MASSACHUSETTS SOCIETY OF ANESTHESIOLOGISTS
REPORT OF COUNSEL
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Implementation of the Massachusetts Health Access Law passed in 2006 is well underway. The law is designed to provide every resident of Massachusetts access to health insurance and imposes a mandate that every resident of the Commonwealth, who can afford it, have health insurance. The latest data indicates that close to 439,000 uninsured people have enrolled into health coverage. Approximately 238,000 of those new insureds are enrolled in the Commonwealth Care Program which provides a subsidized insurance program for individuals who earn less than 300% of the Federal Poverty Level and are ineligible for Medicaid. Prior to the enactment of the law, studies from 2005 indicated there were approximately 600,000 uninsured in the state.

While the Commonwealth celebrates the increase in health insurance access and the Massachusetts law has become a model of interest at the national level, concerns about insurance affordability, and its impact on whether the reform effort can be sustained, has become the dominant health care issue on Beacon Hill. This is not an unexpected development. The question is what will state policy makers try to do to address costs, particularly the rising cost of providing government subsidized health insurance in an economic environment in which the latest forecast indicates a one billion dollar deficit in the current state budget.

HEALTH CARE COST CONTAINMENT

On July 31, 2008, the legislature passed a law (Chapter 305 of the Acts of 2008) which attempts to contain costs and encourage transparency in the health care system. The law would encourage efficiencies by setting up a state wide electronic medical record system by 2012; reinvigorate the health care quality and cost council to look into the possible future overhaul of the current payment system to provide incentives for more efficient care; require annual public hearings on “cost drivers” within the health care and insurance system; provide incentives for physicians to go into primary care; and require health insurers to list nurse practitioners as primary care providers.

The law also includes a controversial ban on gifts to physicians and other prescribers by pharmaceutical and medical device manufacturers. The statute adopts the PHARMA Code on Interactions with Health Care Professionals and bans: meals outside of a practitioner’s office or hospital setting or without an informational presentation by a pharmaceutical marketing agent; entertainment and recreational events; sponsorship or payment for CME that does not meet the ACCME Standards for Commercial Support;

financial support for the cost of travel, lodging or other expenses of non-faculty health care practitioners attending any CME event; and gifts of $50 or more to health care practitioners. The ban is on the giving of gifts by pharmaceutical and device manufacturers and their sales reps. Violation of the ban is subject to a civil fine of up to $5,000. Pharmaceutical and medical device manufacturing companies are required to file with the Department of Public Health disclosure of any fee, payment, subsidy or other economic benefit with a value of at least $50 provided to a physician or health care practitioner. The disclosure must list the recipient and the data would be public. The gift ban was strongly opposed by the pharmaceutical and medical device industry.

FUTURE COST CONTAINMENT EFFORTS?

The enactment of Chapter 305 is only the first step of a continuing effort to deal with health care costs in the Commonwealth. The Massachusetts Health Care Quality and Cost Council, a 16 member group set up by the access law of 2006 and expanded by the 2008 cost containment law to act as a watchdog for statewide healthcare costs, earlier this year instituted a process to develop recommendations to the Legislature to control health care costs. The list of subjects the council is expected to look at includes: evaluating the impact of various cost-sharing measures including patient choice of providers or products; more rate setting for health care provider reimbursement; payment reform to examine alternatives to a fee for service system; technology assessment and adoption of standards; and health plan benefit design. With the state paying more than expected to cover the uninsured, greater pressure will be placed on the council, the Patrick Administration and the Legislature to come up with politically viable solutions to contain costs without affecting access to care. Further efforts are expected at cost containment during the next legislative session, which MSA will monitor very closely.

CRNA PRESCRIPTIVE AUTHORITY

A bill that would grant CRNAs prescriptive authority for pre and post operative care under the supervision of a physician (supervision similar to what all other APNs now have) passed the House in late July. The bill was redrafted by the House and contains language changes in the redraft that has raised concerns for the MSA and other medical societies, which were communicated to the Senate. The bill was not taken up by the Senate prior to the end of the Legislature's formal session on July 31, 2008.

MEDICAID FEES

Medicaid rates for physician services were increased by the state in June. This was the third and final phase in annual increases of Medicaid fees for physician services as part of the Healthcare Access Law of 2006. The conversion factor for anesthesia services was increased 2.96%, from $19.67 to $20.25. The increase became effective July 1, 2008.