



Voices of Medicine



By Del Meyer, MD

How HMOs spend health care premiums, campaigning against Medicare cuts, and the evolving immunity of sexually transmitted diseases.

Why health insurance costs so much

The Bulletin Humboldt-Del Norte County Medical Society summarizes the California Medical Association's report on health plans that spend the least of the premium dollar on health care. Those spending less than 10 percent on administration included Scripps Clinic, Sharp, Kaiser, Cal Optima and others.

Those spending 15 to 25 percent on administration included SmartCare, BC, BS, Aetna, Great-West, Molina, PacificCare, HealthNet, Cigna and UHP Health care. Leonard Schaeffer, the CEO of WellPoint, the parent company of Blue Cross of California, received over \$11 million in total stock, salary and other compensation. Next highest was Aetna CEO John Rowe, MD, at more than \$3.4 million.

CMA states: "We have included three new additions to our report this year. First is the reintroduction of health plans that have become insolvent, filed bankruptcy or who were absorbed by other health plans over the last five years. Second, is the Executive Compensation table that provides a glimpse of salary and bonuses for 2002. Finally, we've included an appendix of websites to access consumer related report cards." To read CMA's entire Knox-Keene Report, go to <http://www.calphys.org/html/bb545.asp>.

Trying to Stop Medicare Rate Cuts

Southern California Physician reports, "The California Medical Association and the American Medical Association launched a grassroots campaign to ask Congress to permanently rewrite the Sustainable Growth Rate (SGR) formula. The SGR formula reimburses physicians based on the gross domestic product, instead of the practice cost index. If the formula isn't fixed soon, physicians will face a 5 percent cut to their Medicare reimbursement starting Jan. 1, 2006, and will see cuts totaling approximately 30 percent over the next six years.

"We want to get rid of Medicare's SGR formula altogether," says Elizabeth McNeil, director of federal issues in the CMA Policy Department. "The formula is based on the gross domestic product. Although that is a general economic indicator, it does not tie to the cost of practicing medicine. We want Congress to at least avert the cuts for the next year."

"But the CMA and AMA not only want to reverse the cuts, they are seeking a rate increase, too. The Medicare Payment Advisory Commission, an independent federal commission established in 1997 to advise Congress on issues affecting Medicare, recently recommended a 2.7 percent physician rate increase in 2006.

"The AMA is going to introduce a bill that will replace the SGR formula and implement a 2.7 percent increase in 2006," McNeil says. "Any rate reform will be attached to a pay-

for-performance initiative, which is based on quality measures."

The entire report by Dina L. Burwell is at http://www.socalphys.com/jun05/policy_news.pdf.

Note: My discussions with patients on physicians' need for higher fees falls on deaf ears. I've had patients tell me physicians could survive a 100 percent cut in income. That may not be entirely the result of our schools' inability to teach math. Hence, the current 31 percent cut in Medicare reimbursement generates no public sympathy for a profession perceived as "well-to-do." When patients realize we are asking for more tax dollars in payment for their health care services, they get very annoyed.

An alternative and probably more appropriate strategy would be for Medicare to try to survive in the medical marketplace. As physicians leave Medicare (and the CMS web site suggests that many in our own area are doing so) patients will resort to the political process. Physicians will then have taken the high road instead of merely lining up at the public trough, and patients who can't find a Medicare physician will take the low road to their politicians. Members of Congress will be more sympathetic to 37 million patients who can't find a doctor than to a half million doctors who don't have enough patients. Thus, market-based medicine can even be a corrective influence on socialistic schemes such as Medicare.

As for the pay-for-performance (P4P) initiative, this is strictly a payment to those physicians most skillful in denial of care that patients need or want. Eventually patients will rise up against this subterfuge, just as they did when HMOs were paying for low-cost performance under the guise of P4P and Quality of Care (QOC) issues. This resulted in such a lower quality of care that improvement became a clarion call against physicians and hospitals when it was really the result of Medicare and HMO reimbursement performance.

Redux: Resistant, Resurgent STDs

Jeffrey D. Klausner, MD, MPH reports in San Francisco Medicine: "In 2004 the San Francisco Department of Public Health (SFDPH) published or collaborated in new research demonstrating the introduction and spread of azithromycin-resistant syphilis in San Francisco; the continued increase in ciprofloxacin-resistant gonorrhea; and the presence of lymphogranuloma venereum (LGV). These three reports resulted in changes in sexually transmitted disease (STD) treatment recommendations of which medical providers who take care of patients with

STDs should be aware...

"Data from a molecular monitoring project of syphilis conducted by the San Francisco Department of Public Health in collaboration with researchers from the University of Washington-Seattle demonstrated that a mutation in *Treponema pallidum* caused azithromycin-treatment failure in patients with syphilis.... Those findings make the use of azithromycin as a preventive or therapeutic treatment for syphilis in San Francisco no longer an option. The current recommended medication for the prevention and treatment of syphilis remains penicillin benzathine G long-acting (LA). In penicillin allergic or intolerant patients, doxycycline 100 mg by mouth twice daily for 14 to 28 days is recommended.

"Gonorrhea, while decreasing in heterosexual men and women, young adults and African-Americans in San Francisco, remains a relatively common infection in men who have sex with men. In 2002, treatment recommendations changed in California such that fluoroquinolones were no longer recommended as first-line therapy. In 2004, those recommendations were expanded to include all men who have sex with men throughout the United States. Continued vigilance is required in all populations throughout the United States. In lieu of treatment with fluoroquinolones, the current recommended treatment for gonorrhea is a third-generation cephalosporin.... All patients treated for gonorrhea should be cotreated for chlamydia (doxycycline 100 mg by mouth twice daily for 7 days) unless

chlamydia has been ruled out. We also recommend that all patients treated for gonorrhea are retested at three months to rule out reinfection.

"Chlamydia trachomatis has two distinct classes or biovars: A-K and L types. Types A-K cause typical urogenital infections like asymptomatic infections, cervicitis or urethritis while the L types cause the disease lymphogranuloma venereum (LGV).

The entire report and summary of new issues and treatment changes in STDs is at <http://www.sfms.org/sfm/sfm605e.htm>.

delmeyer@healthcarecom.net

Sierra Sacramento Valley Medical Society
5380 Elvas Avenue #100 • Sacramento, CA 95819
916.452.2671 PH • 916.452.2690 FX • Email: info@ssvms.org

Copyright © 2000-2008 Sierra Sacramento Valley Medical Society - All Right's Reserved