



Prescriptions *Medical Alert*

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Health Care Reform May Affect Physicians

The Patient Protection and Affordable Care Act (Patient Protection Act) was signed into law by President Barack Obama on March 23, 2010. One week later, the President signed into law the Health Care and Education Reconciliation Act of 2010 (Reconciliation Act), completing reform of the nation's health insurance and delivery systems.

Besides introducing changes to the health insurance industry, the new legislation contains adjustments to Medicare and Medicaid reimbursements and initiatives designed to reduce Medicare expenditures over time. The legislation also provides funding for programs to support and sustain primary care physicians, who may see an influx of new patients as a result of the individual health care coverage mandate.

Provisions for Physicians

As part of the reform package, physicians in family medicine, internal medicine, geriatrics, and pediatrics whose Medicare charges for office visits, nursing home visits, and home visits comprise at least 60% of their total Medicare charges will be eligible for a 10% bonus payment for these services from 2011 to 2016. All general surgeons who perform major surgical procedures in a health professional shortage area will also be eligible for a 10% bonus payment for these services from 2011 to 2016.

For 2010, the law reinstates the national average floor on Medicare's geographic practice cost indexes (GPCI), which expired in 2009. In 2010 and 2011, Medicare will reduce the GPCI for physician practice expenses in rural and low-cost areas. Medicare reimbursement for psychotherapy services increases by 5% for 2010.

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The legislation further provides for the establishment of a new Center for Medicare & Medicaid Innovation starting in 2011. The center will evaluate and promote creative payment and service models, such as the patient-centered medical home, and develop financial incentives for providers to adopt successful models. States may, for example, use Federal funding to experiment with single-payer programs. To help reduce Medicare expenditures, the law also creates an Independent Payment Advisory Board, which has the authority to develop proposals for reducing Medicare costs. If Congress does not enact alternatives, these proposals could become law.

To encourage voluntary participation in Medicare's Physician Quality Reporting Initiative (PQRI), incentive payments of 1% in 2011 and 0.5% from 2012 to 2014 will be available, and an additional 0.5% incentive payment will be offered to physicians who participate in a qualified Maintenance of Certification Program. While the program is currently voluntary, physician payments will be reduced starting in 2015 for physicians who do not participate in the PQRI program.

For 2013 and 2014, the legislation increases the Medicaid payments made to family physicians, general internists, and pediatricians for evaluation and management services and immunizations to Medicare rate levels. Full Federal funding for the incremental increase to states is provided. To promote preventive care, Medicaid will be required to cover tobacco cessation services for pregnant women starting in 2010. Cost-sharing for all proven preventive services, such as wellness visits and health risk assessments, will be eliminated in Medicare and Medicaid starting in 2011. Medicare payments for certain preventive services will be increased to 100% of payment schedule rates, and incentives to encourage Medicare and Medicaid beneficiaries to participate in behavior modification programs will become available.

To ease the administrative burdens on physicians, new rules designed to standardize and streamline health insurance claims processing requirements will be developed starting in 2010, and these will be gradually implemented through 2016. To address rising medical malpractice liability costs, the Secretary of Health and Human Services (HHS) is authorized to award five-year demonstration grants

to states to develop, implement, and evaluate alternative medical liability reform initiatives, such as health courts and early offer programs.

Other General Provisions

As employers that provide health care benefits to employees, the provisions affecting businesses will also have an impact on medical practices. Starting in 2010, small businesses with fewer than 25 employees that pay at least 50% of the health care premiums for their employees qualify for a tax credit of up to 35% of their premiums (50% after 2014 if insurance is purchased through an exchange). The amount of the credit will depend on the number of employees and the average wage.

No penalty is imposed on businesses that fail to provide insurance to workers, but businesses employing 50 or more workers will be subject to so-called "pay or play" rules after 2013. Employers that offer health care coverage may in some cases be required to provide "free choice vouchers" to employees who choose to enroll in a plan in the exchange. Starting in 2011, employers will be required to report the value of health benefits to the IRS, and this value will appear on employee W-2 forms.

Starting in 2014, all U.S. citizens and legal residents who are uninsured will be required to obtain health care coverage, or pay a penalty. Those who already have insurance, individually or through their employers, will not need to make any changes, provided the coverage meets certain minimal requirements. Individuals who fail to maintain coverage will be required to pay tax penalties. To assist those who cannot afford the full cost of premiums, the Medicaid program will be expanded to enroll uninsured individuals with incomes below 133% of the Federal poverty level (FPL). Starting in 2014, subsidies will be provided on a sliding scale to individuals with lower to mid-level incomes who do not qualify for Medicaid. Families and individuals with incomes up to 400% of the FPL may be eligible for a premium assistance tax credit.

To help raise revenue to cover the costs of subsidies, the new law will broaden the Medicare tax base for higher-income taxpayers starting in 2013. This includes levying an additional Hospital Insurance tax rate of 0.9% on earned income in excess of \$200,000

Using Locum Tenens Physicians to Fill Staffing Gaps

When a physician in your practice must take a temporary leave of absence, or the demand for medical services suddenly increases, you may consider recruiting a new physician. But filling a permanent position may not always be feasible, especially if a physician is expected to be away for only a limited period of time. In some cases, it may be unclear if an additional physician will be needed over the long term, or the need for additional help may be urgent, making it difficult to wait until a permanent physician can be recruited. To bridge these gaps, you may consider hiring a locum tenens physician.

Taken from a Latin phrase meaning “to hold the place of,” locum tenens physicians are temporary substitutes. They are generally found through staffing agencies, which often focus on certain specialties or geographic areas. If your practice is

considering using an agency for the first time, you may want to consult with professional organizations or colleagues about their experiences with these firms. Because identifying the right candidate and completing the licensing and credentialing process for a locum tenens assignment can take time, your practice should, whenever possible, notify the agency at least 90 days before a locum tenens physician will be needed.

Agencies generally handle matters involving compensation, benefits, and insurance, including medical malpractice insurance, and they may also provide locum tenens physicians with housing and transportation assistance if the assignment requires them to relocate. These agencies perform the initial screening of and interviews with locum tenens

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for individuals and \$250,000 for married couples filing jointly, as well as a 3.8% unearned income Medicare contributions tax on higher-income taxpayers on the lesser of net investment income or the excess of modified adjusted gross income (MAGI) over the same threshold amounts. Some trusts and estates will also be liable for this 3.8% tax.

Starting in 2018, a 40% nondeductible excise tax will be imposed on health insurance providers or plan administrators for any high-cost, or “Cadillac,” health insurance plan with annual premiums in excess of \$10,200 for individual and \$27,500 for family coverage, with both amounts adjusted for inflation and higher thresholds for employees in certain high-risk professions and non-Medicare retirees aged 55 and older. This tax may be passed along to consumers through higher premiums, as an alternative to or in combination with cost-cutting measures.

For taxpayers claiming the itemized medical expense deduction, the new law will increase the threshold to 10% of adjusted gross income (AGI), from the previous 7.5%, starting in 2013 (2017 for taxpayers age 65 and older and their spouses). Starting in 2011, the definition of qualified medical expenses for flexible spending accounts (FSAs), health savings accounts (HSAs), and health reimbursement arrangements (HRAs) will conform to

that used for the medical expense itemized deduction, thereby excluding tax-free reimbursements for over-the-counter drugs not prescribed by a physician. The annual cap for contributions to FSAs will be set at \$2,500 starting in 2012, with the amount indexed for inflation in subsequent years.

In other general provisions, starting in June 2010, individuals with pre-existing conditions who have been denied insurance can join a high-risk insurance pool. Starting this year, insurance providers will not be permitted to deny coverage to children based on pre-existing conditions, and this will be expanded to include adults in 2014. In addition, starting in 2010, uninsured adult children are permitted to remain on their parents’ health care plans until age 26. Starting in September 2010, insurance companies cannot impose lifetime maximum limits on policies or rescind policies except in cases of fraud. Under the new law, the so-called “doughnut hole” in Medicare prescription drug coverage will be closed over the next several years, and beneficiaries who fall through this coverage gap qualify for a \$250 rebate in 2010.

The Patient Protection Act, as amended by the Reconciliation Act, brings about a number of changes for physicians. For more information on the tax provisions of the new legislation, contact one of our qualified tax professionals. *P*

Trends in Defensive Medicine

The vast majority of physicians between the ages of 25 and 34 report that they have been taught to practice defensive medicine by instructors and mentors, according to a national survey conducted by medical staffing firm Jackson Healthcare.

Results of the survey of 1,407 physicians showed that 83% of respondents aged 25 to 34 were advised to practice defensive medicine in medical school or residency by an attending physician or mentor. In the survey, the term “defensive medicine” is defined as the ordering of medically unnecessary tests and treatments by physicians in an effort to avoid lawsuits.

The findings demonstrated that, with each generation of doctors, the use of defensive medicine is increasing. While just 19% of respondents aged 65 and older reported having been taught to practice defensive medicine as students or residents, the percentage rises to 32% among those aged 55 to 64, 47% among those aged 45 to 54, and 63% among those aged 35 to 44.

The survey findings further suggested that, in addition to driving up costs, defensive medicine may also negatively affect patient access and quality, slowing the adoption of medical innovations and discouraging future generations from taking up the practice of medicine. *P*

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candidates, but your practice may also interview the candidates to ensure they are suitable for the position. Besides the proper credentials and clinical skills, the candidate should be flexible and open to working in a new environment with unfamiliar patients.

Many locum tenens physicians are young professionals who choose to work as independent contractors in order to expand their clinical experience. Some highly skilled physicians, including those approaching retirement, may also choose the locum tenens option for personal reasons, such as a desire to travel or take time off between assignments.

Generally, locum tenens physicians may perform and bill for medical services without restriction. It is important, however, to check for any insurance provider restrictions on the use of locum tenens physicians, including any additional requirements for credentialing for those who serve as substitutes for more than 60 days. If certain providers do not

cover services rendered by locum tenens physicians, staff may need to account for these restrictions when scheduling patients.

There are a number of ways in which practice staff may prepare for the arrival of a locum tenens physician. These preparations may include organizing office space and equipment, assigning physicians or other staff members to provide orientation and instructions, and arranging an appointment schedule. To avoid any confusion or surprises, inform regular patients in advance that they will be seeing a new physician.

Occasionally, a locum tenens assignment can turn into a permanent arrangement. Prior to offering a locum tenens physician a permanent position, the practice may need to negotiate the terms with the locum tenens agency, which may include buying out a contract or establishing a long-term agreement with the agency. *P*