ASA Legislative Conference 2003

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For visitors to our nation's capital, Washington, D.C., stimulates a proud and patriotic feeling of historical reflection and political intrigue. From George Washington's Mount Vernon on the Potomac and the Custis-Lee Mansion atop Arlington Cemetery, to the somber Vietnam Wall, the District of Columbia area epitomizes the richness of American history. The familiar Lincoln and Jefferson Memorials and the Washington Monument remain stunning and majestic pieces of architecture that grace the Mall area from the Capitol Building to the Tidal Basin. The most recent addition to the lengthy list of tributes to legendary American figures is a memorial to those Japanese-Americans who, though wrongly interred during World War II in remote camps throughout the Western United States, volunteered and served with distinction in the armed forces, principally in the European theatre.

But it is still the complexities and the intrigue of the American political arena that provides the drama on a day-to-day basis in Washington, and it is that political process that ASA/CSA members annually attempt to influence.

Each year, the ASA Washington office, under the direction of the Director of Governmental Affairs, Michael Scott, J.D., orchestrates a three-day Legislative Conference for ASA members, usually in the month of April or May. This year, the meeting was held from Monday, May 5th, through Wednesday, May 7th. Among the seventeen individuals attending on behalf of CSA were its officers, including CSA President Patricia Dailey, M.D., President-elect H. Douglas Roberts, M.D., and those politically active members who are familiar with the political scene on Capitol Hill, many of whom have long-established, key-contact relationships with members of Congress. Also attending were CSA's Executive Director, Barbara Baldwin, and CSA's Legislative Advocate, William Barnaby, III, Esq., who, with his unflappable wife, Kristine Reed-Barnaby, Esq., a Deputy District Attorney from Stockton, made innumerable Congressional office visits in support of anesthesiologists in California. The total number of ASA members registered at the conference, and presumably pounding the halls of Congress, was more than 325.

The agenda for this conference usually consists of lectures and discussions on legislative and regulatory issues being considered at the national level, as well as some focused presentations on topics at the state level, such as recent developments in office-based surgery regulations. Key members of Congress or from

the administration frequently address the gathering. This year, among the more notable (or notorious, depending on your political allegiances) congressional speakers were Senator Hillary Rodham Clinton (D-NY) and Senator Elizabeth Dole (R-NC), both of whom spoke eloquently and authoritatively–but not together! Other speakers on the agenda included members of the House of Representatives, as well as Thomas Russell, M.D., the Executive Director of the American College of Surgeons. Two of the most informative lectures were given by ASA members, Dr. Hector Vila and Dr. Jeffrey Apfelbaum, who shared the dais on the subject of office-based surgery regulations. Dr. Vila's analysis of data collected on morbidity and mortality statistics in office-based settings in Florida revealed a striking increase in bad outcomes when no anesthesiologists were involved in the anesthesia care. Another excellent talk was given by Dr. Alex Hannenberg, chair of the ASA Committee on Economics, who explained with great clarity the actuarial complexities of Medicare's Physician Fee Schedule and the problems created by the use of the Sustainable Growth Rate (SGR) methodology to determine annual changes in the conversion factor.

Traditionally, the ASA Washington office prepares position papers on the various Congressional issues of importance to anesthesiologists and other physicians. Attendees of the conference are then asked to focus on one or two keys issues when visiting their Congressional representatives or their legislative aides. For many years, the key message to convey to our elected representatives was the importance of retaining the physician supervision of nurse anesthetists requirement under Medicare's Conditions of Participation for hospitals. Now that the supervision issue has moved to the states, other issues have garnered more attention. This year, lobbying efforts were directed at two specific issues: professional liability reform and physician reimbursement under Medicare.

Professional Liability Reform

In California, physicians have been blessed with the protections offered under the landmark legislation known as MICRA (Medical Injury Compensation Reform Act) passed in 1975 under a legislature ruled by Democrats, and signed into law by then-Governor Jerry Brown. This law has survived numerous legal challenges, and has offered a reasonable formula for damage recovery by patients when medical errors have occurred, while keeping malpractice premiums at a reasonable level. The rest of the country has not been so fortunate. Physicians in Florida, West Virginia, Pennsylvania, New York, and other

states are paying 300-400% as much in premiums for professional liability insurance.

Earlier this year, the House of Representatives narrowly (by a mere 33-vote margin) passed a bill, H.R. 5, introduced by Representative Jim Greenwood (R-Pa), which would provide professional liability reform for physicians across the country similar to the MICRA model. President Bush has publicly endorsed this legislation, as have most physician organizations. However, the bill remains controversial for a number of reasons, and, despite House approval, seems to be going nowhere in the Senate. Presently, the Senate does not have enough votes (60 needed) to bring its version of tort reform legislation (S. 607) to the floor of the Senate chamber. In general, Republicans have voted for tort reform, and the Democrats have voted against. Some have interpreted this as Republicans being sympathetic to the doctors' plight, and Democrats being in the back pockets of the trial lawyers. But wait! There is more to this story!

H.R. 5 and California's MICRA have some significant differences, the most important of which is breadth of coverage. MICRA in California offers protection for physicians only. H.R. 5, the Greenwood Bill, would provide limited liability protection not just for physicians, but also for pharmaceutical companies, manufacturers of medical products, nursing homes, and health insurers. In some ways, physicians have become the "poster-children" for this bill, and yet it is the corporate entities that may benefit the most. When asked if he would carve out the corporate coverage from the bill in order to assure tort reform for physicians, Congressman Greenwood was non-committal. Is there a hidden agenda here? Time will tell.

The second issue of contention on H.R. 5 is the preservation of the cap on non-economic losses ("pain and suffering"). In Sacramento, CSA and CMA have been successful in preventing the trial lawyers from increasing the cap beyond the original figure of $250,000. Also instrumental in holding the line of the cap issue has been CAPP (Californians Allied for Patient Protection), supported by many physician and patient advocacy organizations. With this figure remaining unchanged for 28 years, some legislators feel that an increase in the cap and/or implementation of a cost of living adjustor is long overdue. There are also many members of Congress who support a higher cap figure (e.g., $500,000) for this very reason. In actuality, payments for economic losses including medical expenses, lost wages, rehabilitation, etc. have far surpassed the rate of inflation since the inception of MICRA. In addition, the $250,000 cap is seldom reached in medical malpractice cases. It is ironic that when MICRA

was first conceived, many individuals, including Governor Brown, felt that there should be no provisions for non-economic losses at all.

Some members of the House, who originally voted for H.R. 5 with the $250,000 cap seem to be "soft" on the current cap limit. Even Senator Feinstein, in offering to introduce a bill similar to H.R. 5 in the Senate, initially supported a $250,000 cap. She later joined forces with Senator/Dr. Bill Frist, the Majority Leader of the Senate, to suggest that a $500,000 cap was not a big deal. They were wrong! It IS a big deal, and when Senator Feinstein received a vote of no-confidence from the CMA, she withdrew from the issue with some degree of embarrassment. For physicians in California, an increased cap would be devastating. It has been suggested by some professional liability carrier actuaries that such an increase in the cap could result in a 20-40% increase in premiums for physicians. For anesthesiologists paying $8,000 to $14,000 per year, premiums could cost another $1,600 to $5,000 per year (conceivably, that could amount to an increase in premiums collected from anesthesiologists within the state totaling as much as $125,000,000). Obstetricians now paying $40,000 per year could find premiums increased by as much as $15,000 annually. For some physicians, this could be enough incentive to leave practice or leave the state, thus creating an access-to-care problem. The irony of this situation is that many physicians across the country, including many colleagues attending the ASA Legislative Conference, who do not now have tort reform in their states, would gladly settle for a MICRA-like bill with a $500 K cap. For California physicians, it might be better if no bill on tort reform were passed by the Congress at all.

Physician Reimburement under Medicare

Last year, the Centers for Medicare and Medicaid Services (CMS–formerly HCFA), announced that physicians caring for Medicare beneficiaries would experience another 4.4% reduction in reimbursement in 2003, this despite a 5.4% cut in 2002. In response, many physicians completely withdrew from the Medicare program, while others changed their status from "participating providers" to "non-participating." Congressional leaders all agreed that something needed to be done. Eventually, in early January, House Ways and Means Chairman Bill Thomas (R-CA) proposed actuarial re-calculations of the SGR, eliminating two major formula miscalculations in previous years (1998 and 1999 enrollment projections). The net result of this recalculation was an overall 1.6% increase for the year 2003, as well as projections of continued small increases for years to come. This solution was implemented on March 1, 2003. (It should be noted that the 2003 conversion factor for anesthesia services

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reflected an additional positive adjustment of 1.1% thus a total 2.7% increase as a result of CMS's partial acceptance of ASA's argument that the "work" component under RBRVS was undervalued).

But, soon thereafter, CMS incredibly announced that they had re-calculated their estimates for 2004, and, contrary to their predictions submitted a few weeks earlier, they projected a 4.2% reduction in physician reimbursement for 2004! The problem lies in the use of the SGR methodology which is designed to predict changes in the cost of providing physician services while at the same time adjusting any updates to stay within expenditure targets. The SGR methodology requires that any updates must factor in growth in services (volume targets including "behavioral offsets"), changes in the Gross Domestic Product (GDP), and outpatient drug costs. With predictions of a growth in services to Medicare beneficiaries and an increase in the cost of outpatient drugs, and with economic figures reporting a declining GDP, the Medicare conversion factor continues in a downward spiral. This has become a no-win situation, as physicians are the only category of Medicare providers who are subject to such actuarial schizophrenia. Updates for other categories are based on the inflation of costs, not the SGR system.

Like the rest of the House of Medicine, ASA's request to Congress is to eliminate the SGR methodology, at least the impact of the GDP and outpatient drug costs. It is clear that CMS is unwilling to make that change. While members of Congress uniformly nod in agreement with the plight of the doctors, no legislation has been introduced to offer such relief. With a war effort to fund, a growing budget deficit, promises of a pharmaceutical benefit for seniors, and the legislative mind-set to reduce taxes, there seems to be little left over to increase physician reimbursement.

Perhaps someday Congress will decide to build a monument on the Mall to America's physicians!

CMA Physician's

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