

## SECTION FOUR: RESOURCES FOR STATE ADVOCATES

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### **4.1 Legislative Case Study: Maryland Podiatric Medical Association**

During the 2004 Maryland General Assembly session, Maryland legislators unanimously passed an equal work for equal pay bill supported by the Maryland Podiatric Medical Association (MPMA). The bill became law in 2004, but advocating for the law was a several-year process for Maryland podiatrists. The fact that the bill passed both houses of the Maryland General Assembly unanimously is a testament to Maryland podiatrists' advocacy efforts. The following is a case study in MPMA's successful legislative advocacy efforts.

In 2000, Maryland podiatrists became aware that they were being reimbursed at different rates than their MD/DO colleagues for many of the same procedures. To determine if this problem was widespread, MPMA requested that family, friends, and staff of MPMA podiatrists keep and collect explanation of benefits (EOBs) and share them with MPMA. MPMA's analysis of the EOBs indicated that there were significant reimbursement disparities between MDs and DPMs.

In response to these findings, MPMA requested the Maryland Insurance Administration (MIA) to interpret Section 15-713 of the Maryland insurance code to prohibit fee discrimination against DPMs. Section 15-713 provided:

Notwithstanding any other provision of an individual, group, or blanket health insurance policy, if the policy provides for reimbursement for a service that is within the lawful scope of practice of a licensed podiatrist, the insured or any other person covered by the policy is entitled to reimbursement for the service regardless of whether the service is performed by a physician or licensed podiatrist.

However, the Maryland Attorney General, on behalf of MIA, stated that the law did not provide such protection. Thus, in 2002 MPMA began advocating for adoption of an equal pay for equal work law.

In June 2002, MPMA representatives met with MIA representatives to discuss the fee discrepancies between DPMs and other physician providers. As a result of the meeting, the Maryland insurance commissioner agreed to hold a quasi-legislative hearing on the matter, to investigate the relevant facts, and to issue a report. In addition, the MIA conducted a study on the adequacy of payments relative to costs and the economic environment facing providers in the state of Maryland.

MPMA realized its bill was not going to be passed in 2002, so instead it sought an alternative option. Through the addition of language to another bill that was ultimately passed, MPMA obtained a legislative mandate for the Maryland Health Care Commission to investigate the disparity in the reimbursement between MDs/DOs and DPMs and report back to the Maryland General Assembly.

In February 2003, the MIA issued its findings in a report on podiatric reimbursement practices of certain carriers in the Maryland market. The MIA study revealed that insurance carrier reimbursement practices to podiatrists varied among carriers. The study specifically showed that, for the same procedure codes, there were some instances in which DPMs were reimbursed the same rate as or more than MD and DOs, but other instances in which orthopedists received up to 52% more in reimbursement than podiatrists.

Pursuant to the legislative mandate, in December 2003 the Maryland Health Care Commission released *The Adequacy of Payments Relative to Costs and Implications for Maryland Health Care Providers*. Using a ratio of the total payments to non-MD and DO physicians relative to the total payments that would have been received by the average MD and DO physicians providing the same set of services, this study investigated the extent to which Maryland private insurance payers paid MDs and DOs at higher rate than they paid podiatrists for comparable services.

The study produced the following findings:

- Private insurance payment rates in the state of Maryland were substantially below the US average;
- Non-MD and non-DO health-care providers in the state of Maryland were paid rates that averaged 80-90 percent of the rates paid to MDs and DOs; and
- DPMs in the state of Maryland were paid rates that averaged 91 percent of the rates paid to MDs and DOs.

The Maryland Health Care Commission's study also showed that DPMs were reimbursed higher amounts than orthopedists and other specialists for some CPT codes. This finding, coupled with meetings held with the president of the Maryland Orthopedic Society (MOS) and its lobbyist, caused MOS to take a "no position" stance on the proposed legislation. As a result of the MOS position, the state medical society also took no position on the bill. A no-position stance was just as favorable to podiatrists as a "support position."

Using the information obtained from the commission's study as powerful ammunition, MPMA drafted and introduced the "Health Insurance-Required Reimbursement-Podiatrists" bill, which would require insurance companies to reimburse podiatrists at a rate equal to that of MD/DOs for identical medical procedures based on identical CPT codes. MPMA argued during legislative hearings and during meetings with legislators that the bill would not set or specify any fees paid by the insurers, but simply would require equal pay for equal work for podiatrists. Maryland podiatrists also agreed to amendments to the bill that would not prevent a private

insurer from basing payment on the “preeminent qualifications” or geographic location of a physician or podiatrist.

MPMA lobbied for the bill by attending hearings, offering legislative testimony, and meeting with state legislators. MPMA already had established relationships with key legislators because MPMA leaders regularly hosted a dinner with legislators on key committees. These efforts and the overwhelming amount of evidence to support the DPMs’ bill made it much easier to get the bill passed.

In early 2004, only three years from the beginning of the process, “The Health Insurance–Required Reimbursement-Podiatrists” bill passed the Maryland Senate (44–0) and then the Maryland House of Delegates (138-0). After receiving the governor’s signature, the bill became law, effective in October 2004. The bill amended the existing statute regarding anti-discrimination in reimbursement (Md. Code Ann., Ins. § 15-713) to read as follows:

(b) *In general.*- Notwithstanding any other provision of an individual, group, or blanket health insurance policy or contract subject to this section, if the policy **or contract** provides for reimbursement for a service that is within the lawful scope of practice of a licensed podiatrist, the insured or any other person covered by **or entitled to reimbursement under** the policy or contract is entitled **to the same amount of** reimbursement for the service regardless of whether the service is performed by a physician or licensed podiatrist.

(Emphasis to language added by the amendment in 2004.)

The bill also included the exceptions agreed to by MPMA to allow insurers to vary payments based on certain specified criteria:

(c) *Additional considerations.*- This section does not prohibit, and may not be construed as prohibiting, the determination of reimbursement based on the geographic location of the delivery of service, the preeminent qualifications of a physician or podiatrist, or the need to provide services in an underserved area of the State.

### **Best Practices Gleaned from MPMA’s Experience**

- Gather the evidence: MPMA members gathered informal information from EOBs to demonstrate a disparity which helped persuade the MIA to conduct an investigation to show discrimination in reimbursement practices by insurers.
- Explore administrative avenues as a means of prohibiting fee discrimination: Through its attorneys and lobbyist, MPMA requested an opinion from the MIA that the law protected against discrimination in the amount of reimbursement. However, when MPMA was told that the law did not extend that far, MPMA realized that it had to change the law.

- Change course when necessary: MPMA recognized that its equal pay for equal work law was not going to be passed in 2002, so it sought to obtain more evidence to demonstrate the fee disparity. By having a legislature-mandated study, it was able to provide additional, objective evidence in support of its position. While not originally planned, this course of action ultimately proved successful as it offered additional evidence and neutralized opposition from the state orthopedic society.
- Build and sustain relationships with legislators: Because MPMA members routinely met with state legislators on key committees, they already had established relationships. Building legislative relationships when you are not pursuing specific legislation helps you in the long run when you seek passage of favorable legislation, as demonstrated by MPMA's efforts.
- Build relationships with medical and orthopedic associations' leadership, attorneys, and lobbyists: MPMA's efforts and explanations to their colleagues facilitated their agreement not to oppose the bill.

## 4.2 Legal Case Study: Connecticut Podiatric Medical Association

When Connecticut podiatrists became aware that some private insurers were reimbursing MDs and DOs significantly more for certain procedures, the Connecticut Podiatric Medical Association (CPMA) committed itself to ending this fee disparity. Before deciding on a course of action, CPMA researched the issue and weighed its potential options. First, CPMA reviewed the Connecticut state law, which stated:

### § 38a-816(10) Unfair practices defined.

Notwithstanding any provision of any policy of insurance, certificate or service contract, whenever such insurance policy or certificate or service contract provides for reimbursement for any services which may be legally performed by any practitioner of the healing arts licensed to practice in this state, reimbursement under such insurance policy, certificate or service contract shall not be denied because of race, color or creed nor shall any insurer make or permit **any unfair discrimination** against particular individuals or persons so licensed. (emphasis added).

One of the potential strengths of the Connecticut law was that it was incorporated into the unfair trade practices section of the state law. CPMA sought counsel from its attorneys, reviewed the legislative history of the statute, and spoke with the legislator who drafted the law (who was a patient of a CPMA podiatrist). After conducting this analysis, CPMA members felt that the provision in the law that prohibited “any unfair discrimination” was intended to prevent private insurers from reimbursing DPMs less than MDs and DOs for the same procedures.

CPMA leaders made the membership aware of CPMA's actions and sought their input and support. CPMA members preferred litigation over legislative action and believed the current law should be tested. Membership and CPMA leadership decided to pursue legal action against

the insurers. Because litigation is a costly endeavor, CPMA wanted the support of the membership because special assessments would be needed to pay for the litigation.

CPMA hired a prominent Connecticut health care attorney and law firm. Considering the importance and financial commitment of litigation, CPMA wanted to ensure it had the right team in place to litigate the case. CPMA first threatened to file a lawsuit against Anthem Blue Cross Blue Shield because Anthem was a relatively smaller player in Connecticut, and a positive outcome would potentially affect litigation with other insurers. After CPMA threatened to file the lawsuit, Anthem agreed to meet with and negotiate a compromise with CPMA. The parties agreed that Anthem would implement a three-year plan to ensure fee parity across all CPT codes. In exchange, CPMA withdrew its lawsuit. Once the fees were adjusted, CPMA estimated that members were reimbursed \$10 to \$20 more for in-office visits.

Because of the success of its negotiations, in 2005, CPMA threatened to file a lawsuit against HealthNet. HealthNet was a major private insurer in the state. However, unlike Anthem, HealthNet would not agree to meet with CPMA.

The lawsuit was a class action filed by CPMA and three podiatrists alleging that Health Net violated the Connecticut Unfair Insurance Practices Act (CUIPA) by reimbursing podiatrists at a lower rate than medical doctors for the same foot-related health care services. HealthNet filed a motion for summary judgment, arguing that there was reimbursement disparity but that the law did not prohibit it.

A party is entitled to a summary judgment when there is no issue of material fact requiring a trial to resolve the issue, and in applying the law to the undisputed facts, one party is clearly entitled to judgment. On June 6, 2008, the trial court granted HealthNet's motion for summary judgment. In its decision, the court held that the statute did not mandate payment parity between medical doctors and podiatrists, but rather required coverage of care furnished by podiatrists. Therefore, the court found that the actions of HealthNet in not reimbursing podiatrists and medical doctors the same amounts for the same treatments did not constitute "unfair discrimination" in violation of CUIPA.

CPMA subsequently filed an appeal. However, before filing the appeal, CPMA discussed the risks and benefits with its attorneys, APMA, and its members. In its appeal, CPMA argued that the trial court erred in its interpretation of the statute and that the intent of the legislature was clear. CPMA argued that in enacting CUIPA's unfair discrimination law, the legislature intended to prevent other licensed practitioners of the healing arts from being unfairly discriminated against by insurers in favor of medical doctors. APMA filed an *Amicus Curie* (Friend of the Court) brief in support of CPMA and Connecticut podiatrists. In its brief, APMA argued, among other things, that podiatrists are uniquely qualified to provide the highest quality of foot and ankle care and deserve to be compensated fairly, and Connecticut insurers that reimburse podiatrists less than medical doctors for furnishing identical treatment are violating the state's unfair practices statute. The appeal was originally filed in an intermediary appellate court but then was transferred to the Connecticut Supreme Court. The Connecticut Supreme Court heard oral arguments in the fall of 2010, and a decision is expected in late winter or early

spring of 2011. A favorable decision would overturn the trial court's summary judgment and remand the case to the trial court for a full trial to be decided by a jury.

During the entire process, CPMA diligently kept its members informed on the status of the case and the costs associated with litigating against HealthNet. To fund the litigation and ensuing appeals, CPMA had to enact several mandatory dues assessments. Members were asked to contribute additional dues each year for a total of \$5,000 in special assessments per member as of 2010. To keep costs down, CPMA negotiated with its attorneys to cap the attorney fees and to fund the appeal on a contingency fee. As of 2010, the total cost of the litigation was \$1.2 million. Because CPMA continued to educate its members about the litigation and costs associated with it, members have supported CPMA through the process.

### **Best Practices Gleaned from CPMA's Experience**

- CPMA examined its options. CPMA spoke with attorneys, members, and APMA about the litigation and researched alternative options, including negotiation with insurers and legislative action. CPMA also reviewed the legislative history of the statute in question and spoke with the drafter of the law.
- CPMA first attempted alternatives to litigation. CPMA attempted to negotiate with the private insurers to resolve the fee disparity in a less costly and more amicable manner. CPMA was successful in negotiating a resolution with Anthem. Unfortunately, HealthNet was unwilling to sit down with CPMA officials. However, the increase in reimbursements from Anthem helped fund the costs of the HealthNet litigation.
- CPMA continued to inform its members throughout the litigation about the rising costs of this course of action. Without support from the general membership, it would have been impossible to continue with the litigation.

## **4.3 Talking Points for State Advocates**

### **Doctors of Podiatric Medicine**

- Doctors of podiatric medicine are podiatric physicians and surgeons, also known as podiatrists, qualified by their education, training, and experience to diagnose and treat conditions affecting the foot, ankle, and related structures of the leg.
- Podiatric Medicine is that profession of the health sciences concerned with the diagnosis and treatment of conditions affecting the human foot and ankle, and their governing and related structures, including the local manifestations of systemic conditions, by all appropriate systems.
  - Podiatric physicians provide the full range of foot and ankle care, including palliative care, acute care for injuries, and chronic care for secondary conditions related to diseases such as arthritis and diabetes.



- In 2002, podiatric physicians provided close to 40 percent of all foot care services in the United States, compared to 13 percent for orthopedic physicians and 37 percent for all other physicians, including primary care doctors.
- Doctors of podiatric medicine receive medical education and training comparable to medical doctors, including four years of undergraduate education, four years of graduate education at one of nine podiatric medical colleges, and at least two or three years of hospital-based post-graduate residency training. As such, podiatric physicians are uniquely qualified among medical professionals to treat the foot and ankle based on their education, training, and experience.
- Given its specialization, podiatry is to the foot and ankle what ophthalmology is to the eye or cardiology is to the heart.
- Like all physicians, with the requisite education and training, podiatric physicians can:
  - perform comprehensive medical history and physical examinations;
  - prescribe drugs and order and perform physical therapy;
  - perform basic and complex reconstructive surgery;
  - repair fractures and treat sports-related injuries;
  - prescribe and fit orthotics, insoles, and custom-made shoes; and
  - perform and interpret x-rays and other imaging studies.

### **Ending Fee Discrimination**

- Fee discrimination by private insurers limits consumer choice and increases consumer costs. Podiatric physicians often choose not to participate in health plan networks in order to ensure they receive fair reimbursement. This limits consumers' in-network choices and increases their costs if they have to receive out-of-network care.
- Doctors of podiatric medicine are physicians, surgeons, and specialists and should be reimbursed at the same or a similar rate as their allopathic and osteopathic colleagues.
- Care by podiatric physicians adds value to the health-care delivery and financing systems. A study conducted by Thomson Reuters concluded that:
  - Patients with diabetes who see a podiatric physician are less likely to suffer hospitalization or amputation than patients who do not receive care from a podiatric physician.
  - As a result of keeping patients healthier, preliminary results demonstrate care by a podiatric physician has a positive return on investment. Each dollar invested in care by podiatric physicians offers up to \$51 in savings.
  - A projected \$105 million could be saved in direct health-care expenditures with a 20% increase in the rate of use of podiatric physicians by patients with employer-

sponsored insurance.

- The proposed legislation would allow health plans to vary payment based on quality factors or geographic factors. It would not interfere with pay-for-performance arrangements or other innovative physician payment arrangements. It is intended to prevent reimbursement discrimination based solely on the fact that a physician is a DPM rather than an MD or DO.

*[Tell the local story --- for example, Local Podiatric Medical Association's research shows that three insurers that control 50% of the health-care market in the state are paying podiatric physicians an average of 30 percent less than medical doctors for the exact same services and procedures. Those services include the types of treatments intended to prevent people with diabetes from undergoing amputations or having to be hospitalized – services that research shows podiatric physicians are more likely to provide.]*

## 4.4 Fact Sheet for Policymakers

*Note to state advocates: copy the below issue brief and paste onto state component society's letterhead. Please customize and add any information that pertains specifically to your state.*

### **Prohibiting Fee Discrimination Against Podiatric Physicians and Surgeons**

Fee discrimination against podiatric physicians and surgeons, also known as podiatrists, occurs when a private insurer pays a podiatrist less for furnishing the exact same service as an MD or DO based solely on the fact that the physician is a DPM rather than an MD or DO.

- **Fee discrimination by private insurers limits consumer choice and increases consumer costs.** In order to avoid such discrimination and ensure they receive fair reimbursement, podiatrists must choose not to participate in health plan networks. Electing not to participate allows them to bill at rates that better reflect their costs and value. However, podiatrists' choice not to participate in networks limits consumers' choices of network providers and increases their costs when they have to receive out-of-network care.
- **Fee discrimination is unfair because podiatric physicians have training and costs that are comparable to those of medical doctors.**
  - Doctors of podiatric medicine receive medical education and training comparable to medical doctors, including:
    - four years of undergraduate education;
    - four years of graduate education at one of nine podiatric medical colleges; and



- at least two or three years of hospital-based postgraduate residency training.
  - Doctors of podiatric medicine have the same or similar costs as medical doctors, including
    - the cost of maintaining an office and staff; and
    - the cost of malpractice insurance.
- **Providing access to podiatric physicians is an important component in ensuring quality of care.** The growing epidemics of diabetes and obesity and their concurrent complications, along with the aging of the population, are among the many reasons why podiatric physicians are necessary and important members of the physician community and demand for their services is increasing.
  - In 2007, an estimated 24 million people in the United States, almost 8 percent of the population, had diabetes.
  - Podiatric physicians play an extremely important role in the prevention and management of complications of the lower extremity in those with diabetes and are key members of the diabetes multidisciplinary team.
  - A recent study conducted by Thomson Reuters concluded that patients with diabetes who see a podiatric physician are less likely to suffer hospitalization or amputation than patients who do not receive care from a podiatric physician.
- **Podiatric physicians furnish high value, cost-effective care.** Preliminary results of a recent study conducted by Thomson Reuters indicate that care by a podiatric physician has a positive return on investment. According to the study, each dollar invested in care by podiatric physicians offers up to \$51 in savings. A projected \$105 million could be saved in direct health-care expenditures with a 20% increase in the rate of use of podiatric physicians by patients with employer-sponsored insurance.