Philadelphia Medicine

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Will a Health Insurance Exchange benefit me?

A Health Insurance Exchange is a set of government-regulated and standardized healthcare plans in the US from which individuals may purchase health insurance eligible for federal subsidies. All exchanges must be fully certified and operational by Jan.1, 2014.

Exchanges are not insurers, so they do not bear risk themselves, but determine the insurance companies that are allowed to participate in them. Ideally, a well-designed exchange will promote insurance transparency and accountability, facilitate increased enrollment and the delivery of subsidies, and play a role in spreading risk to ensure that the costs associated with those with serious medical needs are shared more broadly across large groups rather than spread across just a few beneficiaries.

President Obama promoted the concept of a health insurance exchange as a key component of his health reform initiative. He stated that it should be "a market where Americans can one-stop shop for a healthcare plan, compare benefits and prices, and choose the plan that's best for them, in the same way that members of Congress and their families can."

Background

The private health insurance industry fears that restricted eligibility and a market size that is too small could result in higher premiums, encourage insurers to "cherry-pick" customers, and force a clearance of the exchange.

History

Although Congress sought a single national exchange, when the Affordable Care Act was passed, it split exchanges by state, in line with the bill that passed the Senate. States may choose to join together to run multi-state exchanges, or they may opt out of running their own exchange, in which case the federal government will step in to create an exchange.

Private health insurance exchanges

A private health insurance exchange is an exchange run by a private sector company or nonprofit. Health plans and carriers in a private exchange must meet certain criteria defined by the exchange management. Private exchanges combine technology and human advocacy, include online eligibility verification, and mechanisms for allowing employers who connect their employees or retirees with exchanges to offer subsidies. They are designed to help consumers find plans personalized to their specific health conditions, preferred doctor/hospital networks, and budget. These exchanges are sometimes called marketplaces or intermediaries, and work directly with insurance carriers, effectively acting as an extension of the carrier.

Health insurance Exchanges in the Affordable Care Act

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None of these plans should deny coverage on the basis of a preexisting condition, and all of these plans should include an affordable basic benefit package that includes prevention, and protection against catastrophic costs. The insurance sold on the health insurance exchanges in the United States will be exclusively from the private insurers. USI is a broker for many of these private insurers.

To read the full report, visit *www.philamedsoc.org.*

PCMS NEWS

All PCMS Members

8th Annual Tools for Success Conference

Villanova Conference Center
601 County Line Road, Radnor, PA
April 17 and 18, 2013

Health Literacy and Your Practice

Presentations will include information and strategies for dealing with issues of ICD 10, Meaningful Use, Patient Center Medical Home, Medicare update, and legislative and regulatory and payer updates.

Special Wednesday Night Program Physicians and Practice Managers

6:00 PM Reception - 6:45 PM Buffet Dinner
7:15 PM Raymond J. Nolen, Nolen Associates Inc.
Med Mal Market Update
7:30 PM *Working Together to Run a Productive Practice:* Examining physician/patient communications, pay for performance programs, quality scores, productivity expectations, defensive medicine, patient satisfaction, enhancing reimbursement and more.
Presenter is Jaan Sidorov, MD.
Cost is $29 per person. For information phone 610-892-7750.

Call to Action: Ask your state senator to support Physician Apology Bill

All physicians are asked to contact their state senator and urge them to request the Senate's prompt consideration of SB 379 and to vote yes. SB 379 would require liability insurers to encourage benevolent gestures by insured healthcare providers. It would allow physicians and patients to have a full and open conversation after an unforeseen outcome by prohibiting that conversation from being used by plaintiffs in a medical liability lawsuit. The proposed legislation also would also extend the life of the Children's Health Insurance Program (CHIP), which is set to expire at the end of 2013, until the end of 2018.

Clinical Update in Gastroenterology
CME Program
Saturday, April 27, 2013
8 AM -12 Noon
See Enclosed Flyer

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Editorial

Physicians must participate so accountability measures truly promote quality

by Harvey B. Lefton, MD

We are practicing in an age of rapidly changing treatment modalities and increasing pharmacologic options. What is changing even more rapidly is the practice environment that insurers, government agencies and even patients use to judge us. We are all seeing the development of practice guidelines — factors external agencies are using to decide whether we measure up to their standards. It is no longer enough to have patients tell their friends what great physicians we are. We now have specialty societies and government agencies developing professional yardsticks to measure us.

While these guidelines are being used to evaluate us, they are also being used to measure our practice efficiency. When looked at in this light, we can understand that EMR is not only useful for making records readable and portable but also easier for those auditing us! What we must realize is that government created this as much to reduce reimbursements as they did for practice accountability.

We are experiencing a rush to use guidelines to re-engineer the healthcare system. Physicians are forced to adopt EMR while the burden of its cost affects practice income, often not positively. Industry has used computer oversight successfully in the past. IBM was able to re-engineer its credit request process from six days to four hours when a new management team approached the problem. Using computers alone to analyze this process was not enough to make changes.

What finally worked was a team of individuals personally evaluating the process. This professional approach is needed in medicine. EMRs, pay for performance, chronic disease management, and reform to the tort system all must be analyzed if we want to improve efficiency and costs of care. We must also determine how we can integrate lifestyle changes to reduce costs. As long as we have a population consuming 150 pounds of sugar per person each year and twice the recommended daily salt, we will not reduce the chronic problems of obesity, diabetes, heart disease and cancer through technology alone. Clinicians do not have the luxury of television's Dr. Gregory House, who performed every test available until an exotic diagnosis was reached. We are taught to first rely on our skills in history taking and physical exam to make a diagnosis. These skills are often overlooked when practice guidelines are developed as the emphasis is placed on management of disease and medication error.

Sir William Osler once said, "Listen to the patient. He is trying to tell you what is wrong with him." Digital information skills must be integrated into the physician interview to maintain this humanism of medicine and maintain clinical skills.

We would not recommend someone to start exercising by running a four-minute mile. Likewise, we cannot expect physicians to follow new guidelines they have not helped to develop.

We need physicians to participate so accountability measures truly promote quality. These measures need to be continually re-examined to validate their necessity. As an example, the Joint Commission found no relationship between hospital discharge performance measures for congestive heart failure and re-admission rates. This emphasizes the need for education but also highlights developing meaningful measures for patient care.

We would not recommend someone to start exercising by running a four-minute mile. Likewise, we cannot expect physicians to follow new guidelines they have not helped to develop.

There must be a national process to help develop accountability measures that allow us to interact with and produce a comfort level. With a shortage of 100,000 physicians by 2020, we must work together with CMS, insurers, and national societies to develop guidelines that are doctor and patient friendly. Unreasonable accountability guidelines developed without physician input will only deepen this shortage and do little to lower healthcare costs.

Dr. Lefton is the President of PCMS.

Death certificates can pose challenges for physicians; inaccuracies can have widespread consequences

Physicians often face uncertainties about a person's cause of death or how to answer the parts of certificates for which they are responsible. Although the basic format has changed little in the last few decades, doctors face difficulties as some states attempt to convert from paper to electronic certificates.

Doctors need to recognize the importance of the documents and be as specific as possible, said Gregory McDonald, DO, chief deputy coroner of Montgomery County in Pennsylvania.

Information on death certificates is reported to the CDC and used in compiling national mortality data.

Physicians who are new to signing death certificates probably will have the document returned if they make a major error or omission.

The basic information that death certificates require hasn't changed much. Every 10 to 12 years, the Centers for Disease Control and Prevention's National Center for Health Statistics has a committee review the US Standard Certificate of Death. States must follow the standard but may have some variation based on the health concerns in a specific area. The most recent changes to the standard form about 10 years ago included questions about pregnancy and whether tobacco use contributed to a death.

The critical parts of a death certificate that the physician is responsible for are date and time of death, the time the doctor signed the form and the cause of death.

The standard certificate includes a place to list the primary cause of death. Secondary causes, such as other health conditions that may have accelerated a patient's death, can be listed in a separate section.

Certainty can be elusive

Although the goal is to be as specific as possible about the cause of death, meeting that goal sometimes can be a challenge, said Charles Cutler, MD, an internist in Norristown, Pa., and chair-elect of the American College of Physicians Board of Regents.

Dr. Cutler has been signing death certificates for about 34 years. If a patient dies in a hospital, it is easier to pinpoint the cause of death. But when he is called by a funeral director to sign the death certificate of a patient who died at home, he may not have seen the patient for weeks or months. It can be particularly difficult in people with Alzheimer's disease, because such patients are unable to describe their symptoms, he said.

In some states, physicians can use words such as "probable" to qualify a cause of death that they are not completely certain of. That language isn't acceptable in Pennsylvania, Dr. Cutler said. The state requires a specific cause of death to be listed.

In some cases he will talk to family members and make suggestions to gauge their reaction. For example, he might say, "Your father had advanced cancer and a weak heart, but in the end I think it was the heart that did him in. What do you think?" In more than 30 years of signing death certificates, Dr. Cutler said relatives have had questions about the document only a handful of times.

Manner versus cause

In signing death certificates, physicians need to be aware of the difference between the "manner of death" and "cause of death" entries.

In most states, the manner of death would be either natural, suicide, homicide, accident or undetermined. In many states, such as Pennsylvania, only a medical examiner or coroner can answer that question on the form.

In one instance, a person died of a seizure, and the physician thought it was a natural death. It turned out that the seizure occurred as a result of injuries from an assault, making it a murder.

Documents go electronic

Some states have had electronic death certificates for many years, while others are just getting started. The conversion to electronic forms is a complicated process because funeral homes, physicians and others must be able to access the systems.

Having electronic death registration will help increase accuracy because certain checks and balances can be built into the system. For example, if a physician lists the cause of death as cardiac arrest, the system would prompt the doctor to be more specific.

Adapted from an article by Carolyne Krupa in *amednews*.
Posted Jan. 21, 2013.
www.cdc.gov/nchs/data/misc/hb_cod.pdf

Let the collection and reporting begin; CMS publishes final Sunshine Act regs

The Physician Payment Sunshine Act final rule will greatly affect the entire pharmaceutical and medical device industry.

In general, the Sunshine Act requires applicable manufacturers of drugs, devices, biologicals, or medical supplies to report annually to the Secretary of HHS certain payments or other transfers of value to physicians and teaching hospitals. It also requires applicable manufacturers and applicable group purchasing organizations (GPOs) to report certain information about the ownership or investment interests in such entities held by physicians or the immediate family members of physicians.

Data collection will begin on August 1, 2013, for applicable manufacturers and applicable GPOs sufficient time to prepare. Applicable manufacturers and applicable GPOs will report the data for August through December 2013 to CMS by March 31, 2014, and CMS will release the data on a public website by September 30, 2014.

CMS is developing an electronic system to facilitate the reporting process.

pcms people

Mark Blecher, MD, recently received the prestigious Wills Eye Society Silver Tray Award.

Richard Baron, MD, has been named President and CEO of the American Board of Internal Medicine and the ABIM Foundation effective June 2013.

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Host your event at PCMS
Host your next party or conference/seminar at PCMS headquarters. Ample free parking. Contact Louise Eder on 215-563-5343, Ext. 107 to schedule an appointment.

SAVE THE DATE
Saturday, June 8, 2013
President's Installation and Awards Night
Celebrating the Inauguration of
Curtis T. Miyamoto, MD
PCMS 152nd President
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