

Federal Health Care Reform



We've Come to Here, and Now What?

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Federal health care reform (HCR) continues to be extremely difficult to follow—and even more difficult to make sense of. As Chair of the CSA Legislative and Practice Affairs Division, it in part falls to me to try at the very least to provide some commentary, a “snapshot” if you will, for CSA members on the process, the potential outcomes, and how your professional organizations have been laboring on your behalf to try to influence the shape of what may come. It almost goes without saying that this is all a moving and evolving target, specific proposals changing on almost a daily basis, and consequently my perspectives intend to focus largely on the big picture. The situation even may develop in such a way that much of what I say may be irrelevant by the time this piece is published. Nonetheless, consider these points:

1. HCR in the Congress is an attempt to remake one-sixth of the American economy with extremely complex legislation, widely disparate bills having passed the House (HR 3962 and HR 3961) and Senate (HR 3590, a House title because of its financial provisions). HR 3962 is over 2,000 pages long, and it does contain some provisions that will help reign in insurance abuse, increase the percentage of the insured using insurance exchanges, and perhaps even incentivize quality (if you believe that P4P works, and the CSA as a matter of policy has rejected this approach). As ASA President, Dr. Hannenberg points out, it also “incorporates critically important changes sought by the ASA that delink provider payments through the public plan from Medicare rates.” While it is not entirely clear what their members actually prefer with respect to the complexities of HCR, the ASA and AMA urged a “yes vote,” *which both parse as being different from support*, because of the politics involved in successfully changing some important provisions, and for fear of being disenfranchised from later negotiations in a possible House-Senate Joint Committee.
2. Senate bill HR 3590, extensively revised with Senator Reid’s manager’s amendments, passed on Christmas Eve with a 60-39 margin, squeaking past the required cloture margin on a party line vote. It is also more than 2,000 pages, has several items harmful to anesthesiology and other specialties,

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and the ASA issued an alert to its members to lobby Senators against the bill. The ASA and a host of medical societies, including a comprehensive surgical coalition, formally urged this bill to be rejected as written. The AMA supported the bill, although asking for revisions.

3. Dr. Hannenberg, in his December 22 letter to Senator Reid, reiterated ASA's opposition to achieving reform "based on across-the-board cuts and new fees on Medicare physician Part B services," and further lamented the lack of any SGR fix (the House passed HR 3961 to address this). He praised elimination of several egregious provisions (a Medicare buy-in for practitioners for one, and an expansion of Medicare—and thus Medicare payment rates—to those over 55 for another), but expressed strong opposition to the idea of a Medicare Independent Payment Advisory Board with proposed sweeping powers and "unfettered authority" to set payment rates. He also rejected Section 2706 that would "prohibit health plans from distinguishing among widely varying health care providers acting within the scope of that provider's license." This would confuse patients about the "greatly differing levels of education, skills and training among health care professionals. Further, this language inappropriately interjects civil rights concepts into well-established state scope of practice laws."
4. Beyond just the provisions and the unintended consequences of whatever final version may pass, interpretation by regulatory agencies will be fraught with novel and arcane construals and processes for physicians which will further complicate their relations with their patients.
5. The entire debate about the "public option" seems to have crystallized into one about an eventual single payer governmental or quasi-governmental run system of care. A "good public option" appears destined to morph over time into a single payer system. The House version of this in HR 3962 provides for negotiated fees, but how would that work if the government is the one with whom you are negotiating? One Senate version had folks over 55 able to join Medicare, and indeed, would have been a huge public option! It may be that some few CSA members, and perhaps many ASA members (particularly in states like Massachusetts), and likely many AMA members, particularly those in primary care, crave a single payer system, and would be ecstatic about Medicare for all, but this would be lethal to the practice of anesthesiology because of our 33 percent Medicare reimbursement rate.
6. The 60-vote cloture margin in the Senate to move HR 3590 to the floor for passage was accomplished with remarkable political "horse trading," including some very specific rewards for the states of some Democratic Senators. The next step is supposed to be a joint reconciliation committee to produce a single merged bill for both chambers to vote on once again. However, some pundits have predicted that the "merging" may occur

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behind closed doors and within the Democratic caucus so as to avoid “delays” and “filibustering” by Republicans. Therefore, whether the ASA or any interest group will have genuine access to the legislators during their deliberations remains a bit speculative. There are many contentious issues, beyond what is most important to us as anesthesiologists, like how exactly to pay for the reform and federal funding for abortion, and cloture will again need to pass muster in the Senate, unless the dire measure of “reconciliation” is invoked at the last instant.

7. There has been significant push back from the AMA House of Delegates and the ASA Board of Directors concerning the process involving how policy, and even political strategy, is decided. There is little doubt that the ASA and CSA leadership does “get it” in terms of what our membership wants and needs, and appreciate that effective communication is deserved by their members as the channels required to accomplish this continue to be developed.
8. The HCR process at times seems so disconnected from our daily lives, so disenfranchising in how the politics work, and so anxiety producing because so much of it is beyond our control. It feels particularly galling that an attempt at comprehensive HCR does not even adequately begin to address the costs of defensive medicine or the massive expenditures on non-beneficial care. However, participate we must, and at this stage it is critical to follow the directions of our national leaders as they issue action alerts to contact legislators. Congressmen and even Senators do tally calls and e-mails, and focused communication does make a difference.
9. Politics is all about access to those legislators who are supposed to represent us. Without question, we influence what happens by whom we elect. Political Action Committees endeavor to influence the election process, help constituents develop relationships with their legislators, and seek to gain better access to them in order to present our issues and argue our case.
10. Support GASPAC, and get politically involved with the ASA as well. Without them and the professional lobbyists we engage to follow and interpret what is happening, we would have virtually no power. We do in fact have meaningful clout, skill, and access, but we shall just have to see what happens next.
11. The debate about Health Care Reform will not end with whatever happens now from this Congress. Never has a program of this social scope been passed in such a partisan manner. America is extremely polarized and much will be refined, adjusted, re-reformed, and developed. To quote Yogi Berra, “It ain’t over till it’s over.”