Point/Counterpoint on the Health Care De

What Does the Ne Mean to Physici

The ASCRS' positions on current health care legislation.

BY ROGER F. STEINERT, MD, AND PRISCILLA P. ARNOLD, MD,
ON BEHALF OF THE EXECUTIVE COMMITTEE OF ASCRS

For more than a year, in anticipation of the debate on health care reform, the ASCRS has been working in conjunction with the surgical coalition, as well as the Alliance of Specialty Medicine, to identify the key principles of health care/Medicare reform that we could support and the lack of which we would oppose. The coalition comprises more than 20 surgical specialty organizations and the American College of Surgeons. We have also made it clear during this time that our mission is to advocate for sound federal health care policy that fosters patients' access to the highest quality of specialty care and that improves their timely access to high-quality medical care. These considerations have formed the basis for our advocacy activity and policy. Within that framework, the first priority for the ASCRS has been the same for many years: the repeal of the flawed sustainable growth rate formula (SGR). The SGR has threatened Medicare physician reimbursement for the past 7 years and will continue to do so until fundamental reform occurs.

In furthering these principles, we have worked with both the House of Representatives and the Senate during the past year. The ASCRS provided substantive comments and input at various stages on those health reform provisions that especially concern surgical/specialty physicians.

Top Priorities:
- Fix the SGR: repeal and replace the formula with one that provides positive updates for physicians. Physicians are facing a 21.2% reduction in Medicare reimbursement on January 1, 2010, with additional cuts for several years
- Opposition to the formation of the Independent Medicare Advisory Commission or a similar non-elected entity empowered to determine coverage and practice
- Opposition to a primary care bonus based on budget-neutral funding
- Opposition to a punitive Physician Quality Reporting Initiative (PQRI) (penalties for not participating)
- Support of patients' access to and choice of specialty physicians

Other Issues Identified by ASCRS:
- Insurance reform
- Liability (tort) reform

Issues With No Fixed Position Taken in Advance:
- Funding structure for reform
- "Public Plan" option—other than insisting that participation must not be a mandatory requirement for Medicare participation. (We share the concerns of our members and are carefully monitoring the potential problems as the situation develops.)

HOUSE AND SENATE HEALTH CARE REFORM LEGISLATION

House of Representatives

In November 2009, after committee debate and consideration, the House of Representatives introduced its reconciled version of health care reform, HR 3962, the Affordable Health Care for America Act, and a separate bill that repeals and replaces the SGR, HR 3961, the Medicare Physician Payment Reform Act. The House leadership and committee staff listened to our concerns, and as a result, all of our top priorities were addressed positively in the House bill. We were also aware that the Senate legislation would not be favorable in our key areas of concern, despite the same year-long discussion and input.

The House leadership assured the physician commu-

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ew Legislation ans and Patients?

The ASCRS should not have backed HR 3962 and 3961.

BY JOHN F. DOANE, MD

I believe the decisions by the AAO and ASCRS to support HR 3962, the Affordable Health Care for America Act, and HR 3961, the Medicare Physician Payment Reform Act, are shortsighted choices. They do not bode well for solving short-, intermediate-, and long-term issues with health care delivery in the United States. The very names of these resolutions make the skin on the back of my neck crawl, because they foreshadow the Marxist Socialist Pogroms likely in store for us as patients and providers. How anyone could support more socialism from the US government is beyond my comprehension. Medicare and Social Security are bankrupt. It is as if an infinity of wrongs can some how make it right. There are more than $100 trillion in unfunded liabilities (cost of social security, Medicare, and Medicaid going forward) as of spring 2009 per Dallas Federal Reserve President Richard Fisher.[1] The financial costs of socialism started 80 years ago by President Franklin D. Roosevelt in the New Deal Reform and the unbridled costs created 45 years ago with President Lyndon B. Johnson's Great Society Reforms are now coming home to roost. We need less socialism, not more!

HISTORY

With the advent of Medicare under the auspices of President Johnson in 1965, the estimates have been so far off target one would think the estimators were blind, spun round and round, and then asked to successfully pin the tail on the "cost donkey." In 1967, the House Ways and Means Committee predicted that the new Medicare program in its entirety, which was begun the prior year, would cost about $12 billion in 1990. The actual Medicare spending in 1990 was $110 billion[2]—off nearly by a factor of 10.

WHAT IS HAPPENING TODAY?

Since 1990, Medicare spending has grown steadily in both absolute terms and as a percentage of the federal budget. This is evident from fiscal year 2007, when total Medicare spending reached $440 billion, or 16% of all federal spending.[3] Medicare was a pay-as-you-go program from the very beginning. Mysteriously, social spenders have selective recall for the built-in cost-containment mechanisms they championed en route to convincing the citizenry and the legislators that their social program would be fiscally responsible and not lead to monstrous financial overruns. History has shown repeatedly that costs are underestimated by many multiples. These social programs cannot and do not have cost containment due to evolving possibilities from medical scientific invention and the increasing wants of individual citizens who are not directly responsible for nor knowledgeable about the actual cost of the delivered care.

Notably, the 2009 US deficit is larger than the combined federal debt of the first 2 centuries of this country's existence ($1.4 trillion), and the 2010 deficit is projected to be bigger at roughly $1.5 trillion.[4,5] I say, let the 21% physician reimbursement cuts occur, and let it begin with me! I would much rather get the blood-letting done now than continue going back to the abuser time and time again only to be ill treated following the annual efforts of the AAO, ASCRS and other "physician-representing" organizations. Physicians, ophthalmologists in particular, get beaten up collectively every year, yet we continue to believe the downward-spiraling path of reimbursement is the one to stay on.

The US government's track record of cost containment is nonexistent. Furthermore, the socialized purchasing mechanisms it uses are not subjected to the cost containment that can be achieved in a true free market system, where the real

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nity that it intended to pass both bills and viewed the repeal and replacement of the SGR as essential to any meaningful health care reform. The ASCRS Executive Committee, therefore, felt that it was important to support the House legislation so that, if the health care reform legislation ever makes it to a final Senate-House conference on a final bill destined to become law, the House would stand firm on its position related to our key issues. As a result, the ASCRS sent a letter of support of both bills indicating that we viewed them as joint and integral to moving forward with health care reform.

Senate

The Senate Finance Committee has jurisdiction over Medicare physician payment. Unfortunately, at the outset, it released "option papers" on our key priority issues that were in direct opposition to our position. Throughout the entire year, in an effort to maintain a "seat at the table," we provided thoughtful input through our collaborations with the various coalitions and did not threaten opposition to the Senate Finance Committee bill, as the full committee considered it—even though no changes were made to address any of our concerns.

Once the Senate Finance Committee bill was debated and amended by the full committee, and it became even worse with the potential for further reductions in reimbursement, the ASCRS joined the surgical coalition on a letter dated November 4, 2009, that stated we would oppose a final Senate bill if it included those provisions by the Finance Committee. The letter indicated the need to address these concerns to ensure that any final health care reform package would be built on a solid foundation and in the best interest of our patients. Compounding the situation was the fact that the Senate leadership, with very short notice to the physician community, held a vote on a separate SGR bill that would have repealed, but not replaced, the flawed formula, and it failed.

Despite the communication signed by more than 20 surgical specialties, the final Senate Health Care Reform Bill and the Patient Protection and Affordable Care Act failed to adequately address our concerns. As a result, the ASCRS recently joined 19 surgical specialty groups with a letter that refers to the November 4, 2009, letter and states our opposition to the bill as currently written. We also signed a similar letter from the Alliance of Specialty Medicine. Both letters outline the issues of concern, cite a few positive aspects of the bill, and conclude with a commitment to working with the Senate to make the changes that are vital to ensuring that the legislation is based on sound policy and will have a long-term positive impact on patients' access to safe and effective high-quality surgical care.

It is important to note the differences between the two bills (House vs Senate) to further illustrate the reasoning behind the ASCRS Executive Committee's position and strategy. The following sections present a breakdown of the House versus the Senate bill on the key provisions affecting ophthalmology.

> "The House bill (HR 3961) eliminates the 21% cut as well as the debt that has accumulated."

SGR REFORM

The Senate bill includes a 1-year, short-term patch to prevent the 21% cut but, as a result, creates further reductions in the future. The House bill (HR 3961) eliminates the 21% cut as well as the debt that has accumulated. Instead, 2010 Medicare physician payments would be updated based on the Medicare Economic Index. After 2010, there would be two separate targets for physician services: one for evaluation and management services and another for all other services. Annual updates would be based on the Gross Domestic Product plus 2% and Gross Domestic Product plus 1%, respectively.

Most recently the Senate voted to support a 60-day in the scheduled 21.2% physician payment cut. There is no longer a proposed 1-year fix, and in the bill currently there is no long-term fix for the SGR formula.

INDEPENDENT MEDICARE ADVISORY BOARD

The Senate bill establishes the Independent Medicare Advisory Board, which would initiate broad changes to the Medicare program with limited Congressional input. This measure is not included in the House bill.

PQRI

The Senate bill mandates participation in the flawed PQRI program with penalties for not participating. In the House bill, the PQRI remains voluntary, and bonus payments are extended through 2012.

PRIMARY CARE AND RURAL GENERAL SURGERY BONUS PAYMENTS

The Senate bill provides bonus payments to primary care and rural general surgeons funded through reductions in payment to all other physicians. The House bill provides a bonus payment that is not paid for by cuts to other physicians.

The language now states that this will not be budget-

neutral (ie, not by reductions in payments to other providers).

VALUE-BASED PURCHASING MODIFIER

The value-based purchasing modifier was added during the Senate Finance Committee's deliberation. The Senate bill creates a budget-neutral, value-based payment modifier, which the Centers for Medicare & Medicaid Services do not have the capability to implement and creates an unrealistic and unachievable timeline. This modifier is not included in the House bill.

After the most recent Senate vote, value-based purchasing language has been added to the bill for ambulatory surgery centers.

EXCISE TAX ON ELECTIVE COSMETIC MEDICAL PROCEDURES

This measure was added by the leadership during the development of the final merged Senate bill. The Senate bill initiates taxation of elective cosmetic medical procedures and places physicians in the role of tax collector. The tax is not included in the House bill.

After the recent Senate vote, however, this tax was eliminated.

NEXT STEPS AND OUR STRATEGY MOVING FORWARD

The House legislation (HR 3961 and HR 3962) passed the House of Representatives in November 2009. As this article goes to press, the Senate bill is currently being debated on the Senate floor and changes daily. The final reconciled health care bill has not yet been written. There are still opportunities to effect change, as the final House and Senate bills will have to be reconciled through a conference committee and brought back to both bodies for approval before the legislation goes to the President for his signature. It remains to be seen how quickly this process will be accomplished or if it can achieve a comprehensive overhaul of the entire health care system.

The ASCRS is not committed to any promised future support and will be evaluating each step as it develops. Our current plan of action is to continue to work with the surgical/specialty community to alter the language of the Senate's legislation with respect to our priorities. When the final amended Senate bill goes to the Senate floor for a vote, we will evaluate it based upon the criteria of our principles and priorities for a decision of opposition, support, or no action. We believe that our decision to support the House legislation, which addresses all of our priorities in a favorable manner and illustrates our support for meaningful national health care reform, puts us in the best position to improve and strengthen the final legislation that is signed into law.

PERSPECTIVES

Many—perhaps most—members and leaders of the ASCRS would not choose to make massive health care reform a legislative priority at this time. Nor would they choose gargantuan bills with implications that exceed intelligent analysis. The political reality is that a single dominant party in both the Senate and House has partnered with a same-party President to make health care reform (a marketing term) a top priority. We are well aware that the issue on the table is medical care insurance, not the broader issue of health that remains unaddressed, even though poor personal health choices are a major driver of medical costs.

One option is just to say no, and many physicians believe in that choice. Individuals have the freedom to pick up their toys and leave the playground by opting out of Medicare. As a societal action, however, just saying no leaves our members who serve the elderly and continue to participate in Medicare with no voice in national decision making.

Alternatively, we can accept the current political reality and make the best of it. Physicians' opinions are given little weight in the proposed legislation. The ASCRS has supported, among others, Tom Coburn, a US Senator (R, Oklahoma), and physician whose health legislation proposals have not been adopted. Ophthalmology, despite its realtively small size, exercises a disproportionately influential voice but does so within a politically marginalized medical community.

ASCRS chooses to work on behalf of its members by positively and forcefully remaining part of the process. None of the current bills will be the final outcome. Once final legislation is determined, the ASCRS' leadership will use its best judgment about what support, if any, to give to the proposed final law. ■

The members of the ASCRS Executive Committee are Priscilla Arnold, MD; David Chang, MD; Alan Crandall, MD; I. Howard Fine, MD; Edward Holland, MD; Douglas Koch, MD; Stephen Lane, MD; Richard Lindstrom, MD; Nick Mamalis, MD; Stephen Obstbaum, MD Bradford Shingleton, MD; Roger Steinert, MD; and R. Doyle Stulting, MD, PhD. Nancey McCann, the director of government relations for the ASCRS, has contributed greatly to the ASCRS' strategy and to this summary.

Priscilla P. Arnold, MD, is the chair of the Government Relations Committee of the ASCRS. Dr. Arnold may be reached at prisarnold@gmail.com.

Roger F. Steinert, MD, is the Irving H. Leopold professor and chair and director of the Gavin Herbert Eye Institute at the University of California, Irvine. Dr. Steinert may be reached at steinert@uci.edu.

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value of services can be arrived at when two individuals reach a mutual agreement on what a fair price of the valued service is. Unfortunately, with President Johnson's Great Society Medicare program, markedly inflated prices for services have been experienced in the United States, but that could have been avoided. For the AAO and ASCRS to support HR 3962 and 3961 is tantamount to enabling a drunk to keep on drinking. Maybe the effort is well intentioned, but it does not achieve any long-term good for physicians or for individual patients' care. In fact, it jeopardizes the well-being of both. Expanding the same basic system to an additional 30 to 50 million Americans and to promise cost savings to the point of creating budget surpluses with or without marked rationing defines clinical delirium. Ostensibly, the AAO and ASCRS made a "going along to get along " decision. Going with the herd is not what our leadership should be doing. Trying to defy the 21% reimbursement cut will only continue the chains-that-bind strategy employed during the last 20 years by most physician-organization decision makers. Going after the "flawed" sustainable growth rate (SGR) formula that was the basis of the original divide and conquer of physicians with the institution of the resource-based relative value system again is a short-, intermediate-, and long-term folly.

WHAT QUESTION TO ASK

How Is Medicare Working for Physicians?

We ophthalmologists need to ask ourselves the following question: Is the current Medicare status quo working for physicians in America? If we consider the devaluation of physician services during the last 25 years a victory, then the decisions by the AAO and ASCRS make sense. Do the executive committees of these organizations believe Congresswoman Nancy Pelosi (D, California) has physicians' best interests at heart?

How About a Different Approach?

Getting rid of the flawed SGR formula does nothing long term. The central planning bureaucrats will develop another conversion factor that will be just as flawed. To think otherwise is naïve. Our system is socialized and will always have a finite amount of financial resources, yet our leaders at the national level (enabled by the US Treasury) believe our budget can pay for infinity. The leaders on the left are simply buying votes so the appearance of everything for everyone is a de facto part of the bribe. If we were practicing medicine today, like when President Johnson brought us Medicare, we could pay for it. It is important to understand that the average life expectancy in 1965 was 69.7 years of age, so just fewer than 50% of citizens died before they received a dime in benefits. In 1965, we did not have effective cures for cancer or cardiac stents, we had minimal transplantation and joint replacements, and IOLs were not in fashion. We can credit and blame human innovation and scientific research. The unlimited options can never be funded by any financial system long term and certainly not by a socialized system. Taxes and cuts to physician reimbursement will never be enough. Eventually, the vise will squeeze device and pharmaceutical companies, and innovation will stop. Would anyone be surprised if the central bureaucracy rationed expensive unproven cures or opted not to reimburse for high-risk procedures?

Why Do Physicians Continue the Price and Wage Control Game of the Central Government?

We cannot talk about pricing due to antitrust concerns. Yet, Medicare sets reimbursement rates, and miraculously private third-party payers benchmark off these price points. Is this not antitrust? US physicians signed on to socialism in 1965 with its inherent reimbursement whipsaw. It was lucrative for 20 years but after that all downhill.

SOLUTIONS

Much like the Centers for Medicare & Medicaid Services' decision on premium IOLs and the current approach to elective refractive surgery, removing the limiting charge would be the single biggest thing the ASCRS, AAO, AMA, and other medical organizations could do for practicing physicians. I recall reading that Charles Kelman, MD, said something like, "I as the inventor of phacoemulsification get reimbursed the same amount as the worst surgeon in America or the least experienced new resident graduate." To me, this is the biggest joke of the system.

Would Congress ever allow the limiting charge to disappear, or must it retain price control? Until the Congressional Balanced Budget Act of 1997, physicians could collect the difference between what Medicare paid and the cost of the care. The effect of Congressional/third-party payers' intrusion between patients and physicians is always initially innocent but eventually turns pernicious. Whether or not the health care "control" bill passes, removing the limiting charge so third parties can pay their base amount and patients and physicians can let the free market determine or find the value of services could have many benefits. If the patient values receiving care from an internist or surgeon extraordinaire, both parties will be happy. If a doctor will take Medicare assignment only with no charge to the patient, everyone receives care, and all should be happy. The person who wants to pay zero still gets care, and the patient who wants the freedom to purchase premium services can do so from the doctor of his or her choice.

For me, to lock providers into strict price controls is a principal negative of a socialized system (be it government

or private insurance) in that physicians have no external incentive to provide excellent care at all hours of the day. To allow providers to balance bill for what we perceive our services are worth makes sense to me. It also allows us to hire staff, give them benefits, and provide cost-of-living increases in line with inflation to retain employees.

The goal should be to let patients pay market value for our services, with Medicare only setting a base. Let the real free market, free enterprise cost of goods be established, as it has for LASIK, the price of which has not risen for the last 14 years. In contrast, societal medical costs have gone up each year, but we are getting much less in 2009 for cataract surgery than we were in 1995 when laser vision correction was approved.

Steadfastly disagreeing with the administration is totally appropriate in this case. Two statements by President Barak Obama should make clear the administration's position on the value of physicians. The first is, otolaryngologists will take out tonsils to make money instead of giving antibiotics as the first try. The second is that orthopedic surgeons make $50,000 per amputation (the real surgeon's fee is approximately $750.00).[6] Be it ignorance on the president's part, (ie, not knowing what he speaks), as I believe it is, or a direct reflection of how the Democratic Party views physicians' labor, the ultimate value patients place on physician's services could and would be determined in the marketplace of two parties—the patient and the physician.

I would suggest that the ASCRS, AAO, the American College of Surgeons, and other medical organizations push to remove limiting charges across the board. I would also like our leadership to respect the will of the majority of their associations' dues-paying members. Neither the AAO nor ASCRS polls its membership in situations such as this one, and they did not for this specific situation. If either would have, my guess is that a different stance would have been taken. Less socialism, not more, is the proper remedy. ■

John F. Doane, MD, is in private practice with Discover Vision Centers in Kansas City, Missouri, and he is a clinical assistant professor for the Department of Ophthalmology, Kansas University Medical Center. Dr. Doane may be reached at (816) 478-1230; jdoane@discovervision.com.

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