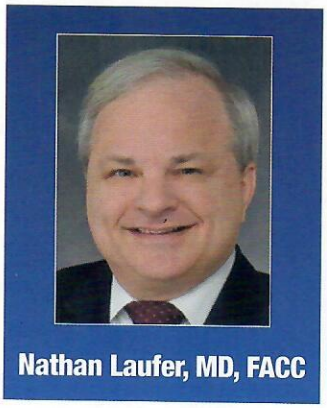
FROM OUR President

Health Care Mandates, or How the Government is taking over Our Professional Lives

"I predict future happiness for Americans, if they can prevent the government from wasting the labors of the people under the pretense of taking care of them."

— Thomas Jefferson



Nathan Laufer, MD, FACC

The Federal Government continues to impose mandates that affect the practice of medicine in the U.S. The most important of these relate to the Affordable Care Act (ACA, or Obamacare), the mandatory use of electronic medical records, and most recently, the conversion to ICD-10 coding. Another mandate that affects numerous small and large businesses, including medical practices, is the raise in minimum wage eligible for a salaried employee to be exempt from overtime. Each of these major mandates that have significant effects on the viability of medical practices.

Affordable Care Act

Beginning Jan. 1, 2015, the ACA imposed an employer mandate that states that employers with 50 or more full-time employees and equivalents (FTE) may be subject to a penalty if they do not offer medical coverage that provides minimum essential coverage (MEC), is affordable, and meets minimum value (MV) requirements. Employers with 50-100 full-time employees and FTEs may be qualified to delay implementation until, 2016. Employers with 100 or more full-time employees and full-time will need to comply in 2015. The employer mandate does **not** apply to small groups with 2-49 employees.

There are two potential employer penalties if the mandated offer is not made to full-time employees and their eligible dependents.

Penalty A: If an employer does not offer any medical coverage or medical coverage that provides MEC to at least 70 percent of their full-time employees, the employer could be subject to a penalty. The annual penalty is $2,000 per year, per full-time employee.

Penalty B: If an employer offers medical coverage or medical coverage that provides MEC but the full-time employee's contribution is deemed unaffordable, for even just one employee, and/or does not meet MV according to the employer mandate requirements, full-time employees may obtain health insurance through a public insurance Exchange and qualify for a premium credit or cost-sharing reduction. The annual penalty of $3,000 per year, per full-time employee would apply if an employee applied to a public insurance Exchange and was deemed eligible for a subsidy.

The ACA also requires that employers report annually to the IRS whether they offer full-time employees and their dependents the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan. This requirement includes providing a written statement to full-time employees. Reporting is required beginning in early 2016 for coverage provided in 2015. The first information return is due January 31, 2016.

A new survey by the International Foundation of Employee Benefit Plans, 2015 Employer-Sponsored Health Care: ACA's Impact, notes:

- One-third of employers (33 percent) expect the greatest cost increase from ACA implementation to take place in 2016, as new reporting, disclosure and notification requirements take effect.
- Over one-quarter (27 percent) expect the largest cost increase in 2018, when the impending excise tax on high-value plans (the "Cadillac tax") kicks in. The nondeductible 40 percent

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excise tax will be levied on plans that cost in excess of statutory thresholds (in 2018, $10,200 for self-only and $27,500 for family coverage), regardless of whether premiums are paid by employers or employees.

High-deductible health plans (HDHPs) are proving a popular option among employers that are looking for a way to hold both current and future health care costs in line. As employers face the upcoming 'Cadillac tax,' it's likely that HDHPs will continue to gain popularity."[1]

How does ACA affect doctors?

To begin with, we are likely to see an uptick in patients over the coming years. As more and more previously uninsured individuals gain access to affordable (or free) health coverage, they will start to take advantage of preventive services like check-ups, physicals, and so on. Over time, this should make for a population that is healthier in general, not to mention fewer emergency medical crises that the government and taxpayers have to cover due to a lack of insurance. In the meantime, however, doctors will have to accommodate a rising number of patients that will now seek preventive medical services or schedule visits due to minor ailments that they would have simply rode out in the past.

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Doctors and their support personnel will have to deal with changes to medical billing related to new forms of insurance. With new options for private insurance, public options, Medicare, Medicaid, CHIP, and so on, medical offices may have to spend more time sifting through forms, billing and coding appropriately, and taking the additional steps necessary to ensure payment for services rendered. This could mean significantly more work for offices that are already understaffed or stretched to the limit. The result for patients could be greater difficulty in scheduling visits, as well as longer in-office wait times as offices get up to snuff with all the new information and processes they have to deal with.

The passage of Obamacare happened to coincide with an anticipated brain drain in the medical profession. Sources like the U.S. Bureau of Labor Statistics have predicted significant losses in healthcare professions in the coming years, thanks to doctors, nurses, administrators, and other medical professionals reaching the age of retirement with fewer students graduating from medical programs to replace them. So pair an increase in patients with a decrease in qualified medical professionals and you can quickly see the looming problem in healthcare.

Another problem for physicians is the mandatory grace period. For patients who have paid at least one month's premium under the ACA, insurers have to provide a 3-month grace period. If that 3-month period goes by without the consumer paying all of their outstanding premiums, then the insurer is required to cancel their coverage, retroactive to the last day of the first month of the grace period. In other words, if premiums are not paid for July, the grace period would last through the end of September. If all unpaid premiums are not paid by the end of September, coverage could be cancelled effective the last day of July. So if any medical care was obtained in July, the insurer would have to pay those claims. But the insurer would not have to pay any claims submitted in August or September. This leaves physicians without payment for services rendered for those two months!

Electronic Medical Records (EMR)

The government wants to shift the health industry into the digital age and has provided reimbursement incentives and an electronic medical records deadline for those who adopt electronic medical records (EMR). However, as with all government benefits, this electronic medical records mandate comes with strings attached. For those who do not meet the electronic medical records deadline for implementation, the government has laid out a series of penalties.

For physicians who either have not adopted certified EHR / EMR systems or cannot demonstrate "meaningful use" by the EMR deadline in 2015, Medicare reimbursements will be reduced by 1%. The deduction rate increases in subsequent years by 2% in 2016, 3% in 2017, and 4% in 2018.

According to EMRandHipaa.com, an average AAFP (American Academy of Family Physicians) user is reimbursed 20% by

Medicare. This means that overall, a private practice with $500,000 of annual income that fails to meet the electronic medical records mandate will lose $1000 in payments in 2015, $2000 in 2016, and so on. These losses will be higher with higher percentages of Medicare patients in a practice.

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Meeting the government's mandate and electronic medical records deadline will not be easy for everyone in the health industry, especially rural hospitals and small, independent physician practices.

As part of the American Recovery and Reinvestment Act, physicians could receive up to $44,000 in Medicare incentive payments beginning in 2011 for implementing EMR systems. EMR implementation require demonstration of "meaningful use," which is measured in stages. Stage 3 of meaningful use is shaping up to be the most challenging and detailed level yet for healthcare providers. Among the elements that warrant attention are quality reporting, clinical decision support and security risk analysis.

In the face of new regulations that will make program requirements under Stage 3 of the electronic health record (EHR) meaningful use program even less achievable and more disruptive, ArMA joined the AMA and 110 other medical associations in sending letters to members of the Senate and the House, urging them to intervene.

The letters point out that "the Centers for Medicare & Medicaid Services (CMS) has continued to layer requirement on top of requirement, usually without any real understanding of the way health care is delivered at the exam room level."

For the past several years, medical professionals have warned that the federal electronic medical records mandate – buried in the trillion-dollar Obama stimulus of 2009 – would do more harm than good. In theory, of course, modernizing record-collection is a good idea, which many private health care providers had already implemented.

Obama's one-size-fits-all EMR regulations have morphed into what one expert called "healthcare information technology's version of cash-for-clunkers." Many primary care physicians converted to "concierge care" because of the meddlesome EMR burden.

Robert Wachter, author of the recently published *The Digital Doctor: Hope, Hype, and Harm at the Dawn of Medicine's Computer Age*, chronicled the damage he's witnessed: "Physicians retiring early. Small practices bankrupted by up-front expenses or locked into ineffective systems by the prohibitive cost of switching. Hours consumed by onerous data entry unrelated to patient care. Workflow disruptions. And above all, massive intrusions on our patient relationships."

The American Medical Association (AMA), which foolishly backed Obamacare, is now balking at top-down government intrusion into their profession. Better late than never. The group launched a campaign called "Break the Red Tape" this summer to pressure D.C. to pause the new medical-record rules as an estimated 250,000 physicians face fines totaling $200 million a year for failing to comply with "meaningful use" EMR requirements.

At a physician townhall recently held in Massachusetts, physicians decried the failure to achieve true "interoperability" between EMR systems despite a $30 billion federal investment through the Obama stimulus. Rep. Steve King, R-Iowa, recently introduced a bill to repeal the draconian penalties.[2]

The percentage of Arizona physicians using electronic medical records (EMRs) increased from approximately 45% in 2007-2009 to approximately 86% in 2013-2015. The current trend suggests that nearly all Arizona physicians will be using EMRs by 2018. The incentives and support provided by Medicare and Medicaid, combined with other influences, have succeeded in increasing EMR adoption, but important obstacles remain.

Reliance on paper records continues to decrease, but utilization of EMRs as the only medical record has not increased proportionately. Instead, there has been a marked increase in the use of EMRs combined with scanned records. The reliance on scanned records appears to reflect barriers to electronic record transfers among health care organizations.

The expected benefits of EMRs, such as the avoidance of duplicative tests, require the exchange of information among health care providers. However, among physicians with EMRs, less than 20%

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(reminders for intervention) to 46% (e-prescribing) of the physicians share the information with others, depending on the type of information being shared.

The single most important obstacle to the inter-organizational transfer of electronic health information is the shortage of Health Information Exchanges (HIEs). The Health Information Network of Arizona (HINAz) is one such HIE. Although HINAz currently serves only forty-nine participants, it continues to expand.

Many discussions among HIE professionals suggest that physicians are very dissatisfied with their EMRs. Results indicate that Arizona physicians are at least somewhat positive about their EMRs, ranking them slightly above the midpoint in the 1-5 scale. The more accurate conclusion may be that physicians seek to improve individual elements of their EMRs, but recognize that EMRs offer advantages not available from scanned records or paper medical records.[3]

ICD-10

For starters, few outside medicine understand the complex process required for doctors to get paid by insurers for their work, but those who don't understand are nevertheless affected by the process. To get paid, a doctor must properly log any work done, along with the reason it was done (the diagnosis), with an assigned code chosen from huge manuals containing tens of thousands of codes.

Medical coding is complex and has no room for error. Pick the wrong code, and a doctor will not get paid. Pick too many wrong codes over time, and a doctor might be investigated by the government. Over the years, an entire industry has sprung up dedicated solely to medical coding.

The number of codes has increased from about 15,000 to almost 70,000, and no code that appears in ICD-9 is valid in ICD-10. Decades of coding experience has carelessly tossed out the window, leaving many doctors to spend precious time figuring the new system out rather than actually treating their patients.

Supporters of ICD-10 (insurance companies, bureaucrats, health IT vendors, and academics) assure us doctors that it is worth the sacrifice. They say that ICD-9 is outdated and lacks the capacity to cover the breadth of modern medicine, and it is true that almost every other country uses ICD-10, so it is time for us to "get with the program."

Overtime Mandate

The U.S. Department of Labor, under a mandate from the Obama Administration will soon require businesses to pay overtime to any exempt salaried employee earning less than $50,440 per year, up from the previous threshold of $23,660. Employers will be forced to hire fewer employees and start them at $50,000, or put rules into place blocking junior employees from burning the midnight oil to excel. For many medical practices, it might mean having to change their exempt/salaried employees to hourly workers, further increasing practice overhead, by forcing overtime pay.

In closing

The mandates I have outlined are having, and will continue to have, deleterious effects on the private practitioner, as well as the overall practice of medicine. I do think that most physicians believe in insuring their employees, without the need for the government to mandate it.

It is unheard of in any other industry that professionals are mandated to provide services for up to two months with no reimbursement.

Electronic records and its meaningful use attestations are transforming doctors of medicine into doctors of documentation. We now stare at our computer screens instead of into the faces of our patients. This does not make for a satisfied patient experience.

Raising the minimal salaries for exempted employees will have the effect that practices will hire less employees or watch the overtime clock resulting in further inefficiencies in our practices.

If these and other mandates continue, physicians will be forced to find alternative sources of medical income to supplement their professional income or 'work at the peak of their license' and employ more physician extenders to cover their growing practices, in order to keep their practices viable. As a last resort, physicians will seek employment in a larger health care delivery system, or quit completely. AM

Nathan Laufer, MD, is the 124th ArMA President. Dr. Laufer is a cardiologist and the medical director of the Heart & Vascular Center of Arizona.

1 *Stephen Miller, CEBS 5/21/2015.*

2 *http://townhall.com/columnists/michellemalkin/2015/10/23/doctors-agree-obamas-electronic-medical-records-mandate-sucks-n2069809/page/full*

3 *"Physicians' Use, Exchange, and Evaluation of Electronic Medical Records," September 2015, William G. Johnson, PhD, Professor & Founder of Center for Health Information & Research (CHiR), College of Health Solutions, Arizona State University, Sponsored by and Prepared for the Arizona Health Care Cost Containment System (AHCCCS).*