

ASA Legislative Conference 2005

By R. Lawrence Sullivan, Jr., M.D., ASA Director California

The Annual Meeting of the ASA Legislative Conference was held at the J.W. Marriott Hotel in Washington, D.C., from May 2-4, 2005, and, like last year, it was attended by over 400 politically inspired anesthesiologists, including 33 enthusiastic residents, representing 46 state component societies and the District of Columbia (the only states not represented were Alaska, Hawaii, Idaho, Mississippi, and South Dakota). The Illinois Society of Anesthesiologists sent 23 of its members, the highest total of any delegation. Representing anesthesiologists in the Golden State of California were CSA President Linda Mason, M.D., President-Elect Edgar Canada, M.D., Immediate Past President H. Douglas Roberts, M.D., ASA Alternate Director J. Kent Garman, M.D., as well as Michael Champeau, M.D., Linda Hertzberg, M.D., Mark Singleton, M.D., Christine Doyle, M.D., Norman Levin, M.D., Jack Moore, M.D., Rebecca Patchin, M.D., Kenneth Pauker, M.D., Michele Raney, M.D., Earl Strum, M.D., CSA's CEO, Barbara Baldwin, and yours truly, for a total of 16 individuals. This meeting often creates a logistical challenge for CSA's representatives. It has been our goal each year to visit every office of California's congressional delegation which numbers 53 in the House of Representatives and two in the Senate. Although not always being able to meet with an elected member, I want to commend resourcefulness and perseverance of CSA's delegation for having visited every office, in most instances having met with the "member" and/or his or her legislative aide on health (often of greater value).

The first two days of the conference were intended to bring practicing physicians up to speed on the specifics of the numerous health-related issues which are currently before the Congress or the various regulatory agencies. On the third day, attendees traveled to Capitol Hill to meet with members of Congress or their legislative assistants. As part of the initial agenda, ASA's new Director of Governmental and Legal Affairs, Ronald Szabat, J.D., LL.M., provided a detailed explanation and assessment of the most pressing issue for physicians: the physician fee schedule under Medicare and the inequities of the Sustainable Growth Rate formula (SGR) which is used to update such fees annually. This was Mr. Szabat's first year at the helm of ASA's Washington office, having previously spent several years with the AMA. His presentation was excellent, and it revealed his extraordinary knowledge on the complex subject of physician fee updates and the SGR, which, for some, is likened to an actuary's nightmare. The rest of the agenda consisted of various governmental speakers, including representatives of the Bush administration as well as members of the House and the Senate,

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Democrats and Republicans alike. All of these individuals displayed in-depth understanding of health-related matters, and they were quite familiar with the controversy surrounding physician reimbursement under Medicare and the looming risks regarding access to care for Medicare beneficiaries. While attendees heard various and sometimes contradictory viewpoints on health care delivery, the speakers portrayed a vivid picture of the political realities involved in providing government subsidized health care in the United States.

Physician Fee Schedule under Medicare

Contrary to previous years when attendees were directed to address three or four issues of importance to anesthesiology, this year there was a singular focus: the critical dilemma of physician reimbursement under the Medicare system. Earlier this year, the Centers for Medicare and Medicaid Services (CMS) estimated that the 2006 Medicare physician fee schedule update will be a **negative** 4.3 percent. Negative updates are also anticipated for the next six to eight years. At the same time, the Bush administration has announced that it intends to reduce federal money for state run Medicaid (Medi-Cal) programs by roughly \$10 billion over five years. The irony is that the government appears to be balancing the budget on the backs of physicians and, at the same time, creating a scenario in which private health plans, which use the Medicare fee schedule as a basis for physician reimbursement, would enjoy windfall profits.

The goal of this meeting was not only to gain increased reimbursement for physicians in 2006, but also to expunge the SGR formula altogether. As many individuals are aware, the SGR has been used for nearly eight years as a unique methodology to determine adjustments to payments for physician services under Medicare Part B. The problem with the SGR is two-fold. First, the annual update is determined using several factors within the SGR formula, one of which is the Gross Domestic Product (GDP)—as the economy goes up, payments go up; if the economy goes down, so does Medicare payments. The second is the impact of other benefits under Part B on physician payments such as the cost of prescription drugs, hospital outpatient services, durable medical equipment, home health care, and recent changes that will provide some preventative health care benefits for seniors, as well as the increased cost of the new Medicare Advantage plan. As the Bush administration is struggling with a deficit budget, all fiscal adjustments are predicated on a budget neutral basis. As a result, physicians, the key providers to America’s seniors, have found themselves at the bottom of the health care food chain.

The problems in Medicare are not just related to a deficit budget. With Republican control of the White House and both houses of the Congress, there is a

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concerted effort to redefine entitlement programs such as Social Security and Medicare. This vision was vividly described by Senator Jim DeMint (R-SC) who suggested that Medicare should no longer be seen as a “defined benefit” health plan for seniors, but rather as a “defined contribution” plan for which the government would have limited liability. The administration’s efforts to promote the Medicare Advantage plan reflects that approach. Presenting the Democratic viewpoint to the attendees was Congressman Frank Pallone (D-NJ) who chairs the Democratic Health Leadership Caucus. His priority is not only keeping Medicare solvent, but also creating incremental relief for 43 million Americans without health insurance. But with a deficit budget, increased benefits such as prescription drugs, and no new money, the long-term survival of Medicare is questionable. For many congresspersons, both Democrat and Republican, there is a fatalistic sense that the sooner a crisis in Medicare occurs, the sooner the real future of Medicare and provision of health care for all Americans will be resolved.

Members of Congress are aware of the frustration that physicians are currently experiencing. Community anesthesiologists are collecting 25 cents on the dollar when caring for Medicare’s beneficiaries. Academic anesthesia programs are collecting half of that amount! It is only a matter of time before a critical threshold is reached when physicians will refuse to care for these patients. However, one congressional staffer claimed that the number of Medicare “participating” (par) physicians has actually increased by two percent, a fact that would dispel any unhappiness on behalf of Medicare providers. In fact, the real reason that more physicians have switched from “non-par” to “par” is that patients are pocketing Medicare payments sent directly to them, and because more groups are integrating or consolidating in a structure in which “par” status becomes a good marketing tool and easier to manage.

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It is also both sad and ironic that Medicare (and private payers) have enabled hospitals to remain solvent, while physicians struggle to survive on a Medicare fee schedule that has not kept pace with inflation. The largest item on any hospital’s expense sheet is labor costs. It is common in California hospitals for senior registered nurses to earn in excess of \$100,000 per year (not including benefits) based on a 40-hour workweek. The point is that the methodology by which hospitals receive periodic updates is different, and it has accommodated cost of living adjustments for the hospital labor force. Such is not the case for doctors, many of whom, especially in office-based practices, struggle to earn six figure incomes.

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At the time of the Legislative Conference, no legislation addressing physician reimbursement under Medicare had been proposed. There have since been two bipartisan companion bills introduced in the Congress, both of which are titled the Preserving Patient Access to Physicians Act. H.R. 2356 and S. 1081 would mandate that Medicare increase physician payments by at least 2.7 percent in 2006 and it would scrap the entire SGR formula in favor of a new formula which would be based on the Medicare Economic Index with a productivity adjustment factor. While these proposals offer some hope, the devil is in the details, especially finding new dollars in a budget which is already in the red. As in previous years, any Congressional solution will most likely occur late in the year. It remains essential that physicians contact their Congressional representatives to emphasize the importance of this issue.

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Medicare Teaching Rule

In previous visits to Congress, there has been much attention given to this subject. Currently, in academic anesthesiology programs, when one faculty member is supervising two residents administering anesthesia to Medicare patients, that anesthesiologist can only bill for half the usual fee on each case. This has created an enormous loss for many academic departments, averaging \$450,000 across the country, with some larger programs experiencing losses in the range of \$1-2 million per year. Last year, ASA was assured by CMS that this *inequity*, which does not apply to surgeons, would be corrected. However, such was not the case. ASA continues to work with CMS on this delicate issue with the added support of key members of the House and Senate.

Reimbursement Parity for Anesthesia Services

Since the implementation of the Medicare fee schedule in 1992, reimbursement for anesthesia services has been undervalued compared to other specialties. Nationwide, anesthesia payments under Medicare run 30 to 40 percent of what is paid by private insurers. In California, it is even less, in some cases 20 to 25 percent. Other specialties are reimbursed by Medicare at 60 to 80 percent of commercial rates. Last year, many members of the House signed on to a resolution asking the General Accounting Office (GAO) to evaluate the extent and impact of this disparity. This study by the GAO remains in progress.

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Extending the “Rural Pass-Through” to Anesthesiologists

Under CMS regulations, there exists a provision that allows hospitals in rural communities, which have low surgical volumes (less than 800 cases per year), to be reimbursed under Medicare Part A for anesthesia services on a reasonable cost “pass-through” basis. This rule is intended to enable the availability of anesthesia care in such settings. However, this provision applies only to CRNAs! In some rural settings, CRNAs are offered multiples of six-figure contracts by hospitals which can then collect this money from Medicare. Anesthesiologists attempting to practice in such locales are left collecting paltry Medicaid and Medicare fees under Part B, which pales in comparison to CRNA income. ASA is seeking legislative relief of this *inequity*.