

# PNHP National Media

From [Dr. Quentin Young's letter in the Chicago Sun-Times](#) to several new blog postings by [Dr. John Geyman](#) and [Dr. Pippa Abston](#), to [Dr. Charles Mathews' letter in the Capital Medical Society \(Tallahassee\) newsletter](#), PNHPers are in the news!

[Medicare has virtually eliminated](#) uninsurance among the elderly; prior to the passage of Medicare a whopping 57% of seniors lacked hospital insurance.

**Prepare to write Op Eds/Letters to the Editor on September 16 when 2009 Census reports the number of uninsured.**



# PNHP National Rationing by inconvenience

## Immigrants' Experience with Publicly Funded Private Health Insurance

Ruth Hertzman-Miller M.D., M.P.H.

On October 31, 2009, Massachusetts involuntarily transferred about 30,000 legal immigrants from Commonwealth Care, the state-subsidized insurance program, to a new private insurance plan. CultiCare, a for-profit insurer, agreed to take over their care for only \$1,300 per person, one third of the state's previous cost<sup>1</sup> and well below the average cost of adequate care nationally.



1 NEJM 2009:298,  
August 5, 2010

# PNHP National Rationing by inconvenience

We searched CeltiCare's Web site for primary care providers within 5 miles. 25% could not be reached at the telephone number provided. Of those available by telephone, only 37% were actually accepting new CeltiCare patients, and the average wait for an appointment was 33 days. In all, only 60 providers were accepting new CeltiCare patients, and only 38 could provide service for even one of the three major linguistic minorities.

We fear that such “rationing by inconvenience” shuts patients out of care to the detriment of their health but to the benefit of CeltiCare's bottom line. Policymakers, in Massachusetts and nationally, should reassess the role of profit-driven insurers in the provision of safety-net care.



# PNHP National Annual Conference

Denver

November 6

Leadership training on Nov. 5

[Register for the meeting here.](#) - \$160

Call 1-800-325-3535 to reserve a room  
at the Denver Sheraton for the PNHP  
Conference rate of \$149 single/double.



# PNHP National Membership Task Force

Goal- Grow and energize membership.

- a) First conference call July 22, next meeting September.
- b) Go to our [Google Group](#) to learn more (need to sign up and request entry).
- c) Strategy- develop programs/outreach for “working docs”.

# PNHP National Member Task Force

## Outreach Ideas

1. Scientific assembly booths
2. Grand rounds
3. Email- tell a friend
4. Public service announcements-
  - \* a) Appeals from working physicians to their colleagues to link arms
  - \* b) Conversations between physicians and their patients
5. Progressive Doctor Groups- NPA, PSR, DFA
6. Community clinic MDs- how do we reach out to this group.
7. Social events- happy hours (appeal to younger MDs)  
Med Student/Professor Mentoring, Student Chapter Development

# PNHP National Member Task Force

## Ideas

### a) Members Services Web Page

business card templates, gifts, Chicago svcs, MD benefits of SP, media

### b) Monthly Podcast/Webinar/Powerpoint

### c) Congressional updates on provider professional concerns

### d) Regional crash courses- speaking, chapter management, media outreach, advocacy

### e) Welcome phone call

# PNHP National Membership Task Force

## Medicare Sustainable Growth Rate “Doctor Fix”

- ❖ 1997- Congress refined the formula by which the annual change in Medicare physician fees was determined
- ❖ Total physician payments per beneficiary should grow no faster than the economy as a whole, as measured by the gross domestic product (GDP).
- ❖ Policymakers were concerned about increases in the volume of services that beneficiaries received; since total spending equals price times volume, under an aggregate cap, if volume grew more quickly, fees would grow more slowly or be reduced.

# PNHP National Membership Task Force

## Medicare Sustainable Growth Rate “Doctor Fix”

- ❖ Medicare Physician Fee Schedule was supposed to change physician payment to increase rewards for primary care services at the expense of procedural and interventional services
- ❖ For various reasons, the fee schedule, which originally did increase the prices of evaluation and management services relative to those of surgery or invasive procedures, turned in the other direction through the process of annual updating of relative value units. 3
- ❖ Surgeons, radiologists, and some medical specialists are now paid two to three times as much per hour as providers of cognitive services, which is about where we began 20 years ago- the situation that the fee schedule was supposed to fix.
  - ❖ 3. Ginsburg PB, Berenson RA. Revising Medicare's physician fee schedule - much activity, little change. N Engl J Med 2007;356:1201-1203.

# PNHP National Member Task Force

## Medicare Sustainable Growth Rate “Doctor Fix”

- ❖ The way to redress the imbalance between primary care and specialty compensation while shrinking the disparity between Medicare and private insurance is to add more money to primary care while leaving specialists' fees unchanged, on average.
- ❖ But doing so worsens the federal deficit, providing fodder for those who pose, at least, as opponents of deficit spending. And then the pundits argue that fixing the current system isn't really worth the bother - that fee-for-service payments are so intrinsically counterproductive that we should just scrap them in favor of something better. Except that no one knows what that something is.

# PNHP California

## 5 Point Plan

Education

Growth  
Fundraising

Advocacy

Growth  
Membership

Growth  
Leadership



# PNHP California Advocacy

- ❖ Campaign Single Payer
  - ❖ Beginning to link the Senate districts
  - ❖ Many Congressional districts done
  - ❖ Most Assembly districts done
  - ❖ Have you joined yet?
  - ❖ More to come at Winter conference...

# PNHP California Advocacy

## SB810 HMO Language

The single-payer model precludes private insurance that duplicates the public coverage - a measure required both to control costs and to avoid the emergence of two-class care. The question of how to treat nonprofit, staff- and group-model HMOs is complex because they combine a nonprofit provider of care (clearly acceptable in a single-payer model) with a private insurance plan (which is not acceptable). After much debate, PNHP decided to include such organizations in its proposals, but with tight restrictions to minimize the problems inherent in the insurance component of HMOs.

### HR676

- (1) be nonprofit;
- (2) "actually deliver care in their own facilities" through salaried physicians who are employees (not contractors) of the HMO;
- (3) not use their capitation or budget payments to cover hospital services (hospital services would be paid for through a global budget paid directly to the hospital); and
- (4) not offer financial incentives based on utilization.

# PNHP California Advocacy

SB810 HMO Definition: “Integrated health care delivery system” means a provider organization that meets both of the following criteria:

- (1) Is fully integrated operationally and clinically to provide a broad range of health care services, including preventative care, prenatal and well-baby care, immunizations, screening diagnostics, emergency services, hospital and medical services, surgical services, and ancillary services.
- (2) Is compensated using capitation or facility budgets, except for copayments, for the provision of health care services.

SB 810's definition of "integrated health care delivery system" removes a third criteria present in SB 840.

- (3) Provides health care services primarily through direct care providers who are either employees or partners of the organization, or through arrangements with direct care providers or one or more groups of physicians, organized on a group practice or individual practice basis.

# PNHP California Education

The Summer Conference

Way to go PNHP Los Angeles!!

[Link to Slideshows, Videos, Photos](#)

Why it Worked:

Corps D'Esprit

A Party!

United the state

United organizations

United generations

Great speakers

Great Food



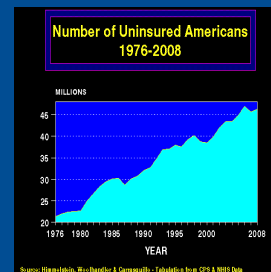
# PNHP California Education

Education Task Force had their first conference call August 31

1. Dedicated to producing CONTENT for healthcare providers.

- a) Website- PNHPCalifornia.org
- b) Conferences
- c) Educational Conference Call/Podcasts
- d) Slideshows
- e) Social Networking- facebook, twitter
- f) Speakers bureau
- g) Press

[Google Group Link](#)



facebook

# PNHP California Growth

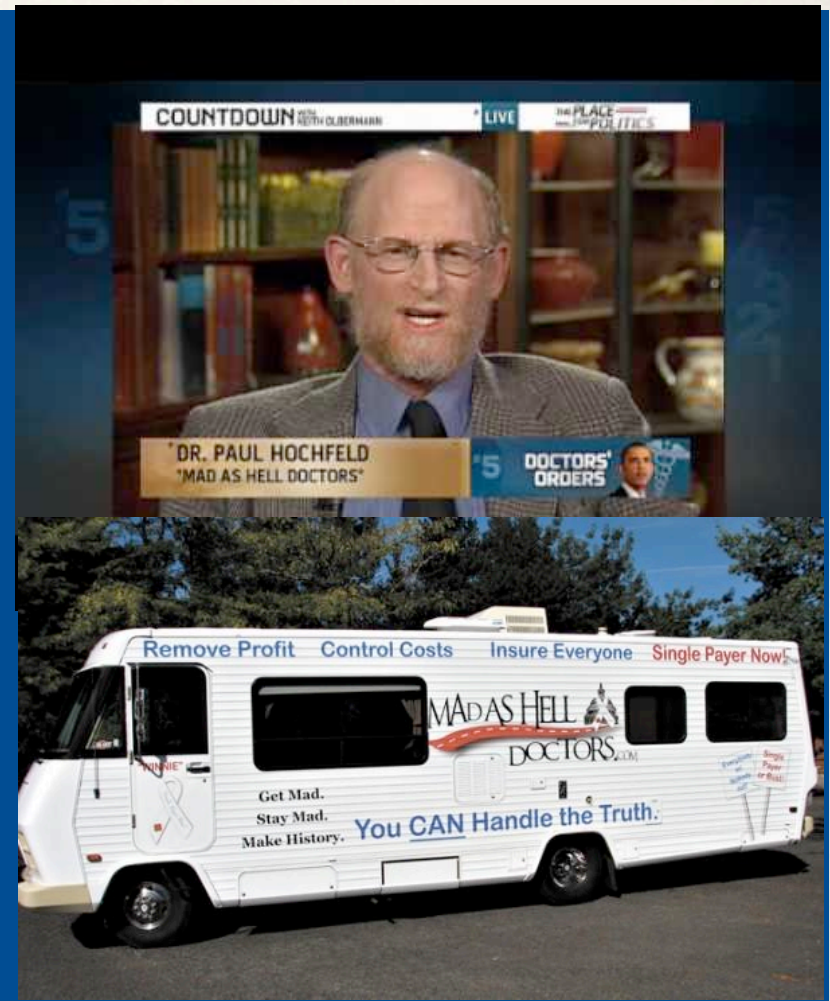
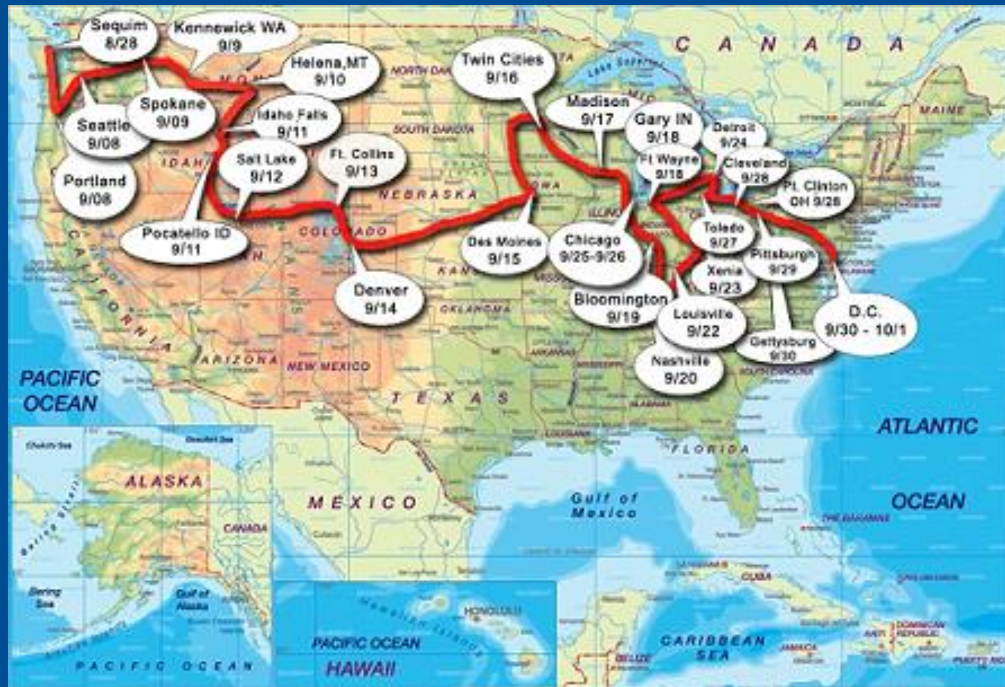
## Member and Chapter Develop. Task Force

1. First conference call September 2.
2. Develop monthly powerpoint for chapters/ chapter debit acct for food
3. Develop protocol for new member outreach
4. Develop protocol for lapsed member outreach
5. More health provider recruitment
  - a) Grand rounds
  - b) Scientific assembly booths sponsored by PNHP



# PNHP California Growth

## Mad As Hell Doctors Tour



# PNHP California Growth

## Mad As Hell Doctors Tour So Cal Stops

- 9/30 – Santa Barbara, evening
- 10/01 – Monterey Park, noon
- 10/01- San Fernando, evening
- 10/02 – Pasadena, 1-2:30 PM
- 10/02- Irvine, evening
- 10/03 – Venice, 1-3:00 PM
- 10/04- San Diego
- 10/06 – Claremont, 3-5 PM

[Link to Map of entire California tour](#)

