Submitter : **Dr. Sean McWilliams**

Organization : **Vein Clinics of America**

Category : **Physician**

Date: 10/05/2006

Issue Areas/Comments

GENERAL

GENERAL

CMS 1321-P

Policy and Recommendation: Comment
Physician Fee Schedule -Practice Expense
Proposal dated September 21, 2006

I am responding to the CMS proposal of 9/21/06 regarding the proposed changes in the physician fee schedule for 36478 and 36479 Endovenous Laser Ablation - office based.

I have reviewed the proposed 2007 fully implemented, non-facility practice expense (PE) RVUs for codes 36478 and 36479 and find several issues of great concern:

1. RVUs have consistently been reduced from 2005 levels:
a. 2006: 46.91
b. 2007: 43.53
c. 2008: 40.84

While practice expenses consistently rise, (salaries, utilities, etc.) it has become increasingly difficult to provide these necessary services. In order to comply with CMS guidelines, the ultrasound component of the procedure requires that the physician employ a Registered Vascular Technologist (RVT) to provide imaging services. These highly skilled technologists are in drastic shortage and therefore are in high demand and as such command extremely high salaries in excess of $70,000 per year plus benefits. It will be impossible to comply with CMS guidelines if the RVUs and subsequent reimbursements continue to drop!

As you know, the 2007 Medicare Physician Fee Schedule is already scheduled for a 5.1% across the board cut in reimbursement. Additionally, there are proposed cuts for non-invasive vascular imaging (vascular ultrasound). All these cuts will cripple the ability of physicians to perform this extremely important procedure and ultimately result in a loss of access to care for Medicare beneficiaries.

2. The proposed conversion factor (CF) for 2007 has been reduced from 2006, thus further decreasing reimbursement for endovenous laser treatment.

3. Values for codes 36475 and 36476, radiofrequency vein ablation have been consistently higher that those for laser ablation:
a. 2006: 51.5
b. 2007: 47.77
c. 2008: 44.52

Each of these technologies are comparable especially when we look at both the initial capital acquisition cost ($37,900 for laser and $25,000 for RF) and the, per patient supply costs ($360 for laser and $750 for radiofrequency for the procedure kits PLUS disposable sterile supplies such as drapes, gowns, Anesthetic solution, IV bags and tubing to name just a few). While the per patient supply cost may be slightly higher for 36475 (radiofrequency ablation), the significantly higher acquisition cost for 36478 (laser ablation) raises the overall physician s cost of delivering the service to the same level (possibly even higher).

I would request that the fully implemented, non-facility practice expense RVU remain at the 2006 rate for 36475 of 51.5 and that the RVU for 36478 be increased to this same level.

I would be happy to discuss this further with members of your committee.

Respectfully submitted,

Sean McWilliams M.D.

Submitter : **Dr. vidal sheen** **Date: 10/05/2006**

Organization : **vein clinics of america**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

CMS 1321-P

Policy and Recommendation: Comment
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I would be happy to discuss this further with members of your committee.

Respectfully submitted,

Submitter : **Dr. Paul Putterman**

Organization : **Vein Clinics of America**

Category : **Physician**

Date: 10/05/2006

Issue Areas/Comments

GENERAL

GENERAL

3. Values for codes 36475 and 36476, radiofrequency vein ablation have been consistently higher that those for laser ablation:
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Respectfully submitted,

Paul Putterman MD

Impact

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Provisions of the Proposed Rule

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As you know, the 2007 Medicare Physician Fee Schedule is already scheduled for a 5.1% across the board cut in reimbursement. Additionally, there are proposed cuts for non-invasive vascular imaging (vascular ultrasound). All these cuts will cripple the ability of physicians to perform this extremely important

procedure and ultimately result in a loss of access to care for Medicare beneficiaries.
2. The proposed conversion factor (CF) for 2007 has been reduced from 2006, thus further decreasing reimbursement for endovenous laser treatment.

Submitter : **Mrs. Nancy Robinson** **Date: 10/05/2006**

Organization : **Bryson Cancer Care**

Category : **Nurse**

Issue Areas/Comments

GENERAL

GENERAL

We are currently happy with the Amgen Contract and are against the current changes proposed by Ortho-biotech to CMS. The reimbursement through CMS is confusing enough without changing the profitability on the most commonly purchased products.

CMS-1321-P-466

Submitter : Dr. James Harry

Date: 10/05/2006

Organization : Vein Clinics of America

Category : Physician

Issue Areas/Comments

Background

Background

As you know, the 2007 Medicare Physician Fee Schedule is already slated for a 5.1% across the board cut in reimbursement. Additionaly, there are proposed cuts for non-invasive vascular imaging (vascualr ultrasound). All these cuts will cripple the ability of physicians to perform this extremely important procedure and ultimately will result in a loss of access to care for Medicare beneficiaries.

Submitter :

Organization :

Date: 10/05/2006

Category : Physician

Issue Areas/Comments

Background

Background

Impact
Making these revisions as proposed will impact negatively on the Medicare populations access to quality health care. The reduction in reimbursement rates will ultimately limit access to physicians who perform these treatments.

Provisions of the Proposed Rule
See General Comment below.

Background
See General Comment Below

General Comment

CMS-1321-P
Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2007 and other Changes to Payment Under Part B Proposal dated August 8, 2006

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I would be happy to discuss this further with members of your committee.

Respectfully submitted,

Garth Rosenberg, MD

Submitter : **Dr. Ellis A Tinsley, Jr.** **Date: 10/05/2006**

Organization : **Wilmington Surgical Associates**

Category : **Physician**

Issue Areas/Comments

Background

Background

Making these revisions as proposed will impact negatively on the Medicare populations access to quality health care. The reduction in reimbursement rates will ultimately limit access to physicians who perform these treatments.

GENERAL

GENERAL

CMS-1321-P
Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2007 and other Changes to Payment Under Part B
Proposal dated August 8, 2006

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I would be happy to discuss this further with members of your committee.

Respectfully submitted,

Ellis A. Tinsley, Jr., M.D., FACS, FACP

Impact

Impact

See General Comment below.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

See General Comment below.

Submitter : Dr. James Doty

Organization : Memorial CyberKinfe Radiosurgery Center

Category : Physician

Date: 10/05/2006

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1321-P-469-Attach-1.DOC

Gulf Coast
Brain and Spine Institute
NEUROSURGERY - SPINE SURGERY

James R. Doty, M.D.
Neurological Surgery

Attchm 4 of 9

October 4, 2006

Reference file code: CMS-1321-P

Submitted electronically via Word document attachment
http://www.cms.hhs.gov./eRulemaking

I appreciate the opportunity to submit comments on 42 CFR Parts 405, 410, 411, 414, 415, and 424 [CMS-1321-P] RIN 0938-AO24 Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2007 and Other Changes to Payment Under Part B.

Image-guided robotic stereotactic radiosurgery (r-SRS) is both an alternative to surgery and an adjunct to radiotherapy involving a defined set of clinical resources to deliver effective treatment. Image-guided robotic stereotactic radiosurgery is not radiotherapy, as it is intended to ablate identifiable lesions, while preserving normal tissue adjacent to the target volume, rather than treat microscopic disease. The CyberKnife® is a complex image-guided robotic stereotactic radiosurgery system (r-SRS), delivering radiosurgical precision throughout the body, for as many treatments (fractions) as the clinician deems necessary for a given situation. CMS currently allows for up to five fractionated image-guided robotic stereotactic radiosurgery treatments and our data indicate that treatments average 3 fractions per course of treatment. Clinicians and patients have recognized the benefits of radiosurgery, which include no incisions, no anesthesia, lower risk of complications, and, therefore, improved patient quality of life.

Image-guided robotic stereotactic radiosurgery is substantially more resource-intensive than other forms of linac-based systems. It was for this reason that CMS created separate HCPCS codes to distinguish these technologies. Further, it is clear that the resources required for image-guided robotic stereotactic radiosurgery treatment are the same regardless of whether the treatment is performed in the first or a subsequent session.

Image-guided robotic stereotactic radiosurgery is a capital intensive technology, and, due to the relatively small number of patients for whom it is clinically appropriate (as compared with, for example, conventional external beam technology), it is not necessarily cost-efficient for a single hospital to provide these services by itself. Robotic stereotactic radiosurgery facilities that are associated with a particular hospital are typically available for use only by physicians on staff at that hospital, thus restricting their ability to serve the larger community and limiting access. Allowing carriers to pay for the technology when provided in freestanding centers would facilitate cost sharing among a number of hospitals (and others) to provide these services, improving device access to a more diverse population of patients in a given geographic region.

Comment:

1340 Broad Avenue Suite 440 Gulfport, MS 39501
T 228.867.4856 F 228.867.4857

Gulf Coast
Brain and Spine Institute
NEUROSURGERY - SPINE SURGERY

A number of temporary codes have been established to enable hospitals to report the technical component c osts o f i mage-guided r obotic s tereotactic r adiosurgery (r-SRS) t reatment (HCPCS Codes G0339 and G0340). The proposed Rule regarding the Physician Fee Schedule for 2007 designates codes G0339 and G0340 as "C – Carriers price the code."

This is consistent with the technical component radiation oncology services of all kinds that are reimbursed under the Physician Fee Schedule, and have been since the inception of the Physician Fee Schedule methodology.

Recommendation:

The CyberKnife Coalition respectfully recommends and encourages CMS to:

- *Adopt the proposed change to include HCPCS Level II codes G0339 and G0340 on the CY 2007 PFS, classifying the codes with the modifier "C" to indicate that they may be carrier priced.*

I support this modification that would clearly establish carrier authority to cover image-guided robotic stereotactic radiosurgery in freestanding settings, subject to their establishment of appropriate quality assurance measures to ensure patient safety and regulatory compliance, to the satisfaction of the carrier.

I appreciate your consideration of our comment.

Sincerely,

1340 Broad Avenue Suite 440 Gulfport, MS 39501
T 228.867.4856 F 228.867.4857

Submitter : **Dr. Lawrence Calabrese** **Date: 10/05/2006**

Organization : **St Joseph's Imaging Associates**

Category : **Physician**

Issue Areas/Comments

Background

Background

Reducing the fee schedule for the out patiet varicise vein treaments will have two potentially damaging effects. Firstly, by limiting the profitability of the procedure, this will limit the number of operators and reduce the access of patients to this minimally invasive treatment. They will then be limited to either suffering with the pain and limited acitivity associated with symptomatic varicose veins or under go more invasive traditional surgical procedures such as vein stripping or ligation. These older surgical procedures will be more costly and result in more complications - further increasing the cost of taking care of these patients.

GENERAL

GENERAL

CMS-1321-P
Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2007 and other Changes to Payment Under Part B
Proposal dated August 8, 2006

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Respectfully submitted,

Lawrence Calabrese MD
St Joseph's Imaging Associates
Northeast Medical Center
Medical Center Drive
Fayetteville, NY

Impact

Impact

please see below

Provisions of the Proposed Rule

Provisions of the Proposed Rule

please see below

Submitter : **Dr. Michael Ingegno**
Organization : **General Vascular Surgery Group**
Date: 10/05/2006
Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

CMS-1321-P
Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2007 and other Changes to Payment Under Part B
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I would be happy to discuss this further with members of your committee.

Respectfully submitted,
Michael Ingegno MD
510-357-4006

Submitter : **Dr. Ehsan Hadjbian** **Date: 10/05/2006**

Organization : **Vein Institute of Utah**

Category : **Physician**

Issue Areas/Comments

Background

Background

I'm responding to the CMS proposal of 8/8/06 regarding the proposed changes in the physician fee schedule for cpt 36478 and cpt 36479 endovenous laser ablation.

I have reviewed this prorosal in detail.
While practice expenses consistently rise,(salaries, malpractice insurance, office expenses) it has become increasingly difficult to provide these neccessary services. There is a limit to the number of procedures that the average physician can perform per year. This make it impossible to continue to offer these treatments to medicare patients if reimbursements continue to drop. As you know there is already a 5.1% cut in reimbursement coming in 2007. There is also a proposal to cut vascular (Imaging)ultrasound reimbursement. All these cuts will cripple the ability of physicians to perform this extremely important procedure and ultimately resul in a loss of access to care for Medicare beneficiaries.
The cost of equipment, staff, and per patient supply cost to perform these procedures is very high. It includes sterile surgical gowns,costly laser catheter, IV bags, Anesthesia solution, and many other disposable sterile supplies.
Reducing the reimbursement for this procedure will place a heavy strain on physician who perform this procedure.

I urge you not to further reduce the reimbursement for these procedures.

I request that the fully implemented, non-facility practice expence RVU remain at the 2006 rate for 36475 of 51.5 and taht the RVU for 36478 be increased to this same level.

I would be happy to discuss this further with members of you committee.

Respectfully submitted,

Ehsan Hadjbian, M.D.
Salt Lake City, Utah
erichaj@utahweb.com

Submitter : **Dr. Oliver Kreitmann** **Date: 10/05/2006**

Organization : **La Clinic**

Category : **Physician**

Issue Areas/Comments

Background

Background

Making these revisions as proposed will impact negatively on the Medicare populations access to quality health care. The reduction in reimbursement rates will ultimately limit access to physicians who perform these treatments.

GENERAL

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I would be happy to discuss this further with members of your committee.
My direct phone number is 301-785-0032

Respectfully submitted,

Oliver Kreitmann, M.D.
Silver Spring, MD
olkreitmann@comcast.net

Impact

Impact

See General Comment below.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

See General Comment Below

Submitter : **Dr. KT Kishan** **Date: 10/05/2006**

Organization : **Dr. KT Kishan**

Category : **Physician**

Issue Areas/Comments

Background

Background

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While practice expenses consistently rise, (salaries, utilities, etc.) it has become increasingly difficult to provide these necessary services. In order to comply with CMS guidelines, the ultrasound component of the procedure requires that the physician employee a Registered Vascular Technologist (RVT) to provide imaging services. These highly skilled technologists are in drastic shortage and therefore are in high demand and as such command extremely high salaries in excess of $70,000 per year plus benefits. Given the limited number of these procedures that the average physician performs per year it is impossible to comply with CMS guidelines if the RVUs and subsequent reimbursements continue to drop!

As you know, the 2007 Medicare Physician Fee Schedule is already scheduled for a 5.1% across the board cut in reimbursement. Additionally, there are proposed cuts for non-invasive vascular imaging (vascular ultrasound). All these cuts will cripple the ability of physicians to perform this extremely important procedure and ultimately result in a loss of access to care for Medicare beneficiaries.

The proposed conversion factor (CF) for 2007 has been reduced from 2006, thus further decreasing reimbursement for endovenous laser treatment.

Values for codes 36475 and 36476, radiofrequency vein ablation have been consistently higher that those for laser ablation:
d. 2006: 51.5
e. 2007: 47.77
f. 2008: 44.52

Each of these technologies are comparable especially when we look at both the initial capital acquisition cost ($37,900 for laser and $25,000 for RF) and the, per patient supply costs ($360 for laser and $750 for radiofrequency for the procedure kits PLUS disposable sterile supplies such as drapes, gowns, Anesthetic solution, IV bags and tubing to name just a few). While the per patient supply cost may be slightly higher for 36475 (radiofrequency ablation), the significantly higher acquisition cost for 36478 (laser ablation) raises the overall physician s cost of delivering the service to the same level (possibly even higher).

I would request that the fully implemented, non-facility practice expense RVU remain at the 2006 rate for 36475 of 51.5 and that the RVU for 36478 be increased to this same level.

I would be happy to discuss this further with members of your committee.

Respectfully submitted,

<KT Kishan MD>
<Warsaw, IN
<vcindiana@yahoo.com

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Submitter : **Dr. Clovis Manley** **Date: 10/05/2006**

Organization : **Plaza Park Family Practice, Newburgh, IN**

Category : **Physician**

Issue Areas/Comments

Background

Background

The EVLT procedure (CPT 36475) replaces the "vein stripping" which is done under a general anesthetic at a hospital or surgery center. The new procedure is done as an outpatient and is safer and more effective than vein stripping. In order to provide this procedure physicians must get a fair reimbursement from Medicare.

GENERAL

GENERAL

It has been proposed that CPT 36475 reimbursement be cut by Medicare. This is a mistake because the current reimbursement is already too low.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

It was very expensive for my practice to add this procedure to our services. I had to attend numberous training meetings at significant expense. We sent three staff members for training at various sites around the country. This training included getting an ultrasound tech fully trained to perform venous procedures and training two nurses to assist in the procedure. We purchased a $100,000 ultrasound machine and a $30,000 laser system in order to perform the procedure. There are also high variable costs to perform each procedure. We have to pay three staff (not counting the physician), use the ultrasound continusously, and use cosumable laser fibers/supplies. These variable costs add up to at least $600 just for salaries and supplies. It will take many many of these procedures to recover our investment.

Submitter : **Dr. Mark Isaacs** **Date: 10/05/2006**

Organization : **Vein Specialists of N. Calif.**

Category : **Physician**

Issue Areas/Comments

Background

Background

There is no question that making these revisions will limit the number of physicians willing to accept Medicare patients, thus limiting this population's access to needed medical care.

GENERAL

GENERAL

CMS-1321-P
Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2007 and other Changes to Payment Under Part B
Proposal dated August 8, 2006

I am responding to the CMS proposal of 8/8/06 regarding the proposed changes in the physician fee schedule for CPT 36478 and CPT 36479 Endovenous Laser Ablation.

I have reviewed the proposed 2007 fully implemented, non-facility practice expense (PE) RVUs for CPT codes 36478 and 36479 and find several issues of great concern:

1. RVUs have consistently been reduced from 2005 levels:
a. 2006: 46.91
b. 2007: 43.53
c. 2008: 40.84

CMS guidelines for this procedure require the use of a vascular technician, expensive equipment and skilled assistants. Expenses for all of these items rise as Medicare reimbursement continues to fall. It will be impossible to continue to provide this treatment under CMS guidelines under proposed reimbursement rates.

2. 3. Values for codes 36475 and 36476, radiofrequency vein ablation have been consistently higher that those for laser ablation:
a. 2006: 51.5
b. 2007: 47.77
c. 2008: 44.52

Each of these technologies are comparable especially when we look at both the initial capital acquisition cost ($37,900 for laser and $25,000 for RF) and the, per patient supply costs ($360 for laser and $750 for radiofrequency for the procedure kits PLUS disposable sterile supplies such as drapes, gowns, Anesthetic solution, IV bags and tubing to name just a few). While the per patient supply cost may be slightly higher for 36475 (radiofrequency ablation), the significantly higher acquisition cost for 36478 (laser ablation) raises the overall physician s cost of delivering the service to the same level (possibly even higher).

I would request that the fully implemented, non-facility practice expense RVU remain at the 2006 rate for 36475 of 51.5 and that the RVU for 36478 be increased to this same level.

I would be happy to discuss this further with members of your committee.

Sincerely,
Mark N. Isaacs, M.D.

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see general comment below

Provisions of the Proposed Rule

Provisions of the Proposed Rule

see general comment below

Submitter : **Dr. Stuart Glassman** **Date: 10/06/2006**

Organization : **Carolina Surgeons**

Category : **Physician**

Issue Areas/Comments

Background

Background

The proposed changes in reimbursement and the need for a certified vascular ultrasound technician will absolutely cripple access to the important and often life changing procedure of endovenous laser ablation of incompetent saphenous veins. This is a clear case of legislation designed to limit or even ration health care for our nations seniors. It is a shameless sham proposed in the name of money savings and improved care, but it is clearly designed to drastically curtail access to this procedure. Our costs for doing the procedure go up almost daily. We actually save money for patients and the government by doing most of these procedures as outpatients in our offices. If we are forced to have only very expensive certified vascular ultrasound technicians to do a test that I normally do myself, I will not be able to afford to do this in my office. Rather I will have to bring these cases to the hospital OR and have their techician assist me. Your proposal will have succeeded in elevating the total cost of the procedure by triple or more. It's simply senseless to make these rules and these cuts in reimbursement.

GENERAL

GENERAL

If these cuts in reimbursements and new rules mandating impossibly expensive techniques they will certainly limit access to a life changing technology for many patients. This is nothing more than health care rationing no matter how it's cloaked.
Shame!

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CMS-1321-P
Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2007 and other Changes to Payment Under Part B
Proposal dated August 8, 2006

I am responding to the CMS proposal of 8/8/06 regarding the proposed changes in the physician fee schedule for CPT 36478 and CPT 36479 Endovenous Laser Ablation.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

This new technology and techniques have been a godsend to many patients.

CMS-1321-P-478

Submitter : **Dr. Mark Kim** **Date: 10/06/2006**

Organization : **MultiCare**

Category : **Physician**

Issue Areas/Comments

Background

Background

Making these revisions as proposed will impact negatively on the Medicare populations access to quality health care. The reduction in reimbursement rates will ultimately limit access to physicians who perform these treatments.

GENERAL

GENERAL

CMS-1321-P
Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2007 and other Changes to Payment Under Part B
Proposal dated August 8, 2006

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As you know, the 2007 Medicare Physician Fee Schedule is already scheduled for a 5.1% across the board cut in reimbursement. Additionally, there are proposed cuts for non-invasive vascular imaging (vascular ultrasound). All these cuts will cripple the ability of physicians to perform this extremely important procedure and ultimately result in a loss of access to care for Medicare beneficiaries.

2. The proposed conversion factor (CF) for 2007 has been reduced from 2006, thus further decreasing reimbursement for endovenous laser treatment.

3. Values for codes 36475 and 36476, radiofrequency vein ablation have been consistently higher that those for laser ablation:
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I would request that the fully implemented, non-facility practice expense RVU remain at the 2006 rate for 36475 of 51.5 and that the RVU for 36478 be increased to this same level.

I would be happy to discuss this further with members of your committee.

Respectfully submitted,

Mark Kim, MD,RVT
735 12th St. SE
Auburn, WA 98002
mskimmd@hotmail.com

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See General Comment below.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

See General Comment below.

Submitter : Dr. Scott Plantz

Date: 10/06/2006

Organization : Dr. Scott Plantz

Category : Physician

Issue Areas/Comments

Background

Background

At what point do I go out of business? I ask myself this question every day. I am a phlebologist and take care of people suffering from painful varicose veins and severe leg ulcers. I have figured my total cost per patient and it comes out to about $1700 (malpractice, staff, kits, rent, etc.). Medicare currently pays about $1900 and private health insurance $2100. My partner and I treat about 30 patients a month working five days a week. Our personal income is down to about $3000 each a month and malpractice and insurance costs doubled again this year! For two months, we received 0 salary. I am currently working during the week in our vein clinic and weekends moonlighting in the Emergency room. I am happy the government wants to save money but the simple reality is that you can't keep increasing expenses while decreasing revenue.

GENERAL

GENERAL

Why can't Medicare focus some of its efforts on lowering our costs? What if Medicare patients could only sue us for a maximum of $100,000. That would cut our malpractice by $50,000 a year and then we could afford to do procedures for a lot less money. At some point I am hopeful that government wakes up. I love practicing medicine but at 46 years old I am looking for an alternative career. The tremendous stress of trying to make sure you are complying with all the Medicare rules, avoid commiting any error, and making sure all outcomes are 100% perfect is getting to be a bit much for $50,000 a year income.

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Further lowering of CPT 36478 (Endovenous Laser Ablation) will put us out of business.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

The other doctors in our area are already dropping the procedure because the costs associated with it are to high. Our office only takes care of vein patients. We are one of the few specialty offices that accepts insurance payments. Most demand cash because it is the only way they can cover their costs. Even with the economy of scale it is tough to do the procedure and come out ahead at our current rate. I am afraid if you decrease payment further, our practice will be the only group doing the procedure in a very large area of Florida. I am doubtful we will be able to afford staying in business if this change passes.