# CSA Board of Directors Meeting

## Los Angeles, January 2008

*By Kenneth Y. Pauker, M.D., Chair, LPAD; Associate Editor,* CSA Bulletin

The landscape of regulatory, legislative, and economic issues that challenge our profession continues to evolve. Powerful forces imperfectly informed about the realities of actually caring for patients seek to compel us to behave in ways we never could have imagined when we contemplated becoming physicians. There are, of course, many national issues that require the expertise and resources of the ASA—restoring full Medicare funding for teaching programs, gaining payment parity under Medicare, fixing the Medicare Sustainable Growth Rate update formula, extending rural pass-through to anesthesiologists, adopting improved antitrust legislation and P4P. Needless to say, the CSA devotes considerable resources to these ASA efforts.

However, there also are state-specific issues. These often are jointly addressed with the CMA, but sometimes need to be developed and driven by the CSA itself—Medi-Cal OB billing rules, payment for non-contracted services, statewide health insurance reform proposals including a single-payer system, Workers' Compensation fee schedules, credentialing for deep sedation, insurance industry abuses, and the heretofore seemingly unadulterated pro-industry Department of Managed Health Care behavior. These state-specific issues call for coherent CSA philosophic principles as well as strategic practical approaches.

CSA's LPAD is charged with communicating with governmental and private entities, "which have or will have a substantial impact upon the professional, medical and/or economic day-to-day practice of anesthesiology," and through dialogue with these parties, advocate for the benefit of CSA members. In addition to year long electronic and telephonic discussion groups, LPAD meets face-to-face twice each year to develop and to digest issues to present to the CSA BOD for action.

This January, the CSA BOD and Legislative and Practice Affairs Division held a special weekend retreat that sought "to create a synergistic opportunity for LPAD and the CSA BOD to examine in detail some important aspects of anesthetic practice in California, and to develop potential plans of action for the benefit of CSA members." The goal was to examine selected critical topics

in depth, beginning with an informative overview on each topic, followed by a keynote address to place all of the issues under one umbrella, and then completed with small group breakout sessions to develop ideas and begin vetting potential actions to be considered at the next CSA BOD meeting.

Topics covered were:

- Retreat Overview and California in Context—Dr. Ken Pauker
- Health Insurance in California—Dr. Jason Campagna
- Future Anesthetic Practice in California—Dr. Patricia Kapur
- Hospital Contracting, the M.D. Perspective—Dr. Mark Zakowski
- Hospital Contracting, the Professional Manager's Perspective—Mr. Dale Zeh, Jr.
- Keynote: The New Payers—Dr. Stan Stead

This issue of the *Bulletin* will provide a digested version of the first presentation. Additional informative articles from this retreat will be forthcoming in future issues.

## Economic and Political Forces Shaping Anesthetic Practice in California

*By Kenneth Y. Pauker, M.D.*

Health care reform is one of the most important topics discussed by politicians—both nationally and in our state—by business, by insurance companies, by individuals, and by the health care industry itself. There are multiple layers to the discussion, broadly falling into the areas of quality, access, and cost. As I prepared this snapshot of the interplay of economic and political forces here in California, what impressed me most is how California is unique in many ways amongst all of our United States—demographically, politically, economically—and then I came to appreciate that each state has its own context and that there is no "one-size-fits-all" national solution to our national problem. What may work well to improve quality/access/cost in some states will not help or even may degrade one or more of these areas in other states.

To this end, data concerning demographics and the economics of healthcare from California may be compared to national data, to some other illustrative data from other states, and to some other California data. The PowerPoint Presentation of this talk appears in the members-only section of the CSA Web Site. Please note that some of the data are from as early as 2005, some as late

as 2007, meaning that the numbers don't all add up. There are also multiple sources, mostly governmental but also the California Healthcare Foundation and some newspaper articles (this was not intended to be an academic treatise, so references are omitted). Going forward, it is anticipated that the CSA will compile an up-to-date, fully referenced compendium of this sort of information, which will be informative to our members and useful in educating the public, legislators, and regulators. Insurers already appreciate much of what is relatively novel information for our members. Hopefully, having this data readily available will help level the playing field for our CSA members in their contract negotiations with large insurance companies. That being said, let me preface what follows with an important caveat:

> *There are three kinds of lies:*
> *Lies, damned lies, and statistics.*
> —Attributed to Benjamin Disraeli; Popularized in U.S. by Mark Twain

California is the seventh largest economy in the world with a projected Gross Domestic Product (GDP is defined as the total market value of all of the goods and services produced within that geographic location) in 2007 of $2.373 trillion—17% of the U.S. GDP of $13.96 trillion. Health care spending in California was 11% of California GDP in 2004 and 10.5% in 2007 (projected). U.S. national healthcare spending was 13% of national GDP in 2004 and 16.2% in 2007 (projected). Healthcare spending in Western Europe in 2003 was in the range of 7-11% of GDP (the U.S. was then 15.2%), highest in Germany at just under 11% and Switzerland at 11.5%. Per capita spending on health care in California in 2007 is estimated at $6,598, 12% less than the national figure of $7,498. In 2004, per capita spending on health care in Massachusetts was 126.5% of the national average, and 144% of California! In 2006, even before the new Massachusetts legislation intending to provide insurance coverage for all its citizens, health care spending in Massachusetts was 20.6% of Massachusetts GDP!

> *The first takeaway message is that health care spending varies dramatically from state to state. One might attempt to analyze or rationalize why this is so, but that it is so strongly suggests that economic forces manifest themselves to variable degrees in different states and that a "national solution" to what some have characterized as unsustainable spending on health care in the U.S. as compared to western Europe may be more beneficial in some states, more detrimental in others.*

Within California's population of 37.7 million, HMOs insure 47.5% (17.9 million); Medicare, 10.9% (4.1 million), of which 32.2% are in HMOs; Medi-Cal, 17.5% (6.6 million), of which 50% are in HMOs; and 18.4% (6.9 million)

are uninsured. This contrasts with national figures (population 301 million) for HMOs, 24.5% (72.2 million); Medicare, 14.3% (43.0 million), of which 14.2% are in HMOs; Medicaid, 15.1% (45.4 million); 63% HMO; and uninsured, 15.5% (46.6 million). In California, there are higher percentages of uninsured and Medi-Cal, and a lower percentage of Medicare patients. HMO penetrance is almost double the national average, and Medicare HMO enrollment is more than double the national average.

| | California | United States |
|---|---|---|
| Gross Domestic Product (GDP) | $ 2.373 Trillion (17% of U.S.) | $ 13.96 Trillion (Projected 2007) |
| Health Care Spending | $ 249 Billion | $ 2.262 Trillion (p 2007) |
| | 10.5% of GDP (est. 2007) | 16.2% of GDP (p 2007) |
| | 11.0% of GDP in 2004 | 13.0% of GDP in 2004 |
| Spending Per Capita | $ 6,598 est. | $ 7,498 (CHCF, p 2007) |
| | $ 4,638 (CMS 2004, 12% < U.S.) | $ 5,283 (CMS 2004) |
| **In 2004, MA per capita spending on health care was 126.5% of U.S. and 144% of California. In 2006, MA spending on health care was 20.6% of MA GDP!** | | $ 3,972 (Utah) |
| | | $ 8,239 (D.C.) |
| | | $ 6,682 (MA) |
| Cost of Living | 135.9 (#49 CA) | 100 |
| | 88.1 (#1 TN) | |
| | 164.4 (#51 HI) | |
| | 137.0 (#50 D.C.) | |

*The next take away is that HMOs "control" a huge fraction of California patients. This fact presumably emboldens the California Association of Physician Groups (CAPG), a trade group which is a coalition of managed care groups (including Alta Bates Medical Group, Sacramento; Beaver Medical Group, Redlands; Cedars-Sinai Medical Group, Beverly Hills; Children's Physicians Medical Group, San Diego; Greater Newport Physicians Medical Group, Newport Beach; Loma Linda University Health Care, Loma Linda; Memorial HealthCare IPA, Signal Hill; Mills-Peninsula Medical Group, Burlingame; Monarch HealthCare, Mission Viejo;*

*Permanente Medical Group, North, Oakland; San Diego Physicians Medical Group, La Jolla; San Jose Medical Group, San Jose; Sharp Community, Sharp Mission, and Sharp Rees-Stealy Medical Groups, San Diego; Southern California Permanente Medical Group, Pasadena; Sutter Health Foundations & Affiliated Groups, Sacramento; UC Davis and UCLA Medical Groups and many more—from the CAPG Web Site at <http://www.capg.org/home/index.asp?page=50>), to claim that it represents and speaks for organized medicine in California.*

| | **California State Market** | **United States National Market** |
|---|---|---|
| Population | 36.5 million | 300 million |
| Uninsured | 18.4% | 15.1% |
| HMO | 49.1% | 24.5% |
| Age > 65 | 10.7% | 12.4% |
| Medicare | 10.9% | 14.3% |
| Medicare Managed Care | 32.2% | 14.2% |
| Medicaid | 17.5% | 15.1% |
| Medicaid Managed Care | 50.0% | 63.0% |
| Medicaid Payments Per Recipient | $ 2,740 (#50)<br>$ 3,143 (# 49 TN) | $ 4,639<br>$ 8,052 (#1 DC)<br>$ 8.050 (#2 ME) |

*CAPG is closely allied with the California Association of Health Plans (CAHP), another trade group that represents HMOs and health plans. Both the CMA and state specialty societies see CAPG as "fronting" for CAHP, with whom it is closely allied on virtually ever issue concerning managed care. CAPG repeatedly asserts that it represents physicians who treat patients and therefore has patients' well being uppermost in mind. It seems much more plausible that CAPG is an agent of the HMOs and a fiscal intermediary more than a group of treating physicians. When CAPG and CAHP take the same side on legislative issues, as they invariably do, their common profit-making motive is cleverly disguised and minimized.*

*CAPG no more speaks for its patients than it does for its contracted doctors, both of whom not infrequently dispute vigorously the substantive assertions of CAPG, as well as the view that having a contract with one of its member IPA or HMO entities somehow implies that CAPG can speak on their behalf. CAPG wraps itself in the mantle of the huge numbers of patients who are connected to it like a game of "telephone," and makes assertions about cost and quality, which at the end of the day are more about maximizing profits for its member businesses, than improving the lot of either its contracted physicians or its covered patients.*

*CAPG aids HMOs immeasurably by making it appear to both the legislature and the lay public that the physician community, the very House of Medicine, is divided, and that HMOs are really not all that bad.*

*Therefore, the critical importance of DMHC in reining in abuses by HMOs becomes clearly manifest. In this regard, DMHC has a long history (and perhaps this is beginning to change because of intense pressure from many quarters) of being a weak regulatory body. In this regard, it is interesting to note that a number of DMHC officials have left to take important positions with both CAHP and CAPG in past years. For example, the present CAPG chief lobbyist was a DMHC attorney before joining CAPG. Similar situations exist with respect to CAHP. While the law technically bars departing state officials from lobbying the agency they left for one year, they are free to lobby other agencies, such as the legislature, and they continue to have friends and former colleagues within the DMHC bureaucracy, and with whom they share a common mindset.*

*The uninsured and those with Medi-Cal are almost 36% of the population. Attempting to enroll the uninsured in programs comparable to Medi-Cal (like SCHIP—State Childrens Health Insurance Program) will greatly amplify the issues of inadequate Medi-Cal payment rates. It is not a stretch to assume that the reason that the average annual income of California anesthesiologists is so much less than that in other areas of the country is related to the HMO industry in California.*

California state Medi-Cal payments per recipient (#50) are 59% of the national average ($2,740 compared to $4,639). The next lowest state (#49) is Tennessee, $3,143, and the highest are D.C., $8,052, and Maine, $8,050. The federal sharing ratio (federal match) varies from 50.0% to 70.0% and is determined by the average income per state. California has a small number of very wealthy individuals and this raises the average significantly, despite the large number of people with marginal incomes. Hence, in California, the federal match is 50.0% or 1:1. This means that when California spends $2,740, the federal government adds $2,740, bringing the total spending per Medi-Cal recipient to approximately $5,500. Of the ten most populous states, California has the highest Medi-Cal enrollment (6.4 million), the highest expenditures ($35.5 billion), the lowest expenditures per eligible ($5,535), and the lowest percentage of Medicaid as a percent of the state budget (18.4%).

Figure HHS-06

**Federal Medicaid Program – Interstate Comparisons**
**Ten Most Populous States**
**Fiscal Year 2006-7**

| Pop. as of 7/1/06 (millions) | Medicaid as % of State Budget | Average Monthly Eligibles as % of Pop. | Total Expen-ditures (millions) of $) | Medicaid Enrollment 6/06 (thousands) | Expen-ditures per Eligible | Federal Sharing Ratio (FMAP) |
|---|---|---|---|---|---|---|
| All States | 21.1 | 14.2 | $308,801 | 42,555 | $ 7,257 | |
| CA (36.5) | 18.4 | 17.7 | $ 35,488 | 6,411 | $ 5,535 | 50.0 |
| TX (23.5) | 26.4 | 12.0 | $ 19,841 | 2,801 | $ 7,084 | 60.7 |
| NY (19.3) | 28.7 | 21.7 | $ 32,388 | 4,177 | $ 7,754 | 50.0 |
| FL (18.1) | 19.8 | 12.1 | $ 14,574 | 2,185 | $ 6,670 | 58.9 |
| IL (12.8) | 28.4 | 14.1 | $ 13,686 | 1,805 | $ 7,582 | 50.0 |
| PA (12.4) | 31.1 | 15.1 | $ 17,671 | 1,877 | $ 9,414 | 55.1 |
| OH (11.5) | 25.9 | 14.0 | $ 14,137 | 1,601 | $ 8,830 | 59.9 |
| MI (10.1) | 21.4 | 14.5 | $ 9,233 | 1,460 | $ 6,324 | 56.6 |
| GA (9.4) | 20.8 | 14.2 | $ 7,219 | 1,326 | $ 5,444 | 60.6 |
| NC (8.9) | 26.2 | 13.3 | $ 9,614 | 1,179 | $ 8,154 | 63.5 |

California spends $47,486 per year on each State prison inmate, $11,732 of which is on health care. This is 24.7% of the prison budget spent on health care, and the number will only increase as inadequate medical care in prisons is addressed with additional mandates by courts.

*The final takeaway is that California state spending per patient on Medi-Cal is far lower than in other states, and a mere fraction of what the state spends on health-care for even state prison inmates. There is a long history of underfunding this program in California, and, with the current budget crisis in Sacramento, state spending across the board is proposed to be reduced by 10%, which includes a 10% reduction in Medi-Cal physician payment rates. Given the huge numbers of uninsured—substantial numbers of whom, depending on state and national politics, might qualify for Medi-Cal or related programs (e.g., SCHIP)—one can only envision an imminent collapse of access to the "safety net," as practitioners increasingly*

*decline to participate in a Medi-Cal program with payment rates that will now be substantially less than the totally inadequate rates that were in effect before the current budget shortfall. It appears that, going forward, it will become increasingly important to find a way to remedy inadequate state Medi-Cal funding.*

| | State of CA | CA Prisons | Medi-Cal |
|---|---|---|---|
| Population | 37,700,000 | 179,000 | 6,600,000 |
| CA Total Spending | $ 128.4 billion<br>$ 101.6 billion (GF) | $ 8.5 billion | $ 14.6 billion (State Gen. Fund) |
| Total Spending per capita | $ 3,405 | $ 233 | $ 387 (CA) |
| Total per recipient | xxx | $ 47,486 | $ 2,212 (CA) |
| Healthcare Spending | $ 249 billion | $ 2.1 billion | $ 37.6 billion (State + Fed Match) |
| Healthcare per capita | $ 6,605 | $ 57.53 | $ 997 (Total) |
| Healthcare per recipient | xxx | $ 11,732 | $ 4,697 (Total) |

## 2007-2008 GASPAC Honor Roll

The 2007-2008 GASPAC Honor Roll is posted on the CSA home page in the Hot Topics section at **www.csahq.org**. Keep in mind that in June 2008, the dues statements for FY 2008-2009 will be mailed, and you will have an opportunity to make the list for next year by making your donations when you receive the dues statement. Those members whose names have asterisks next to them are the Gold Level contributors. That is, they have given at least $500 this year to GASPAC, and of course, the CSA encourages every member to become a Gold Level contributor.