investment of increased patient surveillance at this time.

Clearly, in order for a preventive health care model to be adopted and practiced, the insurers must have an incentive to cover those services. Under this design there would be fewer costs to the Medicare plan when an individual attains senior status. However, this process may take a long time to implement, and may exceed the time that Medicare has funding. Until that change takes place, in order to survive, Medicare must control what is provided, to whom, and when it is to be provided, and cannot continue as an open ended entitlement. The time has come for creativity and flexibility among all stakeholders to improve the physical and fiscal health of our nation. ✦

**Bodenheimer T and Berry-Millett R, Follow the Money – Controlling Expenditures by Improving Care for Patients Needing Costly Services 10.1056/NEJMp0907185 NEJM.ORG accessed on October 1, 2009.*

REMINDER

The WCMS offices will be CLOSED on Wednesday, November 11, 2009 for Veterans' Day.

Your Medical Society Dues

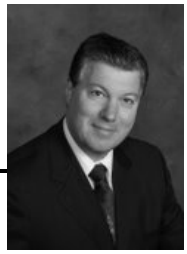
To those members who have already submitted their 2010 dues, we thank you for your commitment to your professional organizations. The strength of the WCMS comes from the support of its membership.

MSSNY will soon be sending their 2nd notices. If you have not already done so, please remit your dues as soon as possible so that we can continue to work on your behalf.

Health Care Reform Debate

An Average Physician's Opinion

By Joseph Tartaglia, MD
WCMS President-Elect



In his address to a joint session of Congress President Obama ~~has~~ focused attention on the critical issues of the health care reform bill HR 3200 and ~~he has~~ made a passionate plea to the American people to adopt it. I think all physicians recognize that health care reform is inevitable and that the time has come to address the problem together or the solution will be imposed on us from Washington without our input. There is much we, as physicians, can agree with in the proposal. But as the debate has become more raucous, it is clear to me that physicians may stand to lose a great deal if we do not unify and negotiate to protect our patients and ourselves from unfair restrictions. Physicians are a diverse group and often don't agree on issues. Despite our different political views, however, I believe we are more united than divided on health care reform. Whereas, physicians may be somewhat divided on the issue of a public plan, the issues where I think there is general agreement are universal coverage, insurance reform, tort reform and protecting Medicare and Medicaid from drastic cuts.

Who can deny the need for universal coverage? Thirty million Americans without health care insurance is unacceptable for a country as advanced as ours. A mandate that requires all Americans to have health insurance like we mandate car insurance is necessary to protect those that have insurance from having to bear the cost for those who do not. When people who can afford insurance gamble and don't buy it, they just don't hurt themselves, they also risk society bearing their costs when they become ill. When the poor go uninsured, they don't seek out preventive care and their care becomes more costly and burdensome to society.

The excesses of the insurance companies are an all too familiar theme to physicians. Most physicians have witnessed the hardship patients suffer when their insurance protection is cut or reduced, and when they can't get insurance because they had a pre-existing condition. The bureaucratic hassles and denials of care are an ever increasing burden to physicians. These practices should be outlawed. I also think President Obama speaks for nearly all physicians when he says insurance companies should be required to pay for preventive care at no extra charge.

The President made a small concession to critics by proposing to explore models of tort reform in "pilot projects" across the nation. A report in the New York Times mentions a paltry 25 million dollars has been proposed for these projects. While admittedly his proposal does not go far enough, at least Obama has begun to compromise. Physicians need to continue to emphasize tort reform as an essential element of health care reform. Canadian doctors tell me that the average Canadian doctor spends $800 dollars for malpractice insurance a year while the average New York doctor spends $35,000. How can the difference be 44 times higher in America and there not be a serious problem with our tort system? But, the higher costs to society stem from doctors changing the way they practice to defend them against a possible lawsuit. According to an editorial in the Wall Street Journal, Kimberley Strassel said defensive medicine could be costing the nation anywhere from a conservative $65 billion to (some experts say) $200 billion per year! Nearly every doctor I speak to feels defensive medicine contributes in a significant way to his ordering excessive unnecessary costs.

The part of HR 3200 physicians should find most objectionable is the idea of funding $500 billion of the $900 billion it is projected to cost over the next ten years by reducing all the "fraud and waste" in Medicare and Medicaid. Healthcare is approaching 17% of our GNP and the Medicare and Medicaid programs are increasing entitlement spending and preventing discretionary spending by congress; much to the chagrin of our Senators and Congressmen who seem to love spending without limitations. Unfortunately, the stimulus package spending spree has raised the national debt so much that health care reform now has to be budget neutral. Clearly, the President when he says, "our health care problem is our deficit problem" intends to radically reduce the cost of Medicare and Medicaid. $177 billion of the savings will come from stopping federal subsidies to private Medicare advantage plans, something which most physicians seem to support. But, where are we going to get the other $323 billion? Daniel Levinson, Inspector General of the U.S. Department of Health and Human Services in his report to Congress stated that he was able to recover or disallow $3.25 billion from Medicare and Medicaid from 2006 to 2008.

(continued on page 15)

Health Care Reform Debate - *An Average Physician's Opinion*

(continued from page 14)

Therefore, even if the Office of the Inspector General quadruples his efforts to uproot fraud, we are unlikely to materialize the 33 billion a year necessary to pay for health care reform. If so much money can be saved from these programs, then why hasn't any prior Administration been able to extract this money for the past 40 years? And what will happen if these savings cannot be found? Then, according to the bill, a budget mechanism would automatically reduce the Medicare budget called a "deficit trigger" by one senior member of the Obama Administration. What will the nature of these budget cuts be? The Administration is vague on details, but President Obama mentions a commission of doctors and experts to find "even more savings." Ironically, the administration had planned to eliminate the flawed physician payment formulas but seems to be substituting a more ominous, far reaching budget ax.

The medical community is divided in its support for the public option. Some physicians, disgusted with the abuses of the insurance companies and managed care say openly that the best option is a government run system. The AMA has endorsed HR 3200 as a strategic maneuver to have a greater influence on the bill. While they have not endorsed a public option per se, a rebellion led by Dr. Palmisano and some state medical societies have split with the AMA's endorsement of HR 3200 principally over this issue. From these physicians' point of view, although Medicare doesn't micromanage physicians like managed care, it pays less than private insurance. Nonetheless, It appears that according to the New York Times, the public option is fading from the debate and may become a mute issue. Without enough votes to pass a public option in the senate, the Obama administration may have to settle on the political middle ground of Co-ops or the Republican idea of allowing insurance to sell their products across state lines.

Now is a critical time for physicians to get involved and make their voices heard. Polls have shown that the public trusts us more than any other interest group, Congress or even the President when talking about health care reform. We can have a great deal of influence on shaping the final bill if we speak up for what is right. We need to hold our representatives accountable. If $900 billion is what is needed for health care reform, then we need to raise $900 billion in new taxes and not make fanciful promises that the money will materialize from cutting "abuse and waste" from vital programs that help our seniors and the indigent. We should insist that savings from tort reform and reducing defensive medicine help finance the bill. We should demand more than just token experiments in tort reform that more than likely will be buried over time. All my professional life I have heard physicians give weak excuses for not belonging to the Medical Society, for not getting involved. They always expect someone else to come forward and protect them. We are watching the biggest change in health care since the formation of Medicare and it's time to make your voice heard. Call us and tell us what you think we should lobby for and then ask us how you can help. Some form of health care reform will likely pass this year and its time we speak with one voice united for change. ✦

We Need Your E-mail Address!

As mentioned in Dr. Stangel's cover article, the WCMS has set up a blast e-mail system so that important and timely information can be distributed to its members as soon as it is received.

If you would like to receive these communications, we will need your e-mail address.

You can send this to us via email to **doneill@wcms.org** or you can fill out and detach this form and either fax it to **(914) 967-9232** or mail it to our office at ***333 Westchester Avenue, Suite LN01, White Plains, NY 10604:***

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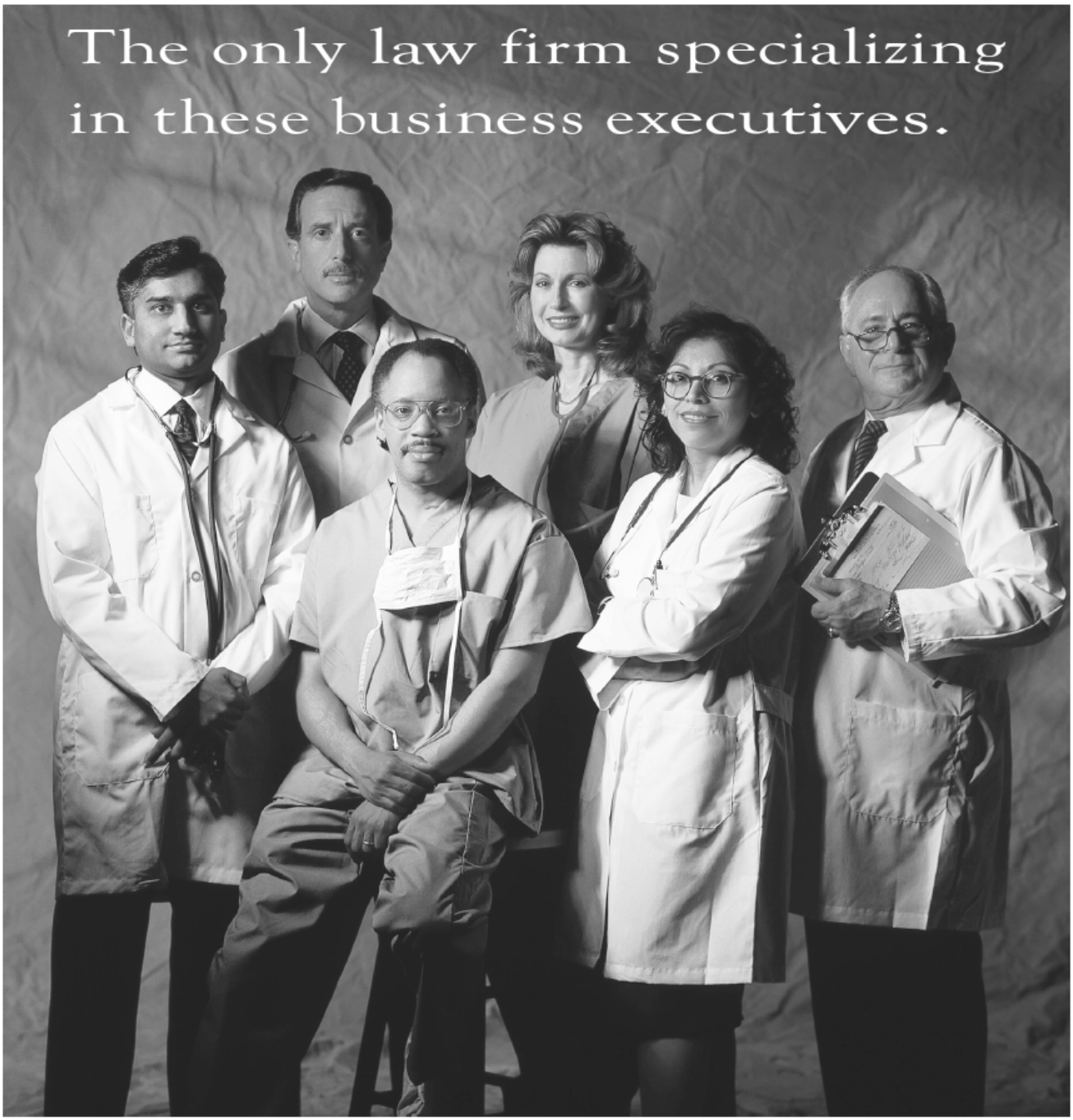
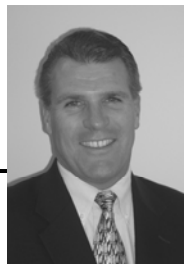


The Last Word . . .
"Get in the Game!"



By Brian O. Foy, Executive Director

I love this time of year. There's a chill in the air, the leaves are changing colors, the kids are back in school (yeah!) and, of course, it's football season. Yes…football is here and thank goodness for that! I never seem to get sick of it. High School, College, Pro…it doesn't matter. Now, it seems there is a game on TV nearly every night of the week. I'm okay with that since I couldn't care less about the latest crime show or reality program. All football, all the time!

As you may have guessed by now, I'm a football fan. Not a casual fan, mind you. When my favorite teams are playing, I tend to question and second guess the play calling. "What were they thinking?" "Why did they run the ball up the middle on first down when you could have faked the defense with a clever play-action pass?" And…"why don't they ever throw the swing pass to the running back out of the backfield?" The list is endless. I almost want to be in the huddle when the play is called. I want to consult with the offensive and defensive coordinators who call the plays. In summary…I want to be IN the game.

The "game" of politics is no different. Many well-intended state and federal legislators make decisions (call plays) on a daily basis that directly or indirectly affect you and your ability to practice medicine. They frequently do this without your input. Just look at all the debate on health care reform. Who better than you to advise them on an issue that may impact your efforts to provide the best possible care for your patients? If YOU don't communicate with them, then who will do it? Your neighbor? Almost every issue has competing interests and in my experience, "they" are making the time to be sure their legislators hear from them. Whether it's a scope of practice issue, reimbursement, insurance coverage, new regulation…you name it…other voices are being heard. What about yours?

You are not alone in this environment. Your Westchester County Medical Society, the Medical Society of the State of New York, the American Medical Association and many other physician advocacy organizations are doing the best they can to represent your interests and the profession of medicine. However, they cannot do this alone. **We need you!** I can't tell you how demoralizing it is to be in a Legislator's Office, whether it be in Washington, DC, Albany, or you name the Capital and State, and hear the words "I haven't heard from any (or many) doctors about this." Unfortunately, we don't always know this to be true, but many times it is. They know where the medical societies stand; that is not their point. They may even understand our position on behalf of all of medicine and patient care. What it usually boils down to is how their OWN constituents feel. That can be the deciding factor in a crucial vote. They know you are busy; however, it is very easy for a Legislator, in the face of a strong campaign from competing interests, to say "I'm not hearing from the docs on this" and vote the other way. This is an easy out. It happens all too often. You cannot allow this to happen…for your practice, your patients, your profession. You must engage. You must be in the game!

Okay…so how best to be in the game? Very simple. First…support MSSNYPAC every year by providing your contribution along with your medical society dues. Choosing to support "Your PAC" is a win-win. Look at this as an investment in your practice and profession. You worked many years and countless hours to get where you are. Don't let others dilute what you have worked so hard to achieve! While you cannot always give your time, and that is understandable, your financial support of the PAC ensures that organized medicine can adequately support legislators who support issues important to the practice of medicine. We need to support our friends in Albany and those who wish to be in Albany representing us.

Secondly, and just as important, get to know your local legislators...personally. Find an opportunity to meet them. Attend a Town Hall Meeting, email them, call them or even seek them out after church. Whatever the opportunity, make the time to establish communication so you eventually become a trusted resource on medical issues. Our legislators need to hear from you. Many of you have done a great job of this over the years; however, we need to deepen the ranks. Your commitment of time and effort in developing some form of a relationship with your elected leaders will go a long way toward improving your practice environment.

I know none of this is new to you and I apologize if this in any way sounds like a lecture. That is not the case. It is simply intended to be a reminder to you that even with your dues and moral support we cannot be as successful without your investment of time. Please consider leaving the stands, coming down to the field and joining the game. Your profession needs you now more than ever. ✦

Letter to the Editor

To the Editor,

In regard to Dr. Tartaglia's lead article in the August 2009 Westchester Physician, **"How to Choose the Right Electronic Medical Record System for your Practice",** he failed to mention one of the great drawbacks of the systems, that is, the significantly increased time required in order to input data into the system as they are presently constituted.

We have gone through about six systems at the Edward S. Harkness Eye Institute of New York Presbyterian Hospital and each system has failed because the residents complained about the significantly increased time necessary to input data. This is in addition to the complexity of the system itself. Unfortunately, all systems seem to suffer from the same requirement that "one size fits all" even when the system is designed for a specific specialty. Because each system requires significant typing, the physician (note I did not say "provider" because I consider the term demeaning) spends considerable time with his back turned to the patient.

Some practices have hired scribes to input data which adds considerably to the cost and reduced, still further, the physician-patient intimacy. I believe many of our fellow physicians will be frustrated, as I am, by the significant negatives of the EMR systems that are presently available.

Sincerely,
Martin E. Lederman, MD

Letters and comments regarding the content in *The Westchester Physician are welcome. Please email your letters/comments to bfoy@wcms.org or fax them to (914) 967-9232.*

NEWSLETTER SUBMISSIONS

If you would like to submit an article for publication in the ***Westchester Physician***, the deadline for the November issue is **October 31st**.
Please email these to Peter Acker, MD, Editor at **Peterrba@aol.com**

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